

Chapter 388-15 WAC

CHILD PROTECTIVE SERVICES

DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER

WAC

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- 388-15-010 Definition of service goals. [Statutory Authority: RCW 74.08.090, 81-20-063 (Order 1708), § 388-15-010, filed 10/5/81; 78-09-098 (Order 1335), § 388-15-010, filed 9/1/78; Order 1238, § 388-15-010, filed 8/31/77; Order 1088, § 388-15-010, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-15-020 Eligible persons. [Statutory Authority: RCW 74.12.340, 87-22-091 (Order 2552), § 388-15-020, filed 11/4/87. Statutory Authority: RCW 74.08.090, 81-18-045 (Order 1697), § 388-15-020, filed 8/28/81; 81-10-013 (Order 1645), § 388-15-020, filed 4/27/81; 81-01-087 (Order 1581), § 388-15-020, filed 12/19/80; 80-02-049 (Order 1477), § 388-15-020, filed 1/16/80; 79-01-041 (Order 1360), § 388-15-020, filed 12/21/78; 78-09-098 (Order 1335), § 388-15-020, filed 9/1/78. Statutory Authority: RCW 43.20A.550, 78-04-004 (Order 1276), § 388-15-020, filed 3/2/78; Order 1238, § 388-15-020, filed 8/31/77; Order 1204, § 388-15-020, filed 4/1/77; Order 1171, § 388-15-020, filed 11/24/76; Order 1147, § 388-15-020, filed 8/26/76; Order 1124, § 388-15-020, filed 6/9/76; Order 1120, § 388-15-020, filed 5/13/76; Order 1088, § 388-15-020, filed 1/29/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-15-030 Rights of applicant for services. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5, 96-20-093, § 388-15-030, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 81-09-058 (Order 1640), § 388-15-030, filed 4/20/81; 79-08-112 (Order 1420), § 388-15-030, filed 7/31/79; Order 1238, § 388-15-030, filed 8/31/77; Order 1147, § 388-15-030, filed 8/26/76; Order 1088, § 388-15-030, filed 1/19/76.] Repealed by 98-07-041, filed 3/12/98, effective 4/12/98. Statutory Authority: RCW 74.08.090 and 1997 c 409 § 209.
- 388-15-100 Services offered by the economic and social services office of the bureau of social services. [Order 1088, § 388-15-100, filed 1/19/76.] Repealed by Order 1238, filed 8/31/77.
- 388-15-110 Information and referral services. [Statutory Authority: RCW 74.08.090, 84-15-059 (Order 2125), § 388-15-110, filed 7/18/84; 82-11-095 (Order 1811), § 388-15-110, filed 5/19/82; Order 1238, § 388-15-110, filed 8/31/77; Order 1088, § 388-15-110, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-15-120 Adult protective services. [Statutory Authority: RCW 74.08.090, chapters 74.34 and 26.44 RCW and 42 USC 1397 and 3058, 97-21-108, § 388-15-120, filed 10/20/97, effective 11/20/97. Statutory Authority: RCW 74.08.090, 91-01-096 (Order 3116), § 388-15-120, filed 12/18/90, effective 1/18/91; 86-20-017 (Order 2426), § 388-15-120, filed 9/22/86; 85-13-059 (Order 2239), § 388-15-120, filed 6/18/85; 84-17-071 (Order 2141), § 388-15-120, filed 8/15/84; 80-16-025 (Order 1562), § 388-15-120, filed 10/30/80. Statutory Authority: RCW 43.20A.550, 78-04-004 (Order 1276), § 388-15-120, filed 3/2/78; Order 1238, § 388-15-120, filed 8/31/77; Order 1088, § 388-15-120, filed 1/19/76.] Repealed by 00-03-029, filed 1/11/00, effective 2/11/00. Statutory Authority: RCW 74.08.090, 74.34.165, and 74.39A.050(9).
- 388-15-130 Child protective services—Authority. [Statutory Authority: RCW 74.15.030, 89-07-024 (Order 2773), § 388-15-130, filed 3/8/89. Statutory Authority: RCW 74.08.090 and 1979 c 155, 79-10-026 (Order 1431), § 388-15-130, filed 9/10/79. Statutory Authority: RCW 74.08.090, 78-09-098 (Order 1335), § 388-15-130, filed 9/1/78; Order 1238, § 388-15-130, filed 8/31/77; Order 1088, § 388-15-130, filed 1/19/76.] Repealed by 02-15-098 and 02-17-045, filed 7/16/02 and 8/14/02, effective 2/10/03. Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW.
- 388-15-131 Child protective services—Special requirements for Indian children. [Statutory Authority: RCW 74.08.090 and 1979 c 155, 79-10-026 (Order 1431), § 388-15-131, filed 9/10/79; Order 1255, § 388-15-131, filed 12/1/77.]

- Repealed by 02-15-098 and 02-17-045, filed 7/16/02 and 8/14/02, effective 2/10/03. Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW.
- 388-15-132 Child protective services—Acceptance of reports—Eligibility for services and limits to authority. [Statutory Authority: RCW 26.44.050 and 26.44.070. 93-13-021 (Order 3567), § 388-15-132, filed 6/9/93, effective 7/10/93. Statutory Authority: RCW 74.15.030. 89-07-024 (Order 2773), § 388-15-132, filed 3/8/89. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-15-132, filed 9/10/79; Order 1238, § 388-15-132, filed 8/31/77.] Repealed by 02-15-098 and 02-17-045, filed 7/16/02 and 8/14/02, effective 2/10/03. Statutory Authority: RCW 74.13.031, 74.04.-050, and chapter 26.44 RCW.
- 388-15-134 Child protective services—Notification. [Statutory Authority: RCW 74.15.030. 97-13-002, § 388-15-134, filed 6/4/97, effective 7/5/97; 89-07-024 (Order 2773), § 388-15-134, filed 3/8/89. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-15-134, filed 9/10/79; Order 1238, § 388-15-134, filed 8/31/77.] Repealed by 02-15-098 and 02-17-045, filed 7/16/02 and 8/14/02, effective 2/10/03. Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW.
- 388-15-136 Central registry—Duty to maintain. [Statutory Authority: 1987 c 206. 87-23-057 and 87-24-039 (Orders 2561 and 2561A), § 388-15-136, filed 11/18/87 and 11/25/87. Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-15-136, filed 9/10/79; Order 1238, § 388-15-136, filed 8/31/77.] Repealed by 93-13-021 (Order 3567), filed 6/9/93, effective 7/10/93. Statutory Authority: RCW 26.44.050 and 26.44.070.
- 388-15-137 Central registry—Reports. [Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-15-137, filed 9/10/79; Order 1238, § 388-15-137, filed 8/31/77.] Repealed by 87-23-057 and 87-24-039 (Orders 2561 and 2561A), filed 11/18/87 and 11/25/87. Statutory Authority: 1987 c 206.
- 388-15-138 Central registry—Information—Release—Dissemination—Expungement. [Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-15-138, filed 9/10/79; Order 1238, § 388-15-138, filed 8/31/77.] Repealed by 87-23-057 and 87-24-039 (Orders 2561 and 2561A), filed 11/18/87 and 11/25/87. Statutory Authority: 1987 c 206.
- 388-15-139 Central registry—Eligibility—Procedures and criteria. [Order 1238, § 388-15-139, filed 8/31/77.] Repealed by 87-23-057 and 87-24-039 (Orders 2561 and 2561A), filed 11/18/87 and 11/25/87. Statutory Authority: 1987 c 206.
- 388-15-140 Residential services. [Statutory Authority: RCW 74.08.044. 79-09-039 (Order 1425), § 388-15-140, filed 8/17/79; Order 1238, § 388-15-140, filed 8/31/77; Order 1147, § 388-15-140, filed 8/26/76; Order 1088, § 388-15-140, filed 1/19/76.] Repealed by 86-16-019 (Order 2392), filed 7/28/86. Statutory Authority: RCW 74.08.-044.
- 388-15-145 Residential care discharge allowance. [Statutory Authority: RCW 74.42.450 and 74.08.090. 96-09-035 (Order 3962), § 388-15-145, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 86-10-021 (Order 2367), § 388-15-145, filed 5/1/86; 79-12-028 (Order 1456), § 388-15-145, filed 11/16/79.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-150 Child foster care. [Order 1238, § 388-15-150, filed 8/31/77; Order 1088, § 388-15-150, filed 1/19/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
- 388-15-160 Adoption services. [Order 1238, § 388-15-160, filed 8/31/77; Order 1088, § 388-15-160, filed 1/19/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
- 388-15-170 Definitions. [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-170, filed 10/22/98, effective 11/22/98. Statutory Authority: RCW 74.12.340 and 45 CFR Part 98.41 Child Care and Development Block Grant. 93-10-021 (Order 3535), § 388-15-170, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.12.340 and 45 CFR 98.20, 98.30, 98.43 and 98.45; and 45 CFR 257.21, 257.30, 257.31 and 257.41. 92-11-062 (Order 3393), § 388-15-170, filed 5/19/92, effective 6/19/92. Statutory Authority: RCW 74.08.090. 88-24-023 (Order 2732), § 388-15-170, filed 12/2/88; 86-12-051 (Order 2387), § 388-15-170, filed 6/3/86; 86-03-078 (Order 2333), § 388-15-170, filed 1/22/86; 83-02-028 (Order 1931), § 388-15-170, filed 12/29/82. Statutory Authority: RCW 43.20A.550. 82-14-048 (Order 1839), § 388-15-170, filed 6/30/82. Statutory Authority: RCW 74.08.090. 82-01-051 (Order 1735), § 388-15-170, filed 12/16/81; 81-10-034 (Order 1650), § 388-15-170, filed 4/29/81; 80-15-010 (Order 1552), § 388-15-170, filed 10/6/80. Statutory Authority: RCW 43.20A.550. 78-04-004 (Order 1276), § 388-15-170, filed 3/2/78; Order 1238, § 388-15-170, filed 8/31/77; Order 1204, § 388-15-170, filed 4/1/77; Order 1147, § 388-15-170, filed 8/26/76; Order 1124, § 388-15-170, filed 6/9/76; Order 1120, § 388-15-170, filed 5/13/76; Order 1088, § 388-15-170, filed 1/19/76.] Decodedified by 99-15-076, filed 7/20/99, effective 7/20/99. Recodedified as 388-165-110.
- 388-15-171 Subsidized child care for teen parents. [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-171, filed 10/22/98, effective 11/22/98.] Decodedified by 99-15-076, filed 7/20/99, effective 7/20/99. Recodedified as 388-165-120.
- 388-15-172 Day care participation. [Statutory Authority: RCW 74.08.090. 80-15-010 (Order 1552), § 388-15-172, filed 10/6/80. Statutory Authority: RCW 43.20A.550. 78-07-021 (Order 1306), § 388-15-172, filed 6/15/78.] Repealed by 82-04-074 (Order 1757), filed 2/3/82. Statutory Authority: RCW 74.08.090.
- 388-15-173 Parent participation day care. [Statutory Authority: RCW 74.08.090. 82-14-046 (Order 1837), § 388-15-173, filed 6/30/82.] Repealed by 86-03-078 (Order 2333), filed 1/22/86. Statutory Authority: RCW 74.08.-090.
- 388-15-174 Subsidized child care for seasonal workers. [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-174, filed 10/22/98, effective 11/22/98.] Decodedified by 99-19-087, filed 9/17/99, effective 9/17/99.
- 388-15-175 Child care for child protective services (CPS) and child welfare services (CWS). [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.-0903. 98-22-008, § 388-15-175, filed 10/22/98, effective 11/22/98.] Decodedified by 99-15-076, filed 7/20/99, effective 7/20/99. Recodedified as 388-165-140.
- 388-15-176 In-home/relative child care. [Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-176, filed 10/22/98, effective 11/22/98.] Decodedified by 99-15-076, filed 7/20/99, effective 7/20/99. Recodedified as 388-165-235.
- 388-15-180 Migrant day care services. [Order 1088, § 388-15-180, filed 1/19/76.] Repealed by Order 1147, filed 8/26/76.
- 388-15-190 Day care for the aged—Age 60 and over. [Order 1238, § 388-15-190, filed 8/31/77; Order 1088, § 388-15-190, filed 1/19/76.] Repealed by 97-18-052, filed 8/28/97, effective 9/28/97. Statutory Authority: RCW 74.08.090 and 1997 c 409 § 209.
- 388-15-192 Long-term care services—Estate recovery procedures. [Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-192, filed 9/28/95, effective 10/29/95.] Repealed by 97-18-052, filed 8/28/97, effective 9/28/97. Statutory Authority: RCW 74.08.090 and 1997 c 409 § 209.
- 388-15-194 Home and community services—Nursing services. [Statutory Authority: RCW 74.09.520 and 74.08.090. 98-20-022, § 388-15-194, filed 9/25/98, effective 10/26/98. Statutory Authority: RCW 74.08.090, 74.09.-520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-194, filed 9/28/95, effective 10/29/95.] Repealed by 02-21-098, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. Later promulgation, see chapter 388-71 WAC.
- 388-15-196 Individual providers and home care agency providers. [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-196, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-196, filed 8/27/98, effective 9/27/98. Statutory Authority: RCW 74.04.050, 74.08.090, 74.39A.005, 74.39A.007, 74.39A.050 and 74.39A.070. 97-16-106, § 388-15-196, filed 8/6/97,

	effective 9/6/97. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-196, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-196, filed 9/28/95, effective 10/29/95.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	
388-15-19600	How do I apply to be an individual provider of an adult client? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19600, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19600, filed 8/27/98, effective 9/27/98.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	388-15-19670
388-15-19610	What requirements must an adult client's individual provider or a home care agency provider meet? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19610, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19610, filed 8/27/98, effective 9/27/98.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	388-15-19680
388-15-19620	How do I get paid as an individual provider? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19620, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19620, filed 8/27/98, effective 9/27/98.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	388-15-198
388-15-19630	Under what conditions will the department deny payment to an individual provider or a home care agency provider? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19630, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19630, filed 8/27/98, effective 9/27/98.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	388-15-200
388-15-19640	Does the individual provider or the home care agency provider have responsibilities in addition to the service plan? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19640, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19640, filed 8/27/98, effective 9/27/98.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	388-15-201
388-15-19650	What are the educational requirements for an individual provider or a home care agency provider? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19650, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19650, filed 8/27/98, effective 9/27/98.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	388-15-202
388-15-19660	Do all individual providers or home care agency providers have to take the fundamentals of caregiving training? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19660,	388-15-203
	filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19660, filed 8/27/98, effective 9/27/98, effective 9/27/98.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	
	Are there special rules about training for parents who are the individual providers of division of developmental disabilities (DDD) adult children? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19670, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19670, filed 8/27/98, effective 9/27/98.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	
	Are there special rules about training for parents who are the individual providers of non-DDD adult children? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842 and 74.39A.050. 99-03-041, § 388-15-19680, filed 1/14/99, effective 2/14/99. Statutory Authority: RCW 74.08.090, 74.09.520, 43.43.842, 74.39A.050, 43.20A.710, 42 C.F.R. 1002.210 and 42 C.F.R. 431.51. 98-18-037, § 388-15-19680, filed 8/27/98, effective 9/27/98.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	
	Home and community services—Client and provider responsibilities. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-198, filed 10/1/96, effective 11/1/96.] Repealed by 00-03-043, filed 1/13/00, effective 2/13/00. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830.	
	Health support services. [Order 1238, § 388-15-200, filed 8/31/77; Order 1147, § 388-15-200, filed 8/26/76; Order 1088, § 388-15-200, filed 1/19/76.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.	
	Long-term care functional eligibility. [Statutory Authority: RCW 74.39A.120, 74.39A.030, 74.09.520, 74.39A.110, [74.39A.]130 and 1998 c 346 § 205 (1)(c) and 206(3). 98-19-055, § 388-15-201, filed 9/15/98, effective 10/16/98. Statutory Authority: RCW 74.08.090, 74.09.035, [74.09.]520, [74.09.]530, 74.39A.110, [74.39A.]120 and [74.39A.]030. 98-04-026, § 388-15-201, filed 1/28/98, effective 2/28/98.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.	
	Long-term care services—Definitions. [Statutory Authority: RCW 74.09.520. 97-20-066, § 388-15-202, filed 9/25/97, effective 10/1/97. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-202, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-202, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.09.520, 74.39.005, 74.08.043 and 74.08.545. 93-06-042 (Order 3501), § 388-15-202, filed 2/24/93, effective 3/27/93.] Repealed by 02-21-098, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. Later promulgation, see chapter 388-71 WAC.	
	Long-term care services—Assessment of task self-performance and determination of required assistance. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-203, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-203, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.09.520, 74.39.005, 74.08.043 and 74.08.545. 93-06-042 (Order 3501), § 388-15-203, filed 2/24/93, effective 3/27/93.] Repealed by 02-21-098, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. Later promulgation, see chapter 388-71 WAC.	

388-15-204	Home and community services—Reassessment. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-204, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-204, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.09.520, 74.39.005, 74.08.043 and 74.08.545. 93-06-042 (Order 3501), § 388-15-204, filed 2/24/93, effective 3/27/93.] Repealed by 02-21-098, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. Later promulgation, see chapter 388-71 WAC.	8/13/90; 89-18-026 (Order 2852), § 388-15-209, filed 8/29/89, effective 9/29/89; 88-17-064 (Order 2674), § 388-15-209, filed 8/17/88; 88-06-088 (Order 2605), § 388-15-209, filed 3/2/88. Statutory Authority: ESHB 1221. 87-22-013 (Order 2550), § 388-15-209, filed 10/26/87. Statutory Authority: RCW 74.08.090. 86-12-040 (Order 2383), § 388-15-209, filed 5/30/86; 84-22-017 (Order 2165), § 388-15-209, filed 10/31/84; 83-21-007 (Order 2028), § 388-15-209, filed 10/6/83; 82-23-056 (Order 1904), § 388-15-209, filed 11/16/82; 81-18-045 (Order 1697), § 388-15-209, filed 8/28/81; 81-06-063 (Order 1618), § 388-15-209, filed 3/4/81.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.	
388-15-205	Long-term care services—Service plan development. [Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-205, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.09.520, 74.39.005, 74.08.043 and 74.08.545. 93-06-042 (Order 3501), § 388-15-205, filed 2/24/93, effective 3/27/93.] Repealed by 02-21-098, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. Later promulgation, see chapter 388-71 WAC.	388-15-210	Chore services for adults and families. [Order 1238, § 388-15-210, filed 8/31/77; Order 1147, § 388-15-210, filed 8/26/76; Order 1124, § 388-15-210, filed 6/9/76; Order 1088, § 388-15-210, filed 1/19/76.] Repealed by 81-06-063 (Order 1618), filed 3/4/81. Statutory Authority: RCW 74.08.090.
388-15-206	Volunteer chore services. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-206, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-206, filed 9/28/95, effective 10/29/95.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.	388-15-211	Chore services for families. [Order 1238, § 388-15-211, filed 8/31/77.] Repealed by 81-06-063 (Order 1618), filed 3/4/81. Statutory Authority: RCW 74.08.090.
388-15-207	Chore personal care services for adults—Legal basis—Purpose—Goals. [Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-207, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.530 and 74.08.545. 93-04-036 (Order 3500), § 388-15-207, filed 1/27/93, effective 2/27/93. Statutory Authority: RCW 74.08.090. 90-15-029 (Order 3041), § 388-15-207, filed 7/13/90, effective 8/13/90; 89-18-026 (Order 2852), § 388-15-207, filed 8/29/89, effective 9/29/89; 88-17-064 (Order 2674), § 388-15-207, filed 8/17/88; 88-06-088 (Order 2605), § 388-15-207, filed 3/2/88; 81-18-045 (Order 1697), § 388-15-207, filed 8/28/81; 81-06-063 (Order 1618), § 388-15-207, filed 3/4/81.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.	388-15-212	Service determination. [Statutory Authority: RCW 74.08.530 and 74.08.545. 93-04-036 (Order 3500), § 388-15-212, filed 1/27/93, effective 2/27/93. Statutory Authority: RCW 74.08.090. 91-08-011 (Order 3152), § 388-15-212, filed 3/26/91, effective 4/26/91; 90-15-029 (Order 3041), § 388-15-212, filed 7/13/90, effective 8/13/90; 89-13-084 (Order 2815), § 388-15-212, filed 6/21/89; 88-17-064 (Order 2674), § 388-15-212, filed 8/17/88; 88-06-088 (Order 2605), § 388-15-212, filed 3/2/88. Statutory Authority: ESHB 1221. 87-22-013 (Order 2550), § 388-15-212, filed 10/26/87. Statutory Authority: RCW 74.08.090. 86-12-040 (Order 2383), § 388-15-212, filed 5/30/86; 84-22-017 (Order 2165), § 388-15-212, filed 10/31/84; 83-21-007 (Order 2028), § 388-15-212, filed 10/6/83; 82-23-056 (Order 1904), § 388-15-212, filed 11/16/82; 81-18-045 (Order 1697), § 388-15-212, filed 8/28/81; 81-11-044 (Order 1652), § 388-15-212, filed 5/20/81; 81-06-063 (Order 1618), § 388-15-212, filed 3/4/81; 79-01-042 (Order 1361), § 388-15-212, filed 12/21/78.] Repealed by 95-20-041 (Order 3904), filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18.
388-15-208	Definitions. [Statutory Authority: RCW 74.08.530 and 74.08.545. 93-04-036 (Order 3500), § 388-15-208, filed 1/27/93, effective 2/27/93. Statutory Authority: RCW 74.08.090. 91-08-011 (Order 3152), § 388-15-208, filed 3/26/91, effective 4/26/91; 90-15-029 (Order 3041), § 388-15-208, filed 7/13/90, effective 8/13/90; 89-13-084 (Order 2815), § 388-15-208, filed 6/21/89; 88-17-064 (Order 2674), § 388-15-208, filed 8/17/88; 88-06-088 (Order 2605), § 388-15-208, filed 3/2/88; 86-12-040 (Order 2383), § 388-15-208, filed 5/30/86; 84-22-017 (Order 2165), § 388-15-208, filed 10/31/84; 83-14-029 (Order 1977), § 388-15-208, filed 6/30/83; 82-23-056 (Order 1904), § 388-15-208, filed 11/16/82; 81-18-045 (Order 1697), § 388-15-208, filed 8/28/81; 81-11-044 (Order 1652), § 388-15-208, filed 5/20/81; 81-06-063 (Order 1618), § 388-15-208, filed 3/4/81.] Repealed by 95-20-041 (Order 3904), filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18.	388-15-213	Payment. [Statutory Authority: RCW 74.08.530 and 74.08.545. 93-04-036 (Order 3500), § 388-15-213, filed 1/27/93, effective 2/27/93. Statutory Authority: RCW 74.08.090. 90-15-029 (Order 3041), § 388-15-213, filed 7/13/90, effective 8/13/90; 88-17-064 (Order 2674), § 388-15-213, filed 8/17/88; 88-06-088 (Order 2605), § 388-15-213, filed 3/2/88. Statutory Authority: ESHB 1221. 87-22-013 (Order 2550), § 388-15-213, filed 10/26/87. Statutory Authority: RCW 74.08.090. 86-08-085 (Order 2361), § 388-15-213, filed 4/2/86; 84-22-017 (Order 2165), § 388-15-213, filed 10/31/84; 83-21-007 (Order 2028), § 388-15-213, filed 10/6/83; 82-23-056 (Order 1904), § 388-15-213, filed 11/16/82; 81-18-045 (Order 1697), § 388-15-213, filed 8/28/81; 81-06-063 (Order 1618), § 388-15-213, filed 3/4/81; Order 1238, § 388-15-213, filed 8/31/77.] Repealed by 95-20-041 (Order 3904), filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18.
388-15-209	Chore personal care services—Eligibility. [Statutory Authority: RCW 74.39A.120, 74.39A.030, 74.09.520, 74.39A.110, [74.39A.]130 and 1998 c 346 § 205 (1)(c) and 206(3). 98-19-055, § 388-15-209, filed 9/15/98, effective 10/16/98. Statutory Authority: RCW 74.08.090, 74.09.035, [74.09.]520, [74.09.]530, 74.39A.110, [74.39A.]120 and [74.39A.]030. 98-04-026, § 388-15-209, filed 1/28/98, effective 2/28/98. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-209, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-209, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.530 and 74.08.545. 93-04-036 (Order 3500), § 388-15-209, filed 1/27/93, effective 2/27/93. Statutory Authority: RCW 74.08.090. 91-08-011 (Order 3152), § 388-15-209, filed 3/26/91, effective 4/26/91; 90-15-029 (Order 3041), § 388-15-209, filed 7/13/90, effective	388-15-214	Chore personal care services—Budget control. [Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-214, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.545. 94-10-025 (Order 3730), § 388-15-214, filed 4/27/94, effective 5/28/94. Statutory Authority: RCW 74.08.530 and 74.08.545. 93-04-036 (Order 3500), § 388-15-214, filed 1/27/93, effective 2/27/93. Statutory Authority: RCW 74.08.090. 90-15-029 (Order 3041), § 388-15-214, filed 7/13/90, effective 8/13/90; 88-19-031 (Order 2693), § 388-15-214, filed 9/12/88; 88-06-088 (Order 2605), § 388-15-214, filed 3/2/88.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
		388-15-215	Chore personal care services—Program limitations. [Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-215, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.530 and 74.08.545. 93-04-036 (Order 3500), § 388-15-215, filed 1/27/93, effective 2/27/93.

	Statutory Authority: RCW 74.08.090, 91-08-011 (Order 3152), § 388-15-215, filed 3/26/91, effective 4/26/91; 90-15-029 (Order 3041), § 388-15-215, filed 7/13/90, effective 8/13/90; 89-18-026 (Order 2852), § 388-15-215, filed 8/29/89, effective 9/29/89; 88-11-062 (Order 2625), § 388-15-215, filed 5/17/88; 85-22-021 (Order 2298), § 388-15-215, filed 10/30/85; 84-22-017 (Order 2165), § 388-15-215, filed 10/31/84; 83-21-007 (Order 2028), § 388-15-215, filed 10/6/83; 82-23-056 (Order 1904), § 388-15-215, filed 11/16/82; 81-18-045 (Order 1697), § 388-15-215, filed 8/28/81; 81-06-063 (Order 1618), § 388-15-215, filed 3/4/81; Order 1238, § 388-15-215, filed 8/31/77.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.	388-15-280	Library services to the blind and physically handicapped. [Order 1088, § 388-15-280, filed 1/19/76.] Repealed by Order 1124, filed 6/9/76.
388-15-216	Chore personal care services—Grandfathered clients. [Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-216, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.530 and 74.08.545. 93-04-036 (Order 3500), § 388-15-216, filed 1/27/93, effective 2/27/93. Statutory Authority: RCW 74.08.090, 91-08-011 (Order 3152), § 388-15-216, filed 3/26/91, effective 4/26/91; 90-15-029 (Order 3041), § 388-15-216, filed 7/13/90, effective 8/13/90; 89-18-026 (Order 2852), § 388-15-216, filed 8/29/89, effective 9/29/89.] Repealed by 98-14-052, filed 6/26/98, effective 7/27/98. Statutory Authority: RCW 74.08.090.	388-15-290	Juvenile delinquency prevention services. [Order 1238, § 388-15-290, filed 8/31/77; Order 1088, § 388-15-290, filed 1/19/76.] Repealed by 81-20-063 (Order 1708), filed 10/5/81. Statutory Authority: RCW 74.08.090.
		388-15-300	Developmental disabilities case services. [Order 1238, § 388-15-300, filed 8/31/77; Order 1088, § 388-15-300, filed 1/19/76.] Repealed by 98-02-058, filed 1/6/98, effective 2/6/98. Statutory Authority: RCW 74.09.290 and 74.08.090.
		388-15-310	Developmental disabilities home (aid) services. [Order 1238, § 388-15-310, filed 8/31/77; Order 1088, § 388-15-310, filed 1/19/76.] Repealed by 98-02-058, filed 1/6/98, effective 2/6/98. Statutory Authority: RCW 74.09.290 and 74.08.090.
		388-15-320	Developmental center services. [Order 1238, § 388-15-320, filed 8/31/77; Order 1088, § 388-15-320, filed 1/19/76.] Repealed by 98-02-058, filed 1/6/98, effective 2/6/98. Statutory Authority: RCW 74.09.290 and 74.08.090.
		388-15-330	Sheltered workshops. [Order 1238, § 388-15-330, filed 8/31/77; Order 1088, § 388-15-330, filed 1/19/76.] Repealed by 98-02-058, filed 1/6/98, effective 2/6/98. Statutory Authority: RCW 74.09.290 and 74.08.090.
388-15-217	Chore personal care services for employed disabled adults. [Statutory Authority: RCW 74.08.530 and 74.08.545. 93-04-036 (Order 3500), § 388-15-217, filed 1/27/93, effective 2/27/93. Statutory Authority: RCW 74.08.090, 90-15-029 (Order 3041), § 388-15-217, filed 7/13/90, effective 8/13/90; 89-18-026 (Order 2852), § 388-15-217, filed 8/29/89, effective 9/29/89; 88-11-062 (Order 2625), § 388-15-217, filed 5/17/88; 83-21-007 (Order 2028), § 388-15-217, filed 10/6/83; 82-23-056 (Order 1904), § 388-15-217, filed 11/16/82; 81-18-045 (Order 1697), § 388-15-217, filed 8/28/81; 81-03-075 (Order 1589), § 388-15-217, filed 1/21/81.] Repealed by 95-23-032 (Order 3919), filed 11/8/95, effective 12/9/95. Statutory Authority: RCW 74.08.090, 74.09.-520 and 1995 1st sp.s. c 18.	388-15-340	Alcoholism treatment. [Order 1238, § 388-15-340, filed 8/31/77; Order 1088, § 388-15-340, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
		388-15-350	Mental health. [Order 1124, § 388-15-350, filed 6/9/76; Order 1088, § 388-15-350, filed 1/19/76.] Repealed by Order 1238, filed 8/31/77.
		388-15-360	Refugee assistance. [Statutory Authority: RCW 43.20A.550, 82-02-032 (Order 1742), § 388-15-360, filed 12/31/81; 81-17-027 (Order 1692), § 388-15-360, filed 8/12/81; 78-04-004 (Order 1276), § 388-15-360, filed 3/2/78; Order 1238, § 388-15-360, filed 8/31/77; Order 1204, § 388-15-360, filed 4/1/77; Order 1147, § 388-15-360, filed 8/26/76; Order 1124, § 388-15-360, filed 6/9/76.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.-090.
388-15-219	Chore personal care service—Payment and client participation. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-219, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-219, filed 9/28/95, effective 10/29/95.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.	388-15-500	Redetermination of service eligibility. [Order 1238, § 388-15-500, filed 8/31/77; Order 1088, § 388-15-500, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.-210, 74.08.090 and 1997 c 409 § 209.
388-15-220	Homemaker services. [Statutory Authority: RCW 74.08.090, 81-17-024 (Order 1689), § 388-15-220, filed 8/12/81; 80-15-003 (Order 1551), § 388-15-220, filed 10/2/80; Order 1238, § 388-15-220, filed 8/31/77; Order 1088, § 388-15-220, filed 1/19/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-15-548	Residential services. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-548, filed 7/28/86.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
388-15-222	Chore personal care services—Employed disabled—Incentive income and resource exemption. [Statutory Authority: RCW 74.39A.120, 74.39A.030, 74.09.520, 74.39A.110, [74.39A.]130 and 1998 c 346 § 205 (1)(c) and 206(3). 98-19-055, § 388-15-222, filed 9/15/98, effective 10/16/98. Statutory Authority: RCW 74.08.-090, 74.09.035, [74.09.]520, [74.09.]530, 74.39A.110, [74.39A.]120 and [74.39A.]030. 98-04-026, § 388-15-222, filed 1/28/98, effective 2/28/98. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-222, filed 9/28/95, effective 10/29/95.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.	388-15-550	Service delivery. [Order 1238, § 388-15-550, filed 8/31/77; Order 1147, § 388-15-550, filed 8/26/76; Order 1124, § 388-15-550, filed 6/9/76; Order 1088, § 388-15-550, filed 1/19/76.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
		388-15-551	Adult family home—Authority to purchase care—Standards. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-551, filed 7/28/86; 79-09-039 (Order 1425), § 388-15-551, filed 8/17/79.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
		388-15-552	Adult family home—Eligible persons. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-552, filed 7/28/86; 83-21-008 (Order 2029), § 388-15-552, filed 10/6/83; 79-09-039 (Order 1425), § 388-15-552, filed 8/17/79.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
388-15-230	Employment oriented casework. [Order 1238, § 388-15-230, filed 8/31/77; Order 1165, § 388-15-230, filed 10/27/76; Order 1105, § 388-15-230, filed 3/11/76.] Repealed by 79-03-013 (Order 1368), filed 2/15/79. Statutory Authority: RCW 74.08.090.	388-15-553	Adult family home—Determination of need. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-553, filed 7/28/86; 79-09-039 (Order 1425), § 388-15-553, filed 8/17/79.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
388-15-250	School age parent services. [Order 1124, § 388-15-250, filed 6/9/76; Order 1088, § 388-15-250, filed 1/19/76.] Repealed by Order 1147, filed 8/26/76.	388-15-554	Adult family home—Placement in facility. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-554, filed 7/28/86; 79-09-039 (Order 1425), § 388-15-554, filed 8/17/79.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
388-15-260	Home delivered meals. [Order 1088, § 388-15-260, filed 1/19/76.] Repealed by Order 1147, filed 8/26/76.	388-15-555	Adult family home—Payments—Standards—Procedures. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-555, filed 7/28/86; 79-09-
388-15-270	Services to the blind. [Order 1088, § 388-15-270, filed 1/19/76.] Repealed by Order 1238, filed 8/31/77.		

- 039 (Order 1425), § 388-15-555, filed 8/17/79.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-560 Congregate care—Definition—Authority to purchase care—Standards. [Statutory Authority: RCW 74.08.-044, 86-16-019 (Order 2392), § 388-15-560, filed 7/28/86; 81-01-077 (Order 1579), § 388-15-560, filed 12/17/80; Order 1238, § 388-15-560, filed 8/31/77.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-562 Congregate care—Eligible persons. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-562, filed 7/28/86; 82-10-064 (Order 1805), § 388-15-562, filed 5/5/82; 81-01-077 (Order 1579), § 388-15-562, filed 12/17/80; Order 1238, § 388-15-562, filed 8/31/77.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-563 Congregate care—Residents of other states. [Statutory Authority: RCW 74.08.044, 81-01-077 (Order 1579), § 388-15-563, filed 12/17/80.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-564 Congregate care—Determination of need. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-564, filed 7/28/86; Order 1238, § 388-15-564, filed 8/31/77.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-566 Congregate care—Placement in facility. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-566, filed 7/28/86; 81-01-077 (Order 1579), § 388-15-566, filed 12/17/80; Order 1238, § 388-15-566, filed 8/31/77.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-568 Congregate care—Payment—Standards—Procedures. [Statutory Authority: RCW 74.08.044, 86-16-019 (Order 2392), § 388-15-568, filed 7/28/86; 82-10-064 (Order 1805), § 388-15-568, filed 5/5/82; Order 1238, § 388-15-568, filed 8/31/77.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-570 Family reconciliation services. [Statutory Authority: RCW 74.08.090, 82-01-040 (Order 1732), § 388-15-570, filed 12/16/81; 81-20-063 (Order 1708), § 388-15-570, filed 10/5/81. Statutory Authority: RCW 74.08.-090 and 1979 c 155, 79-10-026 (Order 1431), § 388-15-570, filed 9/10/79. Statutory Authority: RCW 74.08.090, 78-09-098 (Order 1335), § 388-15-570, filed 9/1/78; Order 1238, § 388-15-570, filed 8/31/77.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
- 388-15-580 Support services. [Order 1238, § 388-15-580, filed 8/31/77.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-15-600 Community options program entry system (COPES)—Purpose—Legal basis. [Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18, 95-20-041 (Order 3904), § 388-15-600, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.04.057 and 74.08.090, 93-13-135 (Order 3577), § 388-15-600, filed 6/23/93, effective 7/24/93. Statutory Authority: 1987 1st ex.s. c 7, 87-23-054 (Order 2558), § 388-15-600, filed 11/18/87. Statutory Authority: RCW 74.08.090, 86-11-024 (Order 2377), § 388-15-600, filed 5/14/86; 83-08-024 (Order 1954), § 388-15-600, filed 3/30/83.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-610 COPES—Eligibility. [Statutory Authority: RCW 74.39A.120, 74.39A.030, 74.09.520, 74.39A.110, [74.39A.]130 and 1998 c 346 § 205 (1)(c) and 206(3), 98-19-055, § 388-15-610, filed 9/15/98, effective 10/16/98. Statutory Authority: RCW 74.08.090, 74.09.-035, [74.09.]520, [74.09.]530, 74.39A.110, [74.39A.]120 and [74.39A.]030, 98-04-026, § 388-15-610, filed 1/28/98, effective 2/28/98. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.-030 and 1996 c 302 § 5, 96-20-093, § 388-15-610, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18, 95-20-041 (Order 3904), § 388-15-610, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.04.057 and 74.08.090, 93-13-135 (Order 3577), § 388-15-610, filed 6/23/93, effective 7/24/93. Statutory Authority: RCW 74.09.500, 92-20-013 (Order 3460), § 388-15-610, filed 9/24/92, effective 10/25/92. Statutory Authority: RCW 74.08.090, 90-15-019 (Order 3039), § 388-15-610, filed 7/12/90, effective 8/12/90. Statutory Authority: 1987 1st ex.s. c 7, 87-23-054 (Order 2558), § 388-15-610, filed 11/18/87. Statutory Authority: RCW 74.08.090, 86-11-024 (Order 2377), § 388-15-610, filed 5/14/86; 85-18-067 (Order 2281), § 388-15-610, filed 9/4/85. Statutory Authority: RCW 74.08.044, 84-12-038 (Order 2101), § 388-15-610, filed 5/30/84. Statutory Authority: RCW 74.08.090, 83-08-024 (Order 1954), § 388-15-610, filed 3/30/83.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-615 COPES—Program restrictions. [Statutory Authority: RCW 74.04.057 and 74.08.090, 93-13-135 (Order 3577), § 388-15-615, filed 6/23/93, effective 7/24/93. Statutory Authority: RCW 74.09.500, 92-18-041 (Order 3445), § 388-15-615, filed 8/27/92, effective 9/27/92.] Repealed by 95-20-041 (Order 3904), filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18.
- 388-15-620 COPES—Services. [Statutory Authority: RCW 74.08.-090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5, 96-20-093, § 388-15-620, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.-090, 74.09.520 and 1995 1st sp.s. c 18, 95-20-041 (Order 3904), § 388-15-620, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.04.057 and 74.08.090, 93-13-135 (Order 3577), § 388-15-620, filed 6/23/93, effective 7/24/93. Statutory Authority: RCW 74.08.090, 90-15-019 (Order 3039), § 388-15-620, filed 7/12/90, effective 8/12/90. Statutory Authority: 1987 1st ex.s. c 7, 87-23-054 (Order 2558), § 388-15-620, filed 11/18/87. Statutory Authority: RCW 74.08.090, 86-11-024 (Order 2377), § 388-15-620, filed 5/14/86; 85-18-067 (Order 2281), § 388-15-620, filed 9/4/85. Statutory Authority: RCW 74.08.044, 84-12-038 (Order 2101), § 388-15-620, filed 5/30/84. Statutory Authority: RCW 74.08.090, 83-08-024 (Order 1954), § 388-15-620, filed 3/30/83.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-630 COPES—Payment procedures. [Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18, 95-20-041 (Order 3904), § 388-15-630, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.04.-057 and 74.08.090, 93-13-135 (Order 3577), § 388-15-630, filed 6/23/93, effective 7/24/93. Statutory Authority: RCW 74.08.090, 90-15-019 (Order 3039), § 388-15-630, filed 7/12/90, effective 8/12/90. Statutory Authority: 1987 1st ex.s. c 7, 87-23-054 (Order 2558), § 388-15-630, filed 11/18/87. Statutory Authority: RCW 74.08.090, 86-11-024 (Order 2377), § 388-15-630, filed 5/14/86; 85-18-067 (Order 2281), § 388-15-630, filed 9/4/85. Statutory Authority: RCW 74.08.044, 84-12-038 (Order 2101), § 388-15-630, filed 5/30/84. Statutory Authority: RCW 74.08.090, 83-08-024 (Order 1954), § 388-15-630, filed 3/30/83.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-650 Purpose. [Statutory Authority: RCW 74.39A.007 and 74.08.090, 99-12-072, § 388-15-650, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.
- 388-15-651 Definitions. [Statutory Authority: RCW 74.39A.007 and 74.08.090, 99-12-072, § 388-15-651, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.
- 388-15-652 Adult day care (COPES level I). [Statutory Authority: RCW 74.39A.007 and 74.08.090, 99-12-072, § 388-15-652, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.
- 388-15-653 Adult day health (level II). [Statutory Authority: RCW 74.39A.007 and 74.08.090, 99-12-072, § 388-15-653, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.
- 388-15-654 Plan of care. [Statutory Authority: RCW 74.39A.007 and 74.08.090, 99-12-072, § 388-15-654, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW

	74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.		
388-15-655	Title XIX adult day health certification and monitoring. [Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-655, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.		
388-15-656	Administration and organization. [Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-656, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.		
388-15-657	Staffing. [Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-657, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.		
388-15-658	Personnel requirements. [Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-658, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.		
388-15-659	Facility. [Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-659, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.		
388-15-660	Coordination of services. [Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-660, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.		
388-15-661	Clients in residential care or nursing facility care settings. [Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-661, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.		
388-15-662	Expenditures not to exceed. [Statutory Authority: RCW 74.39A.007 and 74.08.090. 99-12-072, § 388-15-662, filed 5/27/99, effective 6/27/99.] Repealed by 03-06-024, filed 2/24/03, effective 7/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. Later promulgation, see chapter 388-71 WAC.		
388-15-690	Respite care services—Definitions. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-690, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.44 [74.08.044]. 88-03-020 (Order 2570), § 388-15-690, filed 1/12/88.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.		
388-15-695	Respite care services—Caregiver eligibility. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-695, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.44 [74.08.044]. 88-03-020 (Order 2570), § 388-15-695, filed 1/12/88.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.		
388-15-700	Respite care services—Distribution of cost. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-700, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.44 [74.08.044]. 88-03-020 (Order 2570), § 388-15-700, filed 1/12/88.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.		
388-15-705	Respite care services—Rates of payment. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100,		
	74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-705, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.44 [74.08.044]. 88-03-020 (Order 2570), § 388-15-705, filed 1/12/88.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.	388-15-710	Respite care services—Service priorities. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-710, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.44 [74.08.044]. 88-03-020 (Order 2570), § 388-15-710, filed 1/12/88.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
		388-15-715	Respite care services—Service priority categories. [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5. 96-20-093, § 388-15-715, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.44 [74.08.044]. 88-03-020 (Order 2570), § 388-15-715, filed 1/12/88.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
		388-15-810	Medicaid personal care services—Legal basis—Purpose. [Statutory Authority: RCW 74.08.090. 89-18-029 (Order 2856), § 388-15-810, filed 8/29/89, effective 9/29/89.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
		388-15-820	Medicaid personal care services—Definitions. [Statutory Authority: RCW 74.08.090 and 74.09.520, OBRA '93 and c 21, Laws of 1994 amending RCW 74.09.520, Thurston Co. Superior Court Cause #93-2-1817-4. 94-21-042 (Order 3796), § 388-15-820, filed 10/12/94, effective 11/12/94. Statutory Authority: RCW 74.09.520. 93-10-023 (Order 3538), § 388-15-820, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.08.090. 91-21-026 (Order 3264), § 388-15-820, filed 10/8/91, effective 11/8/91; 90-06-038 (Order 2950), § 388-15-820, filed 3/1/90, effective 4/1/90; 89-18-029 (Order 2856), § 388-15-820, filed 8/29/89, effective 9/29/89.] Repealed by 95-23-032 (Order 3919), filed 11/8/95, effective 12/9/95. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18.
		388-15-830	Medicaid personal care services—Eligibility. [Statutory Authority: RCW 74.39A.120, 74.39A.030, 74.09.520, 74.39A.110, [74.39A.]130 and 1998 c 346 §§ 205 (1)(c) and 206(3). 98-19-055, § 388-15-830, filed 9/15/98, effective 10/16/98. Statutory Authority: RCW 74.08.090, 74.09.035, [74.09.]520, [74.09.]530, 74.39A.110, [74.39A.]120 and [74.39A.]030. 98-04-026, § 388-15-830, filed 1/28/98, effective 2/28/98. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18. 95-20-041 (Order 3904), § 388-15-830, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.090 and 74.09.520, OBRA '93 and c 21, Laws of 1994 amending RCW 74.09.520, Thurston Co. Superior Court Cause #93-2-1817-4. 94-21-042 (Order 3796), § 388-15-830, filed 10/12/94, effective 11/12/94. Statutory Authority: RCW 74.09.520. 93-10-023 (Order 3538), § 388-15-830, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.08.090. 89-18-029 (Order 2856), § 388-15-830, filed 8/29/89, effective 9/29/89.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
		388-15-840	Medicaid personal care services—Assessment—Authorization. [Statutory Authority: RCW 74.08.090 and 74.09.520, OBRA '93 and c 21, Laws of 1994 amending RCW 74.09.520, Thurston Co. Superior Court Cause #93-2-1817-4. 94-21-042 (Order 3796), § 388-15-840, filed 10/12/94, effective 11/12/94. Statutory Authority: RCW 74.09.520. 93-10-023 (Order 3538), § 388-15-840, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.08.090. 91-21-026 (Order 3264), § 388-15-840, filed 10/8/91, effective 11/8/91; 89-18-029 (Order 2856), § 388-15-840, filed 8/29/89, effective 9/29/89.] Repealed by 95-23-032 (Order 3919), filed 11/8/95, effective 12/9/95. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18.
		388-15-850	Medicaid personal care services—Nurse oversight. [Statutory Authority: RCW 74.08.090 and 74.09.520, OBRA '93 and c 21, Laws of 1994 amending RCW 74.09.520, Thurston Co. Superior Court Cause #93-2-1817-4. 94-21-042 (Order 3796), § 388-15-850, filed 10/12/94, effective 11/12/94. Statutory Authority: RCW 74.09.520. 93-10-023 (Order 3538), § 388-15-850, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.08.090. 91-21-026 (Order 3264), § 388-

- 15-850, filed 10/8/91, effective 11/8/91; 89-18-029 (Order 2856), § 388-15-850, filed 8/29/89, effective 9/29/89.] Repealed by 95-20-041 (Order 3904), filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18.
- 388-15-860 Medicaid personal care services—Personal care aide qualifications. [Statutory Authority: RCW 74.09.520, 93-10-023 (Order 3538), § 388-15-860, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.08.-090, 91-21-026 (Order 3264), § 388-15-860, filed 10/8/91, effective 11/8/91; 89-18-029 (Order 2856), § 388-15-860, filed 8/29/89, effective 9/29/89.] Repealed by 95-20-041 (Order 3904), filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18.
- 388-15-870 Medicaid personal care services—Service provision system. [Statutory Authority: RCW 74.09.520, 93-10-023 (Order 3538), § 388-15-870, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.08.090, 91-21-026 (Order 3264), § 388-15-870, filed 10/8/91, effective 11/8/91; 90-06-038 (Order 2950), § 388-15-870, filed 3/1/90, effective 4/1/90; 89-18-029 (Order 2856), § 388-15-870, filed 8/29/89, effective 9/29/89.] Repealed by 95-20-041 (Order 3904), filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18.
- 388-15-880 Medicaid personal care services—Payment procedures. [Statutory Authority: RCW 74.08.090, 74.09.035, [74.09.]520, [74.09.]530, 74.39A.110, [74.39A.]120 and [74.39A.]030, 98-04-026, § 388-15-880, filed 1/28/98, effective 2/28/98. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.-030 and 1996 c 302 § 5, 96-20-093, § 388-15-880, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18, 95-20-041 (Order 3904), § 388-15-880, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.09.520, 93-10-023 (Order 3538), § 388-15-880, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.08.090, 91-21-026 (Order 3264), § 388-15-880, filed 10/8/91, effective 11/8/91; 90-06-038 (Order 2950), § 388-15-880, filed 3/1/90, effective 4/1/90; 89-18-029 (Order 2856), § 388-15-880, filed 8/29/89, effective 9/29/89.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-890 Medicaid personal care services—Program limitations. [Statutory Authority: RCW 74.39A.120, 74.39A.030, 74.09.520, 74.39A.110, [74.39A.]130 and 1998 c 346 §§ 205 (1)(c) and 206(3), 98-19-055, § 388-15-890, filed 9/15/98, effective 10/16/98. Statutory Authority: RCW 74.08.090, 74.09.035, [74.09.]520, [74.09.]530, 74.39A.110, [74.39A.]120 and [74.39A.]030, 98-04-026, § 388-15-890, filed 1/28/98, effective 2/28/98. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5, 96-20-093, § 388-15-890, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.-520 and 1995 1st sp.s. c 18, 95-20-041 (Order 3904), § 388-15-890, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.09.520, 93-10-023 (Order 3538), § 388-15-890, filed 4/28/93, effective 5/29/93.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-895 Termination of services. [Statutory Authority: RCW 74.39A.120, 74.39A.030, 74.09.520, 74.39A.110, [74.39A.]130 and 1998 c 346 §§ 205 (1)(c) and 206(3), 98-19-055, § 388-15-895, filed 9/15/98, effective 10/16/98. Statutory Authority: RCW 74.08.090, 74.09.-035, [74.09.]520, [74.09.]530, 74.39A.110, [74.39A.]120 and [74.39A.]030, 98-04-026, § 388-15-895, filed 1/28/98, effective 2/28/98.] Repealed by 00-04-056, filed 1/28/00, effective 2/28/00.
- 388-15-900 Authority. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-900, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045 (Order 3979), filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040.
- 388-15-905 Assisted living services. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-905, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-080, 74.39A.170, 18.88A.210-240 and 70.129.040.
- 388-15-910 Definitions. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-910, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.-010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.-170, 18.88A.210-240 and 70.129.040.
- 388-15-915 Facility structural requirements. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-915, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-080, 74.39A.170, 18.88A.210-240 and 70.129.040.
- 388-15-920 Service requirements. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-920, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-080, 74.39A.170, 18.88A.210-240 and 70.129.040.
- 388-15-925 External or additional services coordinated by the contractor. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-925, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.170, 18.88A.210-240 and 70.129.040.
- 388-15-935 Contract application process. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-935, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-080, 74.39A.170, 18.88A.210-240 and 70.129.040.
- 388-15-940 Change of parties to the contract. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-940, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-080, 74.39A.170, 18.88A.210-240 and 70.129.040.
- 388-15-945 Client eligibility. [Statutory Authority: RCW 74.39A.-010, 95-15-011 (Order 3864), § 388-15-945, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-240 and 70.129.040.
- 388-15-950 Relocation criteria. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-950, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-080, 74.39A.170, 18.88A.210-240 and 70.129.040.
- 388-15-955 Assisted living services contract payment procedures. [Statutory Authority: RCW 74.39A.010, 95-15-011 (Order 3864), § 388-15-955, filed 7/7/95, effective 8/7/95.] Repealed by 96-11-045, filed 5/8/96, effective 6/8/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-240 and 70.129.040.

PART A—PROGRAM DESCRIPTION

WAC 388-15-001 What is the child protective services program? (1) Child protective services (CPS) means those services provided by the department of social and health services designed to protect children from child abuse and neglect and safeguard such children from future abuse and neglect, and conduct investigations of child abuse and neglect reports (RCW 26.44.020 (12) and (16)).

(2) CPS may include the following:

(a) Investigation of reports of alleged child abuse or neglect.

(b) Assessment of risk of abuse or neglect to children.

(c) Provision of and/or referral to services to remedy conditions that endanger the health, safety, and welfare of children.

(d) Referral to law enforcement when there are allegations that a crime against a child (RCW 26.44.030(4) and 74.13.031(3)) might have been committed.

(e) Out of home placement and petitions to courts when necessary to ensure the safety of children.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-001, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-005 What definitions apply to these rules? The following definitions apply to this chapter.

"Abuse or neglect" means the injury, sexual abuse, sexual exploitation, negligent treatment, or maltreatment of a child as defined in RCW 26.44.020 and this chapter.

"Administrative hearing" means a hearing held before an administrative law judge and conducted according to chapter 34.05 RCW and chapter 388-02 WAC.

"Administrative law judge (ALJ)" is an impartial decision-maker who presides at an administrative hearing. The office of administrative hearings, which is a state agency but not part of DSHS, employs the ALJs.

"Alleged perpetrator" means the person identified in a CPS referral as being responsible for the alleged child abuse or neglect.

"Alternative response system" means a contracted provider in a local community that responds to accepted CPS referrals that are rated low or moderately low risk at the time of intake.

"Appellant" means a person who requests an administrative hearing to appeal a CPS finding.

"Child protection team (CPT)" means a multidisciplinary group of persons with at least four persons from professions that provide services to abused or neglected children and/or parents of such children. The CPT provides confidential case staffing and consultation to children's administration.

"Child protective services (CPS)" means the section of the children's administration responsible for responding to allegations of child abuse or neglect.

"Children's administration (CA)" means the cluster of programs within DSHS that is responsible for the provision of child protective, child welfare, foster care licensing, group care licensing, and other services to children and their families.

"Department" or **"DSHS"** means the Washington state department of social and health services.

"Divisions of child care and early learning (DCCEL)" means the division of economic services responsible for licensing child care homes and child care facilities.

"Division of children and family services (DCFS)" means the division of children's administration that provides child protective, child welfare, and support services to children and their families.

"Division of licensed resources (DLR)" means the division of children's administration responsible for licensing group care and foster care facilities, and responding to allegations of abuse or neglect in such facilities.

"Finding" means the final decision made by a CPS social worker after an investigation regarding alleged child abuse or neglect.

"Founded" means the determination following an investigation by CPS that based on available information it is more likely than not that child abuse or neglect did occur.

"Inconclusive" means the determination following an investigation by CPS that based on available information a

decision cannot be made that more likely than not, child abuse or neglect did or did not occur.

"Mandated reporter" means a person required to report alleged child abuse or neglect as defined in RCW 26.44.030.

"Preponderance of evidence" means the evidence presented in a hearing indicates more likely than not child abuse or neglect did occur.

"Unfounded" means the determination following an investigation by CPS that based on available information it is more likely than not that child abuse or neglect did not occur.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-005, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-009 What is child abuse or neglect?

Child abuse or neglect means the injury, sexual abuse, sexual exploitation, negligent treatment, or maltreatment of a child under circumstances which indicate that the child's health, welfare, and safety is harmed. An abused child is a child who has been subjected to child abuse or neglect as defined in this section.

(1) Physical abuse means the nonaccidental infliction of physical injury or physical mistreatment on a child. Physical abuse includes, but is not limited to, such actions as:

- (a) Throwing, kicking, burning, or cutting a child;
- (b) Striking a child with a closed fist;
- (c) Shaking a child under age three;
- (d) Interfering with a child's breathing;
- (e) Threatening a child with a deadly weapon;

(f) Doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks or which is injurious to the child's health, welfare and safety.

(2) Physical discipline of a child, including the reasonable use of corporal punishment, is not considered abuse when it is reasonable and moderate and is inflicted by a parent or guardian for the purposes of restraining or correcting the child. The age, size, and condition of the child, and the location of any inflicted injury shall be considered in determining whether the bodily harm is reasonable or moderate. Other factors may include the developmental level of the child and the nature of the child's misconduct. A parent's belief that it is necessary to punish a child does not justify or permit the use of excessive, immoderate or unreasonable force against the child.

(3) Sexual abuse means committing or allowing to be committed any sexual offense against a child as defined in the criminal code. The intentional touching, either directly or through the clothing, of the sexual or other intimate parts of a child or allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in touching the sexual or other intimate parts of another for the purpose of gratifying the sexual desire of the person touching the child, the child, or a third party. A parent or guardian of a child, a person authorized by the parent or guardian to provide child-care for the child, or a person providing medically recognized services for the child, may touch a child in the sexual or other intimate parts for the purposes of providing hygiene, child care, and medical treatment or diagnosis.

(4) Sexual exploitation includes, but is not limited to, such actions as allowing, permitting, compelling, encouraging, aiding, or otherwise causing a child to engage in:

(a) Prostitution;

(b) Sexually explicit, obscene or pornographic activity to be photographed, filmed, or electronically reproduced or transmitted; or

(c) Sexually explicit, obscene or pornographic activity as part of a live performance, or for the benefit or sexual gratification of another person.

(5) Negligent treatment or maltreatment means an act or a failure to act on the part of a child's parent, legal custodian, guardian, or caregiver that shows a serious disregard of the consequences to the child of such magnitude that it creates a clear and present danger to the child's health, welfare, and safety. A child does not have to suffer actual damage or physical or emotional harm to be in circumstances which create a clear and present danger to the child's health, welfare, and safety. Negligent treatment or maltreatment includes, but is not limited, to:

(a) Failure to provide adequate food, shelter, clothing, supervision, or health care necessary for a child's health, welfare, and safety. Poverty and/or homelessness do not constitute negligent treatment or maltreatment in and of themselves;

(b) Actions, failures to act, or omissions that result in injury to or which create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child; or

(c) The cumulative effects of consistent inaction or behavior by a parent or guardian in providing for the physical, emotional and developmental needs of a child's, or the effects of chronic failure on the part of a parent or guardian to perform basic parental functions, obligations, and duties, when the result is to cause injury or create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-009, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-011 What is child abandonment? (1) A Parent or guardian abandons a child when the parent or guardian is responsible for the care, education, or support of a child and:

(a) Deserts the child in any manner whatever with the intent to abandon the child;

(b) Leaves a child without the means or ability to obtain one or more of the basic necessities of life such as food, water, shelter, clothing, hygiene, and medically necessary health care; or

(c) Forgoes for an extended period of time parental rights, functions, duties and obligations despite an ability to exercise such rights, duties, and obligations.

(2) Abandonment of a child by a parent may be established by conduct on the part of a parent or guardian that demonstrates a substantial lack of regard for the rights, duties, and obligations of the parent or guardian or for the health, welfare, and safety of the child. Criminal activity or incarceration of a parent or guardian does not constitute abandonment in and of themselves, but a pattern of criminal activ-

ity or repeated or long-term incarceration may constitute abandonment of a child.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-011, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-013 Who may receive child protective services? Children and families may receive child protective services when there is an allegation that a child has been abused or neglected:

(1) By a parent, legal custodian, or guardian of the child; or

(2) In a DSHS licensed, certified, or state-operated facility; or

(3) By persons or agencies subject to licensing under chapter 74.15 RCW, including individuals employed by or volunteers of such facilities.

[Statutory Authority: RCW 74.13.031, 74.04.050 and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-013, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-017 What is the responsibility of CPS regarding reports of abuse or neglect? (1) CPS must record a report from any source alleging child abuse or neglect.

(2) CPS must determine whether alleged incidents or conditions meet the definitions of child abuse or neglect in this chapter or in chapter 26.44 RCW.

(3) CPS must assess or investigate all reports of alleged child abuse or neglect that meet the definitions of child abuse or neglect contained in this chapter or in chapter 26.44 RCW.

(4) CPS must investigate anonymous reports only as provided in RCW 26.44.030(15).

(5) CPS must maintain a record of reports received that are not investigated because they do not meet the definitions of child abuse or neglect as defined in RCW or this chapter.

(6) CPS must report to law enforcement per RCW 26.44.030(4) and 74.13.031.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-017, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-021 How does CPS respond to reports of alleged child abuse or neglect? (1) CPS must assess all reports that meet the definition of child abuse or neglect using a risk assessment process to determine level of risk and response time.

(2) CPS must provide an in-person response to alleged victims and must attempt an in-person response to the alleged perpetrator of child abuse and neglect in referrals assessed at moderate to high risk.

(3) CPS may refer reports assessed at low to moderately low risk to an alternative response system.

(4) CPS may interview a child, outside the presence of the parent, without prior parental notification or consent (RCW 26.44.030(10)).

(5) Unless the child objects, CPS must make reasonable efforts to have a third party present at the interview so long as the third party does not jeopardize the investigation (RCW 26.44.030).

(6) CPS may photograph the alleged child victim to document the physical condition of the child (RCW 26.44.050).

(7) CPS must establish in procedure, timelines for the completion of investigations and standards for written findings.

[Statutory Authority: RCW 74.13.031, 74.04.050 and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-021, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-025 What special requirements must CPS follow for Indian children? (1) These special requirements apply to children defined as Indians in WAC 388-70-091.

(2) The DCFS social worker shall document in case records efforts to keep Indian families together and to avoid separating the Indian child from his parents, relatives, tribe or cultural heritage as per RCW 26.44.010 and WAC 388-70-093.

(3) In alleged child abuse and neglect situations, the DCFS social worker shall document in case records, efforts to utilize staff and services particularly capable of meeting the special needs of Indian children and their families, in consultation with the child's tribe and/or local Indian child welfare advisory committee per WAC 388-70-600 through 388-70-640.

(4) The DCFS social worker shall promptly advise the tribal council and the local Indian child welfare advisory committee that a child affiliated with the tribe is the victim of substantiated child abuse or neglect. The provisions of RCW 26.44.070, WAC 377-70-640, limiting who has access to confidential information, shall be followed in all cases.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-025, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-029 What information may CPS share with mandated reporters? (1) CPS in the conduct of ongoing case planning and consultation with those persons or agencies required to report alleged child abuse or neglect under RCW 26.44.030 and with consultants designated by CPS, may share otherwise confidential information with such persons, agencies, and consultants if the confidential information is pertinent to cases currently receiving child protective services.

(2) When CPS receives a report of alleged child abuse or neglect, mandated reporters, as identified in RCW 26.44.030, and their employees must provide upon request by CPS, all relevant records in their possession related to the child (RCW 26.44.030).

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-029, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-033 When will CPS involve local community resources? (1) CPS may use local community resources to respond to reports of abuse or neglect when the department's assessment of risk determines that a community response is in the best interest of the child and family.

(2) CPS may involve local community resources in the planning and provision of services to help remedy conditions that contribute to the abuse or neglect of children.

(3) CPS must have community based child protective teams (CPT) available for staffing and consultation regarding

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cases of child abuse or neglect. CPS must present cases for staffing with the CPT in accordance with executive order 95-04 and department procedures.

(4) There are special requirements for staffing Indian children cases with the local Indian child welfare advisory committee (WAC 388-70-600).

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-033, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-037 Under what circumstances may CPS place a child in out-of-home care? (1) When CPS determines that a child is at risk of serious harm in the care of the parent, legal custodian, or guardian CPS may seek an out-of-home placement for the child. Before placing a child in out-of-home care one of the following must be in place:

(a) A court order directing that the child be placed in out-of-home care (RCW 13.34.050); or

(b) A law enforcement officer placing the child in protective custody (RCW 26.44.050); or

(c) A physician or hospital administrator detaining a child and CPS assuming custody until a court hearing is held (RCW 26.44.056); or

(d) A voluntary placement agreement signed by the child's parent, guardian, or legal custodian. Voluntary placements of Indian children must comply with RCW 13.34.245.

(2) CPS must attempt to place the child with a relative willing and available to care for the child, unless there is reasonable cause to believe that the health, safety and welfare of the child would be jeopardized or that efforts to reunite the parent and child will be hindered (RCW 13.34.060). If a relative appears suitable and competent with good character to provide adequate care, the background check of a relative shall be completed as soon as possible after the child is placed (RCW 74.15.030).

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-037, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-041 When will CPS involve the juvenile court? CPS may file a dependency petition with the juvenile court when CPS determines that court intervention is necessary for protection of the child.

(1) CPS must file a dependency petition with the juvenile court when a child is to remain in out of home care beyond seventy-two hours (excluding Saturdays, Sundays, and holidays) unless the child's parent or legal custodian signs a voluntary placement agreement.

(2) CPS must make reasonable efforts to notify both parents, guardians, and any legal custodian(s) that a dependency petition has been filed. The notice must inform these parties of the date, time, and location of the initial shelter care hearing and of the parent(s) and any legal custodian's legal rights. If the court has entered an order for the out-of-home placement of the child, a hearing shall be held within seventy-two hours, excluding Saturdays, Sundays, and holidays.

(3) Whenever CPS assumes custody of a child from law enforcement, and places the child in out of home care, a court hearing must be held within seventy-two hours from the time the child is taken into protective custody, excluding Saturdays, Sundays and holidays.

(4) Whenever CPS assumes custody from a physician or a hospital administrator and places the child in out-of-home care, a court hearing must be held within seventy-two hours from the time CPS assumes custody of the child, excluding Saturdays, Sundays, and holidays.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-041, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-045 What are the department's responsibilities regarding notification of the parent or legal custodian in child protective services cases? CPS must notify the parent, guardian, or legal custodian of a child at the earliest possible point that will not jeopardize the investigation or the safety or protection of the child when:

(1) CPS is investigating a report alleging an act or acts of child abuse or neglect, and:

(a) The child is alleged to be the victim; and/or

(b) CPS interviews a child in relation to an alleged act of child abuse or neglect.

(2) CPS takes a child into custody pursuant to a court order issued under RCW 13.34.050.

(3) CPS receives custody of a child from law enforcement pursuant to RCW 26.44.050.

(4) CPS files a dependency petition.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-045, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-049 When must the department notify the alleged perpetrator of allegations of child abuse or neglect? CPS must attempt to notify the alleged perpetrator of the allegations of child abuse or neglect at the earliest point in the investigation that will not jeopardize the safety and protection of the child or the investigation process.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-049, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-053 What steps must the department take to provide an opportunity for the parent(s), guardian, or legal custodian(s) to review case information? To provide an opportunity for the parent(s), guardian, or legal custodian(s) to review case information, CPS must give such person the opportunity to read or obtain relevant parts of the case record, provided the person or persons have requested access to the information and the law does not otherwise prohibit such access (RCW 13.50.100).

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-053, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-057 What limitations does the department have on the disclosure of case information? Information obtained by CPS is confidential pursuant to federal and state law. The department may only disclose case record information as permitted by applicable statutes and the provisions of chapter 388-01 WAC.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-057, filed 7/16/02 and 8/14/02, effective 2/10/03.]

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PART B—NOTIFICATION AND APPEAL OF FINDINGS

WAC 388-15-061 What is the purpose of these rules?

The purpose of these rules is to describe:

(1) The procedures for notifying the alleged perpetrator of any findings made by a CPS social worker in an investigation of suspected child abuse or neglect; and

(2) The process for challenging a founded CPS finding of child abuse or neglect (RCW 26.44.100 and 26.44.125).

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-061, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-065 Does CPS have to notify the alleged perpetrator of the results of CPS investigation? CPS has the duty to notify the alleged perpetrator in writing of any finding made by CPS in any investigation of suspected child abuse and/or neglect.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-065, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-069 How does CPS notify the alleged perpetrator of the finding? (1) CPS notifies the alleged perpetrator of the finding by sending the CPS finding notice via certified mail, return receipt requested, to the last known address. CPS must make a reasonable, good faith effort to determine the last known address or location of the alleged perpetrator.

(2) In cases where certified mailing may not be either possible or advisable, the CPS social worker may personally deliver or have served the CPS finding notice to the alleged perpetrator.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-069, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-073 What information must be in the CPS finding notice? The CPS finding notice must inform the alleged perpetrator of the department's investigative finding, including the legal basis for the findings and sufficient factual information to apprise the alleged perpetrator of the date and nature of the founded reports. The notice must also contain the following:

(1) The alleged perpetrator may submit to CPS a written response regarding the CPS finding. If a response is submitted, CPS must file this response in the department's records.

(2) Information in the department's records may be considered in later investigations or proceedings relating to child protection or child custody.

(3) Founded CPS findings may be considered in determining:

(a) If an alleged perpetrator is qualified to be licensed to care for children or vulnerable adults;

(b) If an alleged perpetrator is qualified to be employed by a child care agency or facility;

(c) If an alleged perpetrator may be authorized or funded by the department to provide care or services to children or vulnerable adults.

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(4) The alleged perpetrator's right to challenge a founded CPS finding.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-073, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-077 What happens to unfounded CPS findings? (1) According to RCW 74.15.130 (2)(b), no unfounded, or inconclusive CPS finding of child abuse or neglect may be used to deny employment in a child care facility or to deny a license to care for children.

(2) According to RCW 26.44.020(19) no unfounded or inconclusive allegation of child abuse or neglect may be disclosed as part of a background check to a child placing agency, private adoption agency, or any other provider licensed under chapter 74.15 RCW.

(3) According to RCW 26.44.031, at the end of six years from the date of the report, the department must remove the unfounded finding from the department's records unless an additional child abuse and/or neglect report has been received regarding the same perpetrator during those six years.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-077, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-081 Can an alleged perpetrator challenge a CPS finding of child abuse or neglect? A person named as an alleged perpetrator in a founded CPS report made on or after October 1, 1998, may challenge that finding.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-081, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-085 How does an alleged perpetrator challenge a founded CPS finding? (1) In order to challenge a founded CPS finding, the alleged perpetrator must make a written request for CPS to review the founded CPS finding of child abuse or neglect. The CPS finding notice must provide the information regarding all steps necessary to request a review.

(2) The request must be provided to the same CPS office that sent the CPS finding notice within twenty calendar days from the date the alleged perpetrator receives the CPS finding notice (RCW 26.44.125).

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-085, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-089 What happens if the alleged perpetrator does not request CPS to review the founded CPS finding within twenty days? (1) If the alleged perpetrator does not submit a written request within twenty calendar days for CPS to review the founded CPS finding, no further review or challenge of the finding may occur.

(2) If the department has exercised reasonable, good faith efforts to provide notice of the CPS finding to the alleged perpetrator, the alleged perpetrator shall not have further opportunity to request a review of the finding beyond thirty days from the time the notice was sent.

(2007 Ed.)

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-089, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-093 What happens after the alleged perpetrator requests CPS to review the founded CPS finding of child abuse or neglect? (1) CPS management level staff or their designees who were not involved in the decision making process will review the founded CPS finding of child abuse or neglect. The management staff will consider the following information:

- (a) CPS records;
- (b) CPS summary reports; and
- (c) Any written information the alleged perpetrator may have submitted regarding the founded CPS finding of abuse and/or neglect.

(2) Management staff may also meet with the CPS social worker and/or CPS supervisor to discuss the investigation/finding. After review of all this information, management staff decides if the founded CPS finding is correct or if it should be changed.

(3) Management staff must complete their review of the founded CPS finding within sixty calendar days from the date CPS received the written request for review.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-093, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-097 How does CPS notify the alleged perpetrator of the results of the CPS management review? CPS will notify the alleged perpetrator in writing of the results of the CPS management review. CPS will send this notice to the last known address of the alleged perpetrator by certified mail, return receipt requested. The notice of the CPS management review decision will also contain information regarding how to request a hearing.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-097, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-101 What happens if CPS management staff changes the founded CPS finding? If CPS management staff changes the founded CPS finding, CPS notifies the alleged perpetrator that the department has changed the finding to either inconclusive or unfounded. CPS management staff or their designee must correct the department's records to show the changed finding.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-101, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-105 What happens if CPS management staff does not change the founded CPS finding? (1) If CPS management staff does not change the founded CPS finding, the alleged perpetrator has the right to further challenge that finding by requesting an administrative hearing.

(2) The request for a hearing must be in writing and sent to the Office of Administrative Hearings. WAC 388-02-0025 lists the current address.

(3) The office of administrative hearings must receive the written request for a hearing within thirty days from the

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date that the person requesting the hearing receives the CPS management review decision.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-105, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-109 What laws and rules will control the administrative hearings held regarding the founded CPS findings? Chapter 34.05 RCW, RCW 26.44.100 and 26.44.125, chapter 388-02 WAC, and the provisions of this chapter govern any administrative hearing regarding a founded CPS finding. In the event of a conflict between the provisions of this chapter and chapter 388-02 WAC, the provisions of this chapter must prevail.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-109, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-113 What effect does a petition for dependency have on an administrative hearing? (1) If a dependency petition, based on chapter 13.34 RCW, regarding the alleged abuse or neglect has been filed, the administrative hearing must be stayed (postponed) until the superior court has entered an order and findings regarding the dependency petition.

(2) The ALJ must consider any superior court dependency findings and order relating to the alleged abuse or neglect.

(3) If the superior court has entered findings that the alleged perpetrator was the person responsible for the alleged child abuse or neglect, the ALJ must uphold the CPS finding. The ALJ must reiterate the court ruling and incorporate that ruling in the decision issued by the ALJ.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-113, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-117 What factors must the ALJ consider in order for the alleged abused and/or neglected child to testify at the administrative hearing? (1) The ALJ must give special consideration to any request by a party for the alleged abused or neglected child to testify in order to protect the physical and emotional well being of the child. For the protection of the child, the ALJ must determine:

(a) If compelling reasons exist to have the child testify. If compelling reasons do exist, the ALJ must consider alternative methods to in-person testimony by the child. Such methods may include, but are not limited to, having the child testify by telephone or videotape; or

(b) If the rights of a party (either the appellant or DSHS) would be prejudiced by not having the child testify in person. If a party's rights would be prejudiced, the ALJ must consider other methods to hear the child's testimony without having the child directly confront the alleged perpetrator.

(2) If the child does testify at the hearing, the ALJ must include a written finding in the administrative hearing decision regarding the compelling reasons for the child's testimony and what alternative methods to in-person testimony the ALJ considered.

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[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-117, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-121 Are there issues the ALJ may not rule upon during an administrative hearing regarding a founded CPS finding? In any administrative hearing regarding a founded CPS finding, an ALJ may not rule upon the department's decisions regarding the following:

- (1) Placement of the alleged abused or neglected child;
- (2) Risk assessments used in making placement decisions regarding the alleged abused and/or neglected child; or
- (3) Service plans for the alleged perpetrator and/or alleged abused or neglected child.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-121, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-125 Are the administrative hearings open to the public? Based on RCW 26.44.125, any administrative hearing regarding founded CPS findings is confidential and must not be open to the public.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-125, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-129 How does the ALJ make a decision regarding the founded CPS finding? (1) The ALJ must decide if a preponderance of the evidence in the hearing record supports a determination that the alleged perpetrator committed an act of abuse or neglect of a child.

(2) If the ALJ determines that a preponderance of the evidence in the hearing record supports the founded CPS finding, the ALJ must uphold the finding.

(3) If the ALJ determines that the founded CPS finding is not supported by a preponderance of the evidence in the hearing record, the ALJ must remand the matter to the department for a change of the finding consistent with the ruling of the ALJ.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-129, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-133 How will the appellant be notified of the ALJ's decision? After the administrative hearing, the ALJ will send a written decision to the appellant and the department.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-133, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-135 What if the appellant or the department disagrees with the decision? If the appellant or the department disagrees with the ALJ's decision, either party may challenge this decision according to the procedures contained in chapter 34.05 RCW and chapter 388-02 WAC.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-135, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-141 What happens if the ALJ rules against the department? If the department challenges the

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ALJ's decision, the department will not change the finding in the department's records and the finding will remain in effect pending the final decision from the department's challenge. If the department does not challenge the ALJ's decision, the department will correct the finding in the department's records consistent with the ALJ's decision.

[Statutory Authority: RCW 74.13.031, 74.04.050, and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-141, filed 7/16/02 and 8/14/02, effective 2/10/03.]

WAC 388-15-240 Family planning. (1) Family planning services are those services which enable individuals including minors and handicapped persons, to make choices regarding the number and spacing of children. These services include outreach, information, referral, support services (such as transportation and child care), counseling, education, medical care and follow-up. Family planning medical services include physical examinations, lab tests, diagnosis, treatment, surgical procedures as appropriate, drugs, supplies, devices furnished, prescribed by or under the supervision of a physician.

(2) Goals for family planning shall be limited to those specified in WAC 388-15-010 (1)(a) through (e). Also see WAC 388-15-010(2).

(3) Family planning is a federally mandated service offered to all appropriate persons in the aid to families of dependent children program and also to any appropriate individual who meets the state's financial eligibility requirements (including anyone who within three months has been an applicant for or a recipient of AFDC (see WAC 388-15-020 (1)(e)(i))). Services will be provided promptly to all of the foregoing individuals who voluntarily request such services.

[Order 1238, § 388-15-240, filed 8/31/77; Order 1204, § 388-15-240, filed 4/1/77; Order 1147, § 388-15-240, filed 8/26/76; Order 1088, § 388-15-240, filed 1/19/76.]

WAC 388-15-400 Services to individuals released from mental hospitals or in danger of requiring commitment to such institutions. (1) These services are those services necessary to enable eligible individuals age 65 or over to remain in the community in lieu of care in a mental hospital, or upon release from a mental hospital, to return to and live in the community. Services may also be provided to recipients of AFDC who are being released from mental institutions.

(2) Necessary adult services shall be provided to beneficiaries of SSI, recipients of Title XIX, and other individuals whose income does not exceed the standard in WAC 388-15-020 who:

- (a) Are released from a mental hospital, or
- (b) Need alternate care to continue to live in the community.

(3) Services provided to accomplish the objective to assist the recipient to maintain or be restored to the greatest possible degree of independent functioning and self help shall be any appropriate adult services described in WAC 388-15-100 through 388-15-400.

(4) Services to be provided to accomplish this objective for recipients of AFDC age 21 or under being released from mental institutions shall be any appropriate family or chil-

dren's service described in WAC 388-15-100 through 388-15-400.

(5) See also chapter 388-95 WAC.

[Order 1088, § 388-15-400, filed 1/19/76.]

Chapter 388-22 WAC

DETERMINING AND VERIFYING ELIGIBILITY—DEFINITIONS

WAC

388-22-030 Definitions.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-22-010 Principles in determining eligibility. [Regulation 5.10, filed 7/27/67; Regulation 5.10, filed 1/24/64.] Repealed by Order 529, filed 3/31/71, effective 5/1/71.

388-22-020 Verifying eligibility and reeligibility. [Order 1016, § 388-22-020, filed 4/1/75; Order 943, § 388-22-020, filed 6/28/74; Order 871, § 388-22-020, filed 11/20/73; Order 529, § 388-22-020, filed 3/31/71, effective 5/1/71; Order 266, § 388-22-020, filed 12/5/67; Regulation 5.20, filed 7/27/67; Regulation 5.20, filed 1/24/64.] Repealed by Order 1241, filed 9/23/77.

WAC 388-22-030 Definitions. This section contains definitions of words and phrases extensively used in the department's rules concerning the financial aid programs. This section provides a central location for definitions while eliminating the need to repeat the same in each WAC chapter. Related definitions are grouped under the key word.

For medical assistance-Title XIX and medical services (fully state-financed) program definitions, see chapter 388-80 WAC. For food stamp program definitions, see chapter 388-49 WAC.

(1) "Adequate consideration" means the reasonable value of the goods or services received in exchange for transferred property approximates the reasonable value of the property transferred.

(2) "Adult" means a person eighteen years of age or older.

(3) "Applicant" means any member of an assistance unit by or for whom a request for assistance has been made.

(4) "Application" means a written request for financial assistance or a written or oral request for medical or social service, provided by the department of social and health services, made by a person in the person's own behalf or in behalf of another person.

(5) "Assistance unit" means a person or group of persons required to be included together when determining eligibility for an assistance program.

(6) "Authorization" means an official approval of a departmental action.

(a) "Authorization date" means the date the prescribed form authorizing assistance is signed.

(b) "Authorization of grant" means attesting the applicant's eligibility for assistance and giving authority to make payment accordingly.

(7) "Automobile" means a motorized vehicle.

(8) "Board and room" means a living arrangement where a person purchases food, shelter, and household maintenance from one vendor.

(9) "Boarding home" means a place where a person purchases food, shelter, and household maintenance on a board and room basis.

(10) "CFR" means the code of federal regulations established by the federal government.

(11) "Cash savings" means money which is not classified as income.

(12) "Certification date" means the date the worker certifies changes in a client's case and authorizes a change in grant.

(13) "Child" or "minor child" means a person under eighteen years of age.

(14) "Chore services" means household, yard, and/or personal care services which assist a person in the person's own home.

(15) "Client" means an applicant and/or recipient of financial, medical, and/or social services.

(16) "Continuing assistance" means payments to persons who are eligible for and receive regular monthly grants on a prepayment basis.

(17) "Dependent child" means a child who is not self-supporting, married, or a member of the armed forces of the United States. Receiving public assistance does not constitute self-support.

(18) "Disability." See WAC 388-93-025.

(19) "Disaster assistance" means a financial grant or temporary housing for eligible victims of an emergency or major disaster as declared by the governor or president.

(20) "Effective date" means the date eligibility for a grant begins, changes, or ends.

(21) "Encumbrances" means any mortgage, claim, lien, charge or other legally enforceable liability, such as past due taxes, attached to and binding on property.

(22) "Energy costs" means space heat, lighting, water heating, and other household energy consumption.

(23) "Entitlement" means any form of benefit, such as compensation, insurance, pension retirement, military, bonus, allotment, allowance payable in cash or in-kind in which a client may have a claim or interest.

(24) "Equity" means quick-sale value less encumbrances.

(25) "Estate" means all real and personal property that a deceased person has a right to or interest in as of the date of death.

(26) "Exception to policy" means a waiver by the secretary's designee to a department policy for a specific client experiencing an undue hardship because of the policy. The waiver may not be contrary to law.

(27) "Fair hearing" means an administrative proceeding to hear and decide a client appeal of a department action or decision.

(28) "Federal aid" means the assistance grant programs funded in part by the United States government.

(29) "Food stamp program" means the program administered by the department in cooperation with the U.S. Department of Agriculture to certify eligible households to receive food coupons used to buy food.

(30) "Funeral" means the care of the remains of a deceased person with, appropriate services including necessary costs of, needed facilities, a lot or cremation, and the customary memorial marking of a grave.

(31) "General assistance" means state-funded assistance to an eligible pregnant or incapacitated person who is not eligible for or not receiving federal aid assistance.

(32) "Grant" means an entitlement awarded to a client and paid by state warrants redeemable at par.

(a) "Grant adjustment" means postpayment of the difference between the amount a client was eligible for in a given period and the amount already paid.

(b) "Initial grant" means the payment due from date of eligibility to the date of the first regular grant.

(c) "Minimum grant" means ten dollars, unless a court decision requires payment of a smaller amount, or the grant would have exceeded ten dollars prior to applying a mandatory overpayment deduction.

(d) "One-time grant" means a payment supplementing or replacing a regular grant.

(e) "Regular grant" means the monthly prepayment of assistance on a continuing basis.

(33) "Grantee" means the person or persons to or for whom assistance is paid.

(34) "House" means a separate structure of one or more rooms.

(35) "Household maintenance and operations" means household supplies, housewares, linens, sewing supplies, household management, laundry, banking, and telephone.

(36) "Income" means any appreciable gain in real or personal property (cash or in-kind) received by a client during the month for which eligibility is determined, and that can be applied toward the needs of the assistance unit.

(a) "Cash income" means income in the form of money, bank notes, checks or any other readily liquidated form.

(b) "Disregarded income" means income which is taken into consideration, but is disregarded in part or entirely when determining need.

(c) "Earned income" means income in cash or in-kind earned as wages, salary, commissions, or profit from activities in which the person is engaged as a self-employed person or as an employee.

(d) "Earned income in-kind" means income in a noncash form received by an assistance unit in lieu of wages, salary, commissions, or profit from activities in which the person is engaged as a self-employed person or as an employee. For grant programs income in-kind shall be evaluated in terms of its cash equivalent under WAC 388-28-600.

(e) "Exempt income" means net income which is not taken into consideration when determining need.

(f) "Net income" means gross income less allowable disregards.

(g) "Nonexempt income" means income which is taken into consideration when determining need.

(h) "Recurrent income" means income which can be predicted to occur at regular intervals.

(i) "Self-produced income" means income from the sale of an item made by a client for personal use. The client has not purchased the item, received it as a gift, or earned it in lieu of wages prior to its sale. For grant programs, self-produced income shall be treated as self-employment income.

(37) "Incapacity" (see WAC 388-24-065 for AFDC and WAC 388-37-030 and 388-37-032 for GA-U).

(38) "Inquiry" means a request for information about the department and/or the services offered by the department.

(39) "Institution" means a treatment facility within which a person receives professional care specific to that facility.

(a) "Institution-medical" provides medical, nursing or convalescent care by professional personnel.

(b) "Institution-private" is operated by nongovernmental authority by private interests.

(c) "Institution-public" is supported by public funds and administered by a governmental agency.

(d) "Institutional services" are those items and services furnished to a person in a particular institution.

(e) "Nursing home" means a public facility or private licensed facility certified by the department to provide skilled nursing and/or intermediate care.

(40) "Intentional overpayment" means a public assistance financial or medical payment, in whole or part, issued on behalf of an assistance unit when:

(a) The unit was ineligible for such payment; and

(b) The assistance was issued due to:

(i) A deliberate, willful act or omission by an assistance unit member; and

(ii) Intent by the assistance unit member to deceive the department with respect to any material fact, condition, or circumstance which affects eligibility or need.

(41) "Joint account" means a numbered account within a financial institution which is registered to two or more parties and is accessible to each party for withdrawal of a cash resource. See WAC 388-28-430 (2)(a).

(42) "Living in own home" means a living arrangement other than a boarding home, hospital, nursing home, or other institution.

(43) "Marketable securities" means stocks, bonds, mortgages, and all other forms of negotiable securities.

(44) "Minor" means a person under eighteen years of age.

(45) "Need" is the difference between the assistance unit's financial requirements, by departmental standards, and the value of all nonexempt net income and resources received by or available to the assistance unit.

(46) "Need under normal conditions of living" means the Washington state gross median income adjusted for family size as promulgated by the secretary of HEW, under the authority granted by Title XX of the Social Security Act minus other income during a period of time when not receiving public assistance.

(47) "Overpayment" means any assistance paid to an assistance unit where:

(a) Eligibility for the payment did not exist; or

(b) Assistance paid was in excess of need.

(48) "Payee" means the person in whose name a warrant or check is issued.

(49) "Permanent and total disability" means the inability to do any substantial gainful activity because of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or is expected to last for at least twelve consecutive months.

(50) "Property" means all resources and/or income possessed by a client.

(a) "Personal property" means any form of property which is not real property.

(b) "Real property" is land, buildings thereon and fixtures permanently attached to such buildings. Growing crops are included. Any structure used as a dwelling shall be considered as real property.

(c) "Transfer of property" means a conveyance of title to, or any interest in, property from one party to another through a bill of sale, deed, or any other instrument conveying the interest in property.

(d) "Used and useful property" means property which currently serves a practical purpose for a client.

(51) "Protective payment" means a grant payment to a person on behalf of an eligible recipient.

(52) "Psychiatric facility" means an institution legally qualified to administer psychiatric inpatient treatment.

(53) "Public assistance" means public aid to persons in need thereof for any cause including services, medical care, assistance grants, disbursing orders, and work relief.

(54) "Recipient" means any person within an assistance unit receiving assistance.

(55) "Reinstate" means an authorization to resume payment of a grant from the category in which payment was previously suspended.

(56) "Requirement" means an item of maintenance or a service recognized by the department as essential to the welfare of an individual.

(a) "Additional requirement" means a requirement which is essential for some clients under specified conditions. See WAC 388-29-150 through 388-29-270.

(b) "Basic requirements" means the needs essential to all persons; food, clothing, personal maintenance and necessary incidentals, shelter, and household maintenance.

(57) "Resource" means an asset, tangible or intangible, owned by or available to a client which can be applied toward meeting financial need, either directly or by conversion into money or its equivalent. Any resource obtained on or after the first of the month in which eligibility is determined is called "income."

(a) "Exempt resource" is a resource which by policy is not considered in computing financial need.

(b) "Nonexempt resource" means a resource which is not exempt, and the value of which is used to determine financial need.

(58) "Restitution" means repayment to the state of assistance paid contrary to law.

(59) "Separate property" means real or personal property which was acquired by either spouse before marriage, or as a result of gift or inheritance, or was acquired and paid for entirely out of income from separate property.

(60) "Statements in support of application" means any form or document required under department regulations.

(61) "Suspension" means a temporary discontinuance of a grant payment.

(62) "Terminate" means discontinuance of payment or suspension status.

(63) "Transfer" means reassignment of a case record from one CSO to another in accordance with a client's change of residence.

(64) "Underpayment" means the amount of public assistance financial payment an eligible assistance unit did not receive, but to which the assistance unit was otherwise entitled.

(65) "Unmarried parents" means a man and a woman not legally married who are the natural parents of the same child.

(66) "Value" means the worth of an item in money or goods at a certain time.

(a) "Ceiling value" means the limitation established by the department on the gross market value of nonexempt property.

(b) "Fair market value" means the price at which a seller willing, but not required to sell, might sell to a purchaser, willing but not required to purchase.

(c) "Quick-sale value" or "forced-sale value" is the value at which property can be converted into cash almost immediately, and without waiting for "the best offer."

(67) "Vendor payment" means an authorized payment to a person, corporation, or agency for goods furnished or services rendered to an individual eligible for public assistance.

(68) "Vocational training" means an organized curriculum in a school, training unit, or training program under recognized sponsorship with a specific vocational training objective.

(69) "Warrant" means the state treasurer's warrant issued in payment of a grant.

(70) "Warrant register" means the list of warrants issued specifying payee's name, amount of payment, warrant number, and for each AFDC payment the number of matchable persons whose need is met by the grant.

(a) "Regular warrant register" means the list of regular grants paid.

(b) "Supplemental warrant register" means the list of initial, adjusting, and one-time grants paid.

[Statutory Authority: RCW 74.04.050, 74.08.090 and 45 CFR 233.20 (a)(3)(iv), (a)(6)(iii) and (a)(6)(v)(B). 94-08-022 (Order 3719), § 388-22-030, filed 3/29/94, effective 5/1/94. Statutory Authority: RCW 74.04.050, 92-24-041 (Order 3483), § 388-22-030, filed 11/25/92, effective 12/26/92. Statutory Authority: RCW 74.04.005, 92-10-050 (Order 3381), § 388-22-030, filed 5/5/92, effective 7/1/92. Statutory Authority: RCW 74.08.090, 89-11-102 (Order 2801), § 388-22-030, filed 5/24/89; 80-09-021 (Order 1521), § 388-22-030, filed 7/9/80; 78-10-036 (Order 1338), § 388-22-030, filed 9/18/78; Order 1131, § 388-22-030, filed 7/8/76; Order 1058, § 388-22-030, filed 10/1/75; Order 745, § 388-22-030, filed 12/7/72; Order 648, § 388-22-030, filed 2/9/72; Order 617, § 388-22-030, filed 10/27/71; Order 529, § 388-22-030, filed 3/31/71, effective 5/1/71; Order 353, § 388-22-030, filed 5/29/69; Regulation 5.30, filed 6/14/66; Regulation 5.30, filed 1/24/64.]

Chapter 388-25 WAC

CHILD WELFARE SERVICES—FOSTER CARE

WAC

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- 388-25-0230 Are adoption support cases exempt from referral to the division of child support (DCS) for collection? [Statutory Authority: RCW 74.13.031, 01-08-047, § 388-25-0230, filed 3/30/01, effective 4/30/01.] Repealed by 05-06-091, filed 3/1/05, effective 4/1/05. Statutory Authority: RCW 74.08.090, 2004 c 183, 74.20.040, and 74.13.020.

PART A: GENERAL

WAC 388-25-0005 What is the legal basis for the foster care program? RCW 74.13.020 authorizes the department to provide foster care placement services.

[Statutory Authority: RCW 74.13.031, 01-08-047, § 388-25-0005, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0010 What definitions apply to the foster care program? The following definitions are important:

"Alcohol affected infant" means a child age birth through twelve months who was exposed to alcohol in utero and may demonstrate physical, behavioral, or cognitive signs that may be attributed to alcohol exposure.

"Behavior rehabilitation services" (BRS) is a comprehensive program of positive behavioral support and environmental structure in a supervised group or family living setting. Resources are designed to modify a child's behavior or to appropriately care for a child's intensive medical condition. Services are tailored to each client's needs and offered in the least restrictive setting possible.

"Child placing agency" means a private licensed or certified agency that places a child or children for temporary care, continued care, or for adoption.

"Children's administration" (CA) means the cluster of programs within the department of social and health services responsible for the provision of child welfare, child protective, child care licensing, and other services to children and their families.

"Crisis residential center" (CRC) means a secure or semi-secure facility established under chapter 74.13 RCW.

"Department" means the department of social and health services (DSHS).

"Dependency guardian" means the person, nonprofit corporation, or Indian tribe appointed by the court pursuant to RCW 13.34.232 for the limited purpose of assisting the court in the supervision of the dependency.

"Division of children and family services" (DCFS) is the division of children's administration that provides child welfare, child protective, family reconciliation, and support services to children in need of protection and their families.

"Division of licensed resources" (DLR) is the division of children's administration responsible for licensing or certifying child care homes and facilities under the authority of chapter 74.15 RCW.

"Drug affected infant" means a child age birth through twelve months who was exposed to drugs or substances in utero and demonstrates physical, behavioral, or cognitive signs that can be attributed to exposure to drugs or substances.

"Early and periodic screening, diagnosis and treatment" (EPSDT), also known as "healthy kids," is a federal program for preventive health care for children and teens served by Medicaid. The physical/well child examination helps find health problems early and enables the child to receive treatment for concerns identified in the examination.

"Foster care" means twenty-four-hour per day temporary substitute care for the child placed away from the child's parents or guardians and for whom the department or a licensed or certified child placing agency has placement and care responsibility. This includes but is not limited to placements in foster family homes, foster homes of relatives, licensed group homes, emergency shelters, staffed residential facilities, and preadoptive homes, regardless of whether the department licenses the home or facility and/or makes payments for care of the child.

"Foster care services" for the department include:

- (1) The determination of needs of the child;
- (2) The determination of need for foster care;
- (3) The placement of the child in the type of foster care setting that best meets the child's needs;
- (4) The referral of a child to a private child placement agency or institution to meet the child's specific needs;
- (5) Medical services according to the rules of the department's medical program;
- (6) Reimbursement for the care of a child in a licensed family foster home;
- (7) The purchase of care from a licensed private child placing agency, behavioral rehabilitation services provider, or maternity home;
- (8) Supervision of the foster care placement by direct supervision through departmental social work services; or indirect supervision through evaluation of periodic reports from private child placing agencies, rehabilitation services providers, or maternity homes with which the department has contractual arrangements.

"Foster home or foster family home" means person(s) regularly providing care on a twenty-four-hour basis to one or more children in the person's home.

"Group care" means a twenty-four-hour facility licensed or certified under chapter 388-148 WAC for more than six children. The facility provides the basic needs for food, shelter, and supervision. The facility also provides therapeutic services required for the successful reunification of children with the children's family resource or the achievement of an alternate permanent living arrangement.

"Independent living services" means the program services and activities established and implemented by the department to assist youth sixteen years or older in preparing to live on their own after leaving foster care.

"Overpayment" means any money paid by the department for services or goods not rendered, delivered, or authorized or where the department paid too much for services or goods or services rendered, delivered, or authorized.

"Regional support network" is an administrative body which oversees the funding for provision of public mental health services.

"Relative" means a person who is related as defined in RCW 74.15.020 (2)(a).

"Responsible parent" means a birth parent, adoptive parent, or stepparent of a dependent child or a person who has signed an affidavit acknowledging paternity that has been filed with the state office of vital statistics.

"Responsible living skills program" means an agency licensed by the secretary that provides residential and transitional living services to persons ages sixteen to eighteen who are dependent under chapter 13.34 RCW and who have been unable to live in his or her legally authorized residence and, as a result, lives outdoors or in another unsafe location not intended for use as housing.

"Staffed residential home" means a licensed home providing twenty-four-hour care for six or fewer children or expectant mothers. The home may employ staff to care for children or expectant mothers.

"Shelter care" means the legal status of a child at entry in foster care prior to a disposition hearing before the court.

"Vendor" means an individual or corporation that provides goods or services to or for clients of the department and that controls operational decisions.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0010, filed 3/30/01, effective 4/30/01.]

PART B: PLACEMENT AUTHORIZATION AND PAYMENT

WAC 388-25-0015 What are the department's placement priorities? Within the limits of available financial resources, the department provides placement services to children according to the following ordered priorities:

(1) The department must place children who urgently need protection from child abuse or neglect (CA/N) if the department has legal authority for placement consistent with WAC 388-25-0025.

(2) The department may place children whose mental, emotional, behavioral or physical needs present a risk to their safety and resources do not exist within the family to provide for those needs.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0015, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0018 What is the agency's goal as to the maximum number of children who remain in foster care in excess of twenty-four months? The placement goal for the foster care program is to limit the number of all children who remain in care in excess of twenty-four months to no more than thirty-five percent of the foster care population.

[Statutory Authority: RCW 34.05.353 and 74.13.055. 03-14-062, § 388-25-0018, filed 6/25/03, effective 7/26/03.]

WAC 388-25-0020 What are the department's limitations on placement? Children's administration (CA) social workers must place only those children who meet the criteria for child protective services (CPS), family reconciliation services (FRS), or child welfare services as defined in RCW 74.13.020. Children in situations outlined below do not meet those criteria:

(1) Children whom the CA social worker determines, after assessment, will not be helped in out-of-home care.

(2) Youths ages twelve through seventeen years of age in conflict with their parents and who have not received family reconciliation services, except families receiving adoption support that have already received extensive counseling services.

(3) Youths ages twelve through seventeen years of age whose family has received family reconciliation services and parents are unwilling to have the youths at home solely due to misbehavior.

(4) Youths for whom the primary placement issue is community protection, including sexual predators covered by the sexually aggressive youth (SAY) statute, RCW 74.13.-075.

(5) Youths who are unwilling to live in the home of parents who are willing to have them at home, when this is the only presenting problem.

(6) Youths who have a mental illness and are a danger to themselves or others as defined by a mental health professional (see chapter 71.34 RCW).

(2007 Ed.)

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0020, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0025 When may the department or a child placing agency authorize foster care placement? The department or a child placing agency may place a child in foster care only under the following circumstances:

(1) The child has been placed in temporary residential care after having been taken into custody under chapter 13.32A RCW, Family Reconciliation Act, to alleviate personal or family situations that present an imminent threat to the health or stability of the child or family.

(2) The child, the child's parent(s), or the department has filed a petition requesting out-of-home placement for the child pursuant to RCW 13.32A.120 or 13.32A.140:

(a) Placement has been approved after a fact finding hearing under RCW 13.32A.170; or

(b) A child has been admitted directly to placement in a crisis residential center (CRC), and the parents have been notified of the child's whereabouts, physical and emotional condition, and the circumstances surrounding the child's placement.

(3) A child has been placed in shelter care under one of the following circumstances:

(a) The child has been taken into custody by law enforcement or through a hospital administrative hold and placed in shelter care; or

(b) A petition has been filed with the juvenile court alleging that the child is dependent; that the child's health, safety, and welfare will be seriously endangered if not taken into custody; and the juvenile court enters an order placing the child in shelter care (see RCW 13.34.050 and 13.34.060).

(4) A juvenile court has made a determination of dependency for a child and has issued a disposition order under RCW 13.34.130 that removes the child from the child's home.

(5) A juvenile court has terminated the parent and child relationship as provided in chapter 13.34 RCW and has placed the custody of the child with the department or with a licensed or certified child placing agency.

(6) The child's parent(s) or persons legally responsible to sign a consent for voluntary placement that demonstrates agreement with an out-of-home placement as described in RCW 74.13.031.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0025, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0030 When may the department serve a child through a behavior rehabilitation services program? (1) The department may serve a child through the behavior rehabilitation services (BRS) program only when the CA social worker has assessed the child's and family's needs and determined that rehabilitative services are necessary and that this is the most appropriate placement for the child.

(2) The department may only provide financial support for a child's BRS placement when the CA social worker has determined this level of care is necessary, the placement is in a licensed or certified home or facility, the provider meets the department's qualifications, and the department has contracted with the provider for that service.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0030, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0035 What is the department's authority to remove a child from a behavior rehabilitation services placement? The department has the authority to remove the child after at least seventy-two hours notice to the child care provider. The department may waive notice in emergency situations or when a court has issued an order changing a child's placement.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0035, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0040 How long may a child served by the department remain in out-of-home placement before a court hearing is held? Within seventy-two hours after a child enters care, a shelter care hearing must be held. Saturdays, Sundays and holidays are excluded in the seventy-two-hour requirement. A court order must be obtained to keep a child in shelter care for longer than thirty days.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0040, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0045 Under what circumstances may a parent sign a consent for voluntary placement of a child in foster care with the department? (1) If alternative placement resources, including social supports in the family home, have been considered and eliminated; and

(2) The department agrees that the child needs to be placed; then

(3) A child's parent may sign a consent for voluntary placement of a child in foster care (if the child is Native American refer to the Indian Child Welfare Act):

(a) If the child and a parent cannot agree to the child's return home but do agree to the child's placement out of the home; or

(b) When a parent is unable to care for a child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0045, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0050 What must a parent do to place the child in foster care with the department? A child's parent may sign a Voluntary Placement Agreement (VPA), DSHS 09-004B(X), to voluntarily place a child in foster care. The consent for voluntary placement must agree with child welfare services as described under RCW 74.13.031. The consent becomes valid when signed by a representative of children's administration.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0050, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0055 How long may a voluntary placement last with the department? A voluntary placement must last no longer than one hundred eighty days. By the end of one hundred eighty days, the child must return to the child's parent or guardian unless the juvenile court has made a judicial determination that:

(1) Return to the parent or guardian is contrary to the welfare of the child; and

(2) Continued placement in foster care is in the best interest of the child.

[Title 388 WAC—p. 290]

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0055, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0060 May the department grant an exception to the length of stay in voluntary placement? (1) The DCFS regional administrator or the regional administrator's designee may grant exceptions to the one hundred eighty-day limit on voluntary placements only:

(a) If the department conducts an administrative review fulfilling the requirements of title 42, United States Code (USC), chapter 675, section 475, and the review chairperson recommends continuation of voluntary placement; and

(b) If a specific date within six months is scheduled for the child to return home; or

(c) The child is seventeen years of age or older.

(2) Exceptions which cause the child to remain in care for longer than twelve months require a court review hearing that meets the dispositional and permanency plan hearing requirements of 42 USC 675, section 475.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0060, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0065 What are the department's placement procedures for an infant residing in foster care with the infant's teen parent? (1) When a teen parent and infant reside in the same facility, the infant's "home" is considered to be the infant's parent's home. Maintenance payments for the teen parent must be increased to provide for the maintenance of the infant. A legal authorization-to-be-placed is not required in order to include an amount sufficient for the infant's maintenance or to issue medical coupons for the infant.

(2) For protection of the infant, a dependency order placing the child in temporary custody of the department may be appropriate. Even if dependency is established, a legal authorization-to-be placed must be obtained to keep the infant in out-of-home care should the teen parent placement setting change so as not to include the infant.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0065, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0070 When does the department authorize foster care payments? The CA social worker authorizes foster care payments when:

(1) The CA social worker documents the need for the type and level of foster care; and

(2) The social worker has documentation showing the department's authority for the placement of the child in foster care as required by WAC 388-25-0025.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0070, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0075 To whom does the department make payment for foster care? (1) The department makes foster care payments only to persons and agencies the department has appropriately licensed and approved, or, if not subject to licensing, the department has certified as meeting the department's licensing requirements, or:

(a) If in another state, persons or agencies meeting the requirements of that state; or

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(b) If in a tribal program, persons or agencies meeting the requirements of that tribal program.

(2) The department makes payment for out-of-state foster care placements only after approval from the two state offices involved (see WAC 388-25-0440).

(3) The department may make foster care payments to licensed or certified foster parents and to persons granted dependency guardianship, if the dependency guardians are licensed or certified as foster parents (see RCW 13.34.234).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0075, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0080 Are dependency guardians who are licensed foster parents able to receive payment from more than one source? (1) When the child is eligible for foster care payments and Social Security Act, Title XVI, Supplemental Security Income (SSI) payments, or Social Security Act, Title II, Survivor's Benefits, Veterans' Administration (VA) benefits, or other sources of income, the dependency guardian may choose one payment source or the other, but not more than one.

(2) If the dependency guardian chooses to receive foster care payments rather than SSI payments or another source in behalf of the child, the department places SSI benefits or the other cited benefit in an account the department may use to meet the cost of care or special needs of the child in accordance with RCW 74.13.060.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0080, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0085 What happens if the dependency guardian receives payments from more than one source? If the dependency guardian has received payment from SSI or another source as well as foster care, an overpayment has occurred. The department must recover the foster care payments made to the dependency guardian for those months for which the dependency guardian also received SSI or other benefits, as well as foster care payments, in behalf of the child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0085, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0090 What are the department's expectations for foster care providers to whom the department makes reimbursement for services? (1) Foster care providers are responsible for:

(a) Protecting and nurturing children in a safe, healthy environment that provides positive support and supervision for the child in care;

(b) Taking the child to a physician or nurse practitioner to complete an EPSDT (early and periodic screening, diagnosis and treatment) examination. EPSDT exams must be scheduled within one month of initial placement and annually thereafter.

(c) Reporting to the social worker the fact that an EPSDT examination took place and if the examination showed that further treatment is needed.

(d) Observing and sharing information about the child's behavior, school and medical status, response to parental visits, and the child's growth and development with persons des-

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igned by the assigned CA social worker (see chapter 388-148 WAC).

(e) Meeting the developmental needs of the child by:

(i) Teaching age appropriate skills;

(ii) Supporting cultural identity;

(iii) Helping the child attach to caring adults;

(iv) Building self esteem;

(v) Encouraging and modeling positive social relationships and responsibilities;

(vi) Supporting intellectual and educational growth;

(f) Supporting the permanent plan for the child;

(g) Participating as a member of the child's treatment team by taking part in the development of the service plan for the child and providing relevant information about the child's progress for court hearings;

(h) Providing assistance to the social worker, when working with the biological parents is part of the service plan, by assisting in family visitation and modeling effective parenting behavior for the family.

(2) Therapeutic foster care and rehabilitative service providers are responsible for additional therapeutic services as defined in their service agreements or contracts with the department.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0090, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0095 What are the requirements for release of foster parents' care records? Foster parent care records may be disclosed upon request in accordance with RCW 42.17.260.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0095, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0100 What are the department's responsibilities regarding financial assistance to support children in the department's foster homes and child placing agency foster homes? (1) The department pays only for placements and plans the department has approved.

(2) The department has final responsibility for determining initial and ongoing eligibility for financial support.

(3) Payment for children served through the behavior rehabilitation services program is limited to those children who are ages six to eighteen.

(4) The department maintains control and oversight of placements and payments through written agreements with the child placing agencies, quarterly reports, and planning meetings with the agency or facility.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0100, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0105 What is the effective date for payment of foster care? (1) The department begins foster care payment for a child on the date the department or its authorized designee places the child in the licensed foster home.

(2) The department pays for each night a child resides in foster care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0105, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0110 What is the effective date for termination of foster care payments? (1) The department ends payment on the day before the child actually leaves the foster home or facility. The department does not pay for the last day that a child is in a foster care home or facility.

(2) The department terminates family foster care payments for children in family foster care effective the date:

(a) The child no longer needs foster care; or

(b) The child no longer resides in foster care except as provided in WAC 388-25-0180; or

(c) The child reaches the age of eighteen. If the child continues to attend, but has not finished, high school or an equivalent educational program at the age of eighteen and has a need for continued family foster care services, the department may continue payments until the date the child completes the high school program or equivalent educational or vocational program. The department must not extend payments for a youth in care beyond age twenty.

(3) The department must terminate foster care payments for children in the behavior rehabilitative services program effective the date:

(a) The child no longer needs rehabilitative services; or

(b) The child is no longer served through contracted rehabilitative services program except as provided in WAC 388-25-0030; or

(c) The child reaches the age of eighteen and continues to attend, but has not finished, high school or an equivalent educational program and has a need for continued rehabilitative treatment services, the department may continue payments until the date the youth completes the high school program or equivalent educational or vocational program. The department must not extend payments for a youth in care beyond age twenty.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0110, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0115 What are the department's general standards for family foster care reimbursement? (1) The standards of payment explained in WAC 388-25-0120 through 388-25-0215 are the basis for the reimbursement rates the department provides for care of children placed in licensed foster care under the department's direct supervision and those children under the supervision of child placing agencies.

(2) The CA social worker must determine the payment plan for all types of family foster care through a review of the needs and resources of each child and the activities of the foster parent which meet those needs.

(3) The CA social worker must discuss any plan above the basic foster care rate with the foster parent so that the foster parent knows:

(a) The basis for payment;

(b) Any increased expectations of the foster parent for service delivery or participation in the case plan for the child; and

(c) The amount included for each item of the child's care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0115, filed 3/30/01, effective 4/30/01.]

[Title 388 WAC—p. 292]

WAC 388-25-0120 What is the department's reimbursement schedule for regular family foster care? (1) The foster care basic rate reimburses the foster parent for costs incurred in the care of the child for room and board, clothing, and personal incidentals. The amount of reimbursement varies according to the age of the child.

(2) The department's children's administration may approve exceptions to the basic rates.

(3) To determine the payment rates, the department considers the child's birth date to be the first day of the month in which the child's birthday occurs.

(4) The standard reimbursement rate allowed is limited to the scheduled rate in existence for the time period(s) in which the child was placed in the foster home.

(5) The department's foster care reimbursement rates are as follows:

Effective Date*

July 2000

Age	0-5	6-11	12 & Older
Totals**	\$351.31	\$426.81	\$499.95

*Schedule will be updated to comply with mandated changes.

**Totals include room and board, clothing allowance, and personal incidentals.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0120, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0125 When may the department authorize a clothing allowance for a child in out-of-home care?

When the department or a contracted child placing agency places a child in foster care or, at other times, the social worker may authorize a clothing allowance to supplement a child's clothing supply, when necessary. This allowance may not exceed two hundred dollars unless authorized by the DCFS regional administrator or the regional administrator's designee. The allowance must be based on the needs of the child and be provided within available funds. Clothing purchased becomes the property of the child and will be sent with the child if placement changes.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0125, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0130 What are the standards for use and reimbursement of receiving home care? The department or a child placing agency uses receiving homes to place a child in a licensed family foster home on a temporary, emergent, or interim basis to provide sufficient time for the development of a plan. This planning includes the involvement of the child, the child's parent(s), and the child's extended family whenever possible.

(1) A DCFS regional administrator must designate family foster homes which are to receive child placements twenty-four hours per day. These homes provide care for children on a temporary, emergent, or interim basis as regular or specialized receiving homes.

(2) If the regional administrator designates a receiving home to be available on a twenty-four-hour basis, the regional administrator must specify this designation in a written agreement with the foster parent. Regular foster homes may also agree to accept children on an emergent basis.

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[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0130, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0135 What are the types of receiving homes and what children are served in them? There are two types of receiving homes: Regular and specialized. Each type of home provides the following services:

(1) Regular receiving homes for children age birth through age seventeen; and

(2) Specialized receiving homes for children who require more intensive supervision than normally provided to children in foster care. The child may require more intensive supervision due to behavioral problems, developmental disability, emotional disturbance, erratic and unpredictable behavior or medical condition (not on personal care or medically intensive DDD program).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0135, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0140 Who decides on the number of receiving homes needed in an area? Each DCFS regional administrator must decide on the number of receiving homes needed for the regional administrators' respective geographical areas.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0140, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0145 How long may a child stay in a receiving home? (1) The department limits a child's maximum length of stay in a receiving home:

(a) Maximum length of stay for regular receiving homes is thirty consecutive days per placement;

(b) Maximum length of stay for specialized receiving homes is fifteen-consecutive days per placement.

(2) The DCFS regional administrator or the administrator's designee may approve extensions of a child's stay in a licensed family foster home paid at a receiving care rate beyond the limits contained in subsection (1) of this section.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0145, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0150 What are the rates for reimbursement to receiving home providers? The current reimbursement rates, effective July 1, 2000, to receiving homes are:

Type of Home	Monthly Retention Fee - Per Bed	Daily Rate per Child in Care
Regular receiving (all ages)	\$51.12	\$19.06
Special receiving, ages 12-17	\$102.99	\$26.08

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0150, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0155 How are rates authorized for reimbursement to receiving home providers? (1) The DCFS regional administrator or the administrator's designee may authorize payments in excess of the standard for individual child-specific situations. The department may, within available funds, purchase clothing and personal incidentals for the child in receiving home care as needed.

(2) The department does not pay the receiving home rate if the child is expected to stay in this placement for longer than thirty days.

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(3) The department may make reimbursement for assessment and interim care through the behavior rehabilitative services program.

(4) The department may, at the direction of the DCFS regional administrator or designee, use qualified, contracted behavior rehabilitative services to provide assessment or interim care for children and youth requiring that level of care as determined by the CA social worker. Unless the department and the provider make an alternate agreement, the department must pay for contracted rehabilitative services at the facility's contracted daily rate for interim or assessment care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0155, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0160 What are the reimbursement standards for payments above the basic foster care rate?

(1) In addition to the basic rate for regular family foster care specified in this chapter, the department may reimburse an additional amount for the specialized care of a child with special needs.

(2) For the child to be eligible for payment above the basic rate, the department's social worker must assess the child's behaviors, intellectual functioning, and/or physical disabilities and determine, with the child's foster parent or prospective foster parent, what services the foster parent will provide to meet the child's special needs.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0160, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0170 What other services and reimbursements may be provided for the support of children placed in foster care by the department? (1) The department may provide additional support services and reimbursements to meet specific needs of the child in care or of the family foster home provider. The department must approve all services and reimbursement amounts in advance of the service being provided. Services are subject to the availability of funds.

(2) Additional services may include the following:

(a) **Receiving home contracted and noncontracted respite** - This service for receiving homes includes child care, relief care, extra supervision for special activities, as well as basic respite care. Respite is subject to the availability of respite homes. Respite contracted but not available will be reimbursed to the regular foster parent.

(b) **Receiving home transportation** - This service reimburses receiving home parents for selected transportation costs, such as demands for training or special appointments for a child in care. The department makes direct payment to the receiving home parent.

(c) **Receiving home contracted support services** - These services are intended to enhance the capacity of regular and specialized receiving homes by increasing the skills of the provider to provide a stable emergency placement. The services include consultation for obtaining resources, training, case conferences, and visits to a child's parents' home by the receiving home provider.

(d) **Receiving home ancillary support services** - These services are reimbursements for activities or items enabling receiving homes to provide extra services to youth in care.

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Examples of such supports include craft items, recreational materials, and tickets to events.

(e) **Hourly or daily foster care respite** - Respite care by the hour or day for receiving and regular foster homes. The department may reimburse foster parents for relief supervision or additional supervision for special activities. The department defines "day" as either an eight-hour period or a block of time, up to twenty-four hours, paid as an eight-hour day. "Light" is defined as care provision that is not significantly different from that required by a child in the general population. However, the child may require some additional attention or assistance. The appropriate rate is determined after assessing the child's care requirement as either "light" or "heavy." "Heavy" is defined as care that requires the caregiver to provide intensive attention or total assistance. Regular intervention is needed to meet the needs of the child. Children having areas of need that are "light" in one area and "heavy" in another are assessed as "moderate."

(f) **Hourly or daily agency foster care respite** - Respite care by the hour or day for receiving and ongoing foster homes. Care may be child specific or related to all the children in the foster home. The department reimburses agencies for purchase of relief supervision and additional supervision for special activities.

(g) **Foster care clothing and personal incidentals** - The monthly rate that the department may reimburse to defray the cost of clothing and personal items for children in selected circumstances when the department is not paying for the child's board and room. The department makes reimbursement to the foster home or facility.

(h) **Foster care personal incidentals** - An amount to reimburse foster parents for purchase of personal items needed by a child in receiving care.

(i) **Foster care medical services** - Reimbursement arranged and made for medical services not covered by the department's regular health insurance program (e.g., orthodontia or corrective surgery) for a child in foster care placement.

(j) **Foster care physical examination/report** - This medical service is used after the decision to place the child has been made and if the child is ineligible for an EPSDT examination or does not have private medical insurance. The service includes arranging and making payment for a physical examination and/or report necessary for a child in or needing foster care placement.

(k) **Foster care psychological evaluation and report** - The department may arrange for this service and make payment to a psychologist, psychiatrist, or other appropriate person for an evaluation of a child, parent, or foster parent. The department authorizes this service to assist in preventing a foster care placement or making an appropriate placement to implement a permanent plan.

(l) **Foster care psychological treatment and report** - The department arranges this service and makes payment to a psychologist, a psychiatrist, or other appropriate person for treatment of a child and/or parent(s) necessary to assist in preventing out-of-home placement, making an appropriate out-of-home placement, or implementing a permanent plan. This service includes a written report of the treatment goals, progress and outcomes.

(m) **Foster care transportation** - Reimbursement for the cost of transportation by car and associated expenses incurred by or on behalf of a child in foster care, receiving family reconciliation services (FRS), adoption services, or for return of a runaway. The department makes reimbursement directly to a vendor or to a foster parent.

(n) **Foster care business account transportation** - Reimbursement for the cost of air and rail transportation and associated expenses incurred by or on behalf of a child in foster care, receiving family reconciliation services (FRS), adoption services, or for return of a runaway. The department makes reimbursement directly to a vendor and charges expenses to the business transportation account (BTA).

(o) **Parent-child visitation** - Transportation and visitation services for children in out-of-home care. Services include:

- (i) Transportation to and from scheduled visits;
- (ii) Monitoring and supervision of family visits; and
- (iii) Reports regarding the nature and progress of visits and the parent/child interaction.

(3) The rates for the specialized services described in this section are contained in the following table. The rates are effective July 1, 2000.

Specialized Services and Reimbursement Rates		
Receiving Care Service	Rating*	Per Hour
Receiving home contracted and non-contracted respite	Light	\$5.84
	Moderate	\$5.98
	Heavy	\$6.25
Receiving home transportation	Amount authorized	
Receiving home contracted support services	Contracted amount	
Receiving home ancillary support services	Amount authorized	
Receiving Foster Care Service	Rating*	Per Hour
Hourly foster care respite	Light	\$6.39
	Moderate	\$5.53
	Heavy	\$6.84
Daily foster care respite	Light	\$49.97
	Moderate	\$52.15
	Heavy	\$54.65
*To determine rating for child's care requirements in physical/medical and behavior/psychological areas:		
Rating of light in both areas = light		
Rating of light in one area and heavy in the other area = moderate		
Rating of heavy in both areas = heavy		
Foster care clothing/monthly (for children not in a paid placement)	Age	7/1/2000
	0-11	\$37.13
	12 & older	\$44.14
Foster care personal incidentals (one time payment)	Age	7/1/2000
	0-5	\$50.65
	6-11	\$55.10
	12 & older	\$59.13
Foster care medical services	Amount authorized	
Foster care physical examination by health care practitioner	\$8.50 - \$25.00 (one time payment)	
Foster care psychological evaluation/report	Up to \$105.00 per unit of service	
Foster care transportation	Up to \$1,000.00	
Foster care business transportation account transportation	Up to \$1,000.00	
Foster care psychological treatment/report	Up to \$1100.00 per unit of service	
Parent-child visitation	As contracted	

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0170, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0175 Under what circumstances may the department provide foster care for educational purposes? (1) The department may provide licensed foster care for a child with physical or mental disabilities when requested by a school district and in concurrence with the wishes of the parents, in accordance with WAC 388-25-0030.

(2) The department will not make the payment when the only need for foster care arises from the need for an education. The department will only pay the cost of foster care when one of the conditions of WAC 388-25-0030 applies.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0175, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0180 Under what circumstances may the department provide reimbursement for foster care if the child is temporarily absent from the foster home or facility? (1) When a child is temporarily absent from a foster home or a facility to which the department is paying the cost of placement, the department may pay for the actual number of days absent, if the number of consecutive days of absence does not go over fifteen days within a thirty-day period. The care provider must notify the DCFS social worker of the absence and whether the absence is planned or unplanned.

(2) The following requirements apply to planned absences:

(a) The care provider must notify the DCFS social worker at least three days in advance of any planned absence. The notification must include the following information:

- (i) Child's name;
- (ii) The address the child will visit;
- (iii) The reason for the visit;
- (iv) The planned beginning and ending dates of absence;

and

(v) A statement as to whether or not the foster care provider will hold the child's unoccupied bed for the child's return to the home or facility.

(b) A private agency must report the frequency, duration, and reasons for visits to the responsible DCFS social worker or local office in the child's quarterly progress report prepared by the private agency.

(c) When there is a planned temporary absence of a child from a foster family home supervised by DCFS, the assigned social worker will participate in the plan.

(3) The following requirements apply to unplanned absence of children from out-of-home care:

(a) The foster care provider must notify the supervising DCFS social worker by the next working day or within eight hours following the child's unplanned absence. Notification may be by a telephone call to the DCFS social worker or the worker's supervisor. The written notification must provide the following information:

- (i) Child's name, age, and home address;
- (ii) Date and time the child left the premises;
- (iii) A statement as to whether the foster care provider is willing to accept the child back into the home or facility; and
- (iv) A statement as to whether or not the foster care provider will hold the child's unoccupied bed for the child's return to the home or facility.

(b) If the foster care provider is willing to accept the child back and holds a vacant bed for the child, the depart-

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ment may continue payment for fifteen days from the date of the child's departure.

(c) The foster care provider must notify the DCFS social worker or local office of the date of the child's return.

(4) In addition to the preceding requirements, the department places the following limitations on the payments for temporary absences of children from foster care:

(a) A child's cumulative total of forty-five days of absence within a six-month period is the maximum allowable for payment unless the DCFS regional administrator or the administrator's designee approves an exception request.

(b) The social worker must provide adequate justification of unusual circumstances to support a request for extension of the consecutive fifteen-day and cumulative forty-five-day limitations.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0180, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0185 May the department consider foster care payments to the foster family in determining eligibility for public assistance? When the department or a child placing agency places a child in foster care with a family receiving public assistance under 42 U.S.C. 601, et seq., the department must not consider payment received by the family for the foster child in determining the family's eligibility for public assistance. The department makes payments, including special or exceptional payments, for the child's board, clothing and personal incidentals.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0185, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0190 What are the department's standards for making foster care payment to a relative providing care to the child served by department? (1) A relative caregiver, licensed or certified as a family foster home under chapter 74.15 RCW and eligible for temporary assistance for needy families (TANF) in behalf of the child, may select either foster care or TANF payments in behalf of the child, but not both.

(2) A relative caretaker who is not related to the specified degree defined in RCW 74.15.020 by blood, marriage, or legal adoption may receive foster care payments in behalf of the child if licensed as a foster family home under chapter 74.15 RCW.

(3) A relative caretaker who is not licensed or certified for foster care may apply for TANF.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0190, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0195 How does the department make reimbursement for foster care for a child served by the department who moves out-of-state with the foster family? (1) A child may join a foster family in a move out-of-state only if this move supports achieving a permanency goal as outlined in the child's case plan.

(2) The department and the foster parent must follow CA requirements when a foster child and the licensed foster family moves out-of-state. This may include obtaining permission of the court before the move.

(3) When the foster family moves to another state, the department must arrange with the other state or local social service agency to license and supervise the home and the placement (see chapter 26.34 RCW). The department does not need to make such arrangements for supervision when the family leaves this state during a vacation.

(a) Before the foster family moves from Washington to the new state, the social worker or the foster parent may request a foster home license application from the new state.

(b) If the department and the foster parent are unable to obtain an application for license before the foster family leaves Washington, the foster parent must, upon arrival in the new state of residence, contact the local foster home licensing agency in the new state to apply for a license in that state.

(4) When the foster family moves to another state with a child in the department's custody, the child's DCFS social worker must submit necessary interstate compact on the placement of children (ICPC) application forms to the department's ICPC program manager. The social worker must do this as soon as the foster family has a new residence or address in the new state. The ICPC request must ask that the new state license the family as a foster home and provide ongoing supervision of the child in care.

(5) The department continues payments at the department's current rates until the other state fully licenses the home. After receiving a copy of the foster family home license from the other state, the DCFS supervising social worker authorizes payment at the receiving state's rates (see WAC 388-25-0195).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0195, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0200 What payment procedures must the department follow for children placed across state borders? (1) When the department places a child into a new placement with a family residing and licensed in another state, the DCFS social worker must obtain the payment rates from that state. Following receipt of the other state's rates, the department will pay that state's rates in accordance with ICPC procedures when:

- (a) Those rates are higher than Washington's rates; and
- (b) The other state identifies its rates to the department.

(2) When the child welfare department in another state places a child, who is a resident of the state of Washington, in foster care the department makes foster care payments at the rate requested by that state.

(3) The CA ICPC program manager must approve out-of-state placement before the department makes payment for foster care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0200, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0205 How does the department treat the earnings of a child in foster care? The department does not include the earnings of a child in out-of-home care when considering if a child is eligible for a particular funding source nor when determining a child's possible participation in the cost of care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0205, filed 3/30/01, effective 4/30/01.]

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WAC 388-25-0210 How does the department treat resources and unearned income of a child in foster care?

(1) Unearned income includes Supplemental Security Income (SSI), Retirement, Survivors and Disability Insurance (RSDI), veteran's benefits, railroad retirement benefits, inheritances, or any other payments for which the child is eligible, unless specifically exempted by the terms and conditions of the receipt of the income. The department must use income not exempted to cover the child's cost of care, except for resources held in trust for an American Indian child.

(2) Any person, agency or court that receives payments on behalf of a child in out-of-home care must send the payments to the department's division of child support.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0210, filed 3/30/01, effective 4/30/01.]

PART C: PARENTAL SUPPORT OBLIGATION

WAC 388-25-0215 What is the parents' obligation to support their child in foster care? Parents of children in foster care must provide financial support for their child in accordance with rules contained in chapter 388-14A WAC.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0215, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0220 Who has authority to recommend or negotiate amounts for parental participation in the cost of foster care? (1) The department's division of child support determines the amount of parental financial support, except when stated in a superior court order. Chapter 74.20A RCW and chapter 388-14A WAC provide the authority and procedures for the division of child support to collect financial support from the parent to pay for a child in foster care.

(2) Only the division of child support may recommend to the court, on behalf of the department, to establish, raise, lower, release, or forgive support payments for a child placed in foster care. No other agency or staff may make agreements with parent(s) or their representatives regarding this matter.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0220, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0225 What cases must be referred to the division of child support (DCS)? Each case where the department participates in the payment of foster care must be referred to the division of child support, except when:

- (1) Collection would not be cost effective, including placements of seventy-two hours or less;
- (2) Collection is exempt by law; or
- (3) A child with developmental disabilities is eligible for admission to or discharged from a residential habilitation center as defined by RCW 71A.10.020(8), unless the child is placed as a result of an action taken under chapter 13.34 RCW.

[Statutory Authority: RCW 74.08.090, 2004 c 183, 74.20.040, and 74.13.020. 05-06-091, § 388-25-0225, filed 3/1/05, effective 4/1/05. Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0225, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0226 Does children's administration refer foster care cases to the division of child support where good cause exists? The children's administration

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must refer to the division of child support foster care cases in which sufficient good cause exists to not pursue collection or establish support or paternity.

[Statutory Authority: RCW 74.08.090, 2004 c 183, 74.20.040, and 74.13.020. 05-06-091, § 388-25-0226, filed 3/1/05, effective 4/1/05.]

WAC 388-25-0227 What constitutes good cause for not pursuing the collection or establishment of child support or paternity? Children's administration uses the following criteria to determine whether sufficient good cause exists for requesting that DCS not pursue collection or establish child support or paternity on foster care cases:

- (1) It is not in the child's best interest;
- (2) The parent or other legally obligated person, or the parent or other person's child, spouse, or spouse's child was the victim of the offense for which the child was committed to the custody of the juvenile rehabilitation administration (JRA) and the child is being placed directly into foster care from a JRA facility until this placement episode closes;
- (3) Adoption proceedings for the child are pending in court or the custodial parent is being helped by a private or public agency to decide if the child will be placed for adoption;
- (4) The child was conceived as a result of incest or rape and establishing paternity would not be in the child's best interest;
- (5) The juvenile or tribal court in the dependency proceeding finds that the parents will be unable to comply with an agreed reunification plan with the child due to the financial hardship caused by paying child support. The social worker also may determine that financial hardship caused by paying child support will delay or prevent family reunification; or
- (6) The custodial parent and/or the child may be placed in danger as a result of the presence of or potential for domestic abuse perpetrated by the person that the division of child support would be pursuing for collection action.

[Statutory Authority: RCW 74.08.090, 2004 c 183, 74.20.040, and 74.13.020. 05-06-091, § 388-25-0227, filed 3/1/05, effective 4/1/05.]

WAC 388-25-0228 Does the division of child support pursue collection or establish child support or paternity on cases in which good cause has been determined? If children's administration determines that there is good cause the division of child support does not pursue collection or establish support or paternity on a foster care case.

[Statutory Authority: RCW 74.08.090, 2004 c 183, 74.20.040, and 74.13.020. 05-06-091, § 388-25-0228, filed 3/1/05, effective 4/1/05.]

WAC 388-25-0229 Who may request a good cause determination? The department or a parent, including an adoptive parent or legal guardian, may initiate a request for good cause determination at any time.

[Statutory Authority: RCW 74.08.090, 2004 c 183, 74.20.040, and 74.13.020. 05-06-091, § 388-25-0229, filed 3/1/05, effective 4/1/05.]

WAC 388-25-0231 When may a good cause determination be requested? A request for determination of good cause may be made at any time.

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[Statutory Authority: RCW 74.08.090, 2004 c 183, 74.20.040, and 74.13.020. 05-06-091, § 388-25-0231, filed 3/1/05, effective 4/1/05.]

WAC 388-25-0235 To whom must parents' send child support payments for their child in foster care? The parents must make all payments for the benefit of the child and/or the costs for a child in out-of-home care to the division of child support, unless a court order directs payment through a clerk of the court. A clerk of the court must send payments, under a court order, to the division of child support.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0235, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0240 Under what circumstances must child care judgment and limited power of attorney for parental support payments be assigned to the department? (1) The department must advise any person or agency having custody of the child that court ordered child support payments are to be received by the department under RCW 74.20A.030 and 74.20A.250.

(2) The person or agency having custody must acknowledge this transferred right to the department by execution of an assignment of judgment and limited power of attorney, which must remain in effect as long as the child receives foster care assistance.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0240, filed 3/30/01, effective 4/30/01.]

PART D: VETERANS' BENEFITS

WAC 388-25-0245 Who receives veterans' benefits for children in foster care? By agreement with the regional office of the veterans' administration, the department may receive benefits on behalf of children who have been placed by court order under the department's supervision or custody.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0245, filed 3/30/01, effective 4/30/01.]

PART E: ADMINISTRATIVE HEARINGS

WAC 388-25-0250 What limitations exist on administrative hearings regarding foster care payments? The foster care provider, the licensed or certified child placement or care agency, and the parents are not entitled to request an administrative hearing to dispute established rates. Chapters 34.05 and 43.20A RCW, chapters 388-01 and 388-148 WAC, and this chapter provide specific rights to administrative hearings.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0250, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0255 What standards must the department apply to contracted and noncontracted service providers and vendors when the department has identified an overpayment to the provider or vendor? (1) RCW 43.20B.675 provides that all vendors have the right to request a hearing if they have a bona fide overpayment dispute. The department must offer a prehearing conference to all clients and vendors that request an administrative hearing.

(2) Contracted and noncontracted service providers may seek dispute resolution through these rules, under the Admin-

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istrative Procedure Act and RCW 43.20B.675, with respect to overpayments. However, the following limitations apply:

(a) The right of vendors to seek an administrative hearing to contest alleged overpayments applies only to overpayments for goods or services provided on or after July 1, 1998.

(b) These procedures do not create a right to a hearing where no dispute right previously existed except as provided in RCW 43.20B.675.

(c) These rules limit disputes for foster family and child day care providers to alleged overpayments. Homes and facilities licensed under chapter 74.15 RCW may appeal adverse licensing actions under the provisions of chapter 388-148 or 388-155 WAC, as applicable.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0255, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0260 Do vendor overpayment rules in this chapter also apply to adoptive parents? Adoptive parents who receive assistance through the adoption support program are not vendors within the meaning of the law and do not fall within the scope of this chapter.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0260, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0265 Are there time limitations on identifying and recovering an overpayment? There is no time limit on identifying and initiating recovery of overpayments.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0265, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0270 May overpayments be waived or forgiven? Children's administration employees do not have authority to forgive or waive overpayments nor to offset overpayments from future payments. All such authority rests with the department's office of financial recovery (OFR). Designated CA staff may mediate a disputed payment with the vendor, but final approval for any negotiated proposed settlement rests with OFR.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0270, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0275 Do other governmental organizations have the right to an adjudicative hearing? Governmental organizations, including Indian Tribes, with an inter-local agreement with the department do not have the right to an adjudicative hearing through the office of administrative hearings (OAH). The disputes process described in the agreement between the entity and the department governs the resolution process.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0275, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0280 What steps must a provider or vendor take when requesting an administrative hearing in regards to an overpayment? A provider or vendor must follow the procedure indicated on the department's Vendor Overpayment Notice, DSHS 18-398A(X), dated 07/1998.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0280, filed 3/30/01, effective 4/30/01.]

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WAC 388-25-0285 When is payment due on an over-payment? When a vendor files a timely and complete request for an administrative hearing, payment on the overpayment is not due on the amount contested until the office of administrative hearings or its designee makes a final decision about the vendor's liability and any amount due.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0285, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0290 Which is the deciding authority if another WAC rule or the provisions of the Administrative Procedure Act conflict with the information in this chapter? The Administrative Procedure Act, chapter 34.05 RCW, chapter 388-02 WAC, and this chapter govern the proceeding. The provisions in this chapter govern if a conflict exists in chapter 388-02 WAC. Chapter 34.05 RCW is the overall governing authority.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0290, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0295 Who establishes guidelines to identify overpayments and to mediate overpayment disputes? (1) Each DCFS regional administrator, division of licensed resources (DLR) regional manager, or CA division director, as applicable, must establish procedures to provide for consistency in the handling of provider or vendor disputes in accordance with the children's administration prehearing procedures and this chapter.

(2) Staff at the following organizational levels will handle disputes:

(a) The DCFS regional administrator is responsible for the dispute resolution process for:

(i) All payments authorized by local office social workers;

(ii) All payments authorized under regionally managed contracts and service agreements.

(b) Regional staff are responsible for the following activities to resolve disputes:

(i) Prehearing conferences;

(ii) Mediation activities;

(iii) Administrative hearings for payments authorized in local offices; and

(iv) Administrative hearings for regionally-managed contracts.

(c) For CA child care subsidy program payment disputes, DLR office of child care policy (OCCP) headquarters staff is responsible for:

(i) Prehearing conferences;

(ii) Mediation activities; and

(iii) Administrative hearings.

(d) Assigned CA division of program and policy development or office of foster care licensing (OFCL) headquarters staff, as applicable, will handle disputes arising from headquarters-managed contracts and service agreements. These staff will handle:

(i) Prehearing conferences;

(ii) mediation activities; and

(iii) Administrative hearings.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0295, filed 3/30/01, effective 4/30/01.]

PART F: FOSTER PARENT LIABILITY FUND

WAC 388-25-0300 What is the foster parent liability fund? (1) The foster parent liability fund authorized under RCW 74.14B.080 allows for insurance coverage for foster parents licensed under chapter 74.15 RCW. The coverage includes personal injury and property damage caused by foster parents or foster children that occurred while the children were in foster care.

(2) Such insurance covers acts of ordinary negligence but does not cover illegal conduct or bad faith acts taken by foster parents in providing foster care. Monies paid from liability insurance for any claim are limited to the amount by which the claim exceeds the amount available to the claimant from any valid and collectible liability insurance.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0300, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0305 What is the period of coverage for foster parent liability fund? Coverage under the foster parent liability fund is for valid claims arising out of occurrences on or after July 1, 1991.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0305, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0310 Who is eligible for coverage under the foster parent liability fund? A person eligible for foster parent liability fund coverage must be licensed or certified by the department or a child placing agency under chapter 74.15 RCW to provide foster family care.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0310, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0315 What are the limits of coverage under the foster parent liability fund? The limits of coverage under the foster parent liability are:

(1) Up to twenty-five thousand dollars per occurrence. "Occurrence" means, for purposes of this chapter, the incident which led to the claim.

(2) The claim must be for a third party personal injury or property damage arising from a foster parent's act or omission in the good faith provision of family foster care and supervision of a foster child.

(3) The department must not make a payment of claims from this liability fund if the foster parent is not liable to the third party or the foster child's birth or adoptive parent or guardian because of any:

- (a) Immunities;
- (b) Limitations; or
- (c) Exclusions provided by law.

(4) The foster parent must, first, exhaust all monetary resources available from another valid and collectible liability insurance before seeking payment from this liability fund. Coverage under this foster parent liability fund must be in excess of any other available liability insurance.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0315, filed 3/30/01, effective 4/30/01.]

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WAC 388-25-0320 The department excludes what claims from coverage under the foster parent liability fund? The department excludes the following claims from coverage under the foster parent liability fund:

(1) Claims arising as a result of a foster parent's illegal conduct or bad faith acts in providing family foster care. Such conduct or act includes but is not limited to:

- (a) Loss arising out of a dishonest, fraudulent, criminal, or intentional act or omission;
- (b) Loss arising out of licentious, immoral, or sexual behavior;

(c) Loss occurring because the foster parent provided a foster child with an alcoholic beverage or controlled substance, other than medication prescribed for the foster child in the amounts prescribed by a physician or other licensed or authorized medical practitioner;

(d) A judgment against the foster parent based on alienation of affection.

(2) Claims based on an occurrence not arising from the family foster care relationship. This includes a foster child's act occurring while the child was temporarily assigned outside the jurisdiction of the foster parent.

(3) Claims for a bodily injury or property damage arising out of the operation or use of any motor vehicle, aircraft, or water craft owned by, operated by, rented to, or loaned to any foster parent; or

(4) Claims for an injury or damage from an occurrence before July 1, 1991.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0320, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0325 What if there are multiple claims for one occurrence under the foster parent liability fund? The twenty-five thousand dollar limitation per occurrence must apply regardless of whether there are multiple claims arising from the same occurrence. The department will consider a claim by one or more foster parents occupying the same household a single claim.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0325, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0330 May another source be used to recover on the same claim paid by the liability fund? (1) If the liability fund pays for a claim, the foster parent must transfer to the department the foster parent's rights of recovery against any person or organization against whom the foster parent may have a legal claim.

(2) The foster parent must sign and deliver to the department any documents necessary to transfer such foster parent's rights to the state.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0330, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0335 What are the department's authority and the foster parent's responsibilities regarding investigation of claims? (1) The department may conduct an investigation of any foster parent liability fund claim.

(2) The foster parent must fully cooperate with the department for any liability fund claims filed against the foster parent.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0335, filed 3/30/01, effective 4/30/01.]

PART G: FOSTER PARENTS PROPERTY DAMAGE REIMBURSEMENT

WAC 388-25-0340 What are the department's responsibilities and limitations for reimbursement for damage or loss caused by a child in family foster care? (1) Within available funds and subject to the conditions in this chapter, the department must reimburse family foster care providers who incur property damages, losses, and emergency medical treatment expenses that are caused by the foster child or respite care child during placement in the foster family's home.

(2) For occurrences on or after October 1, 1999, the department must reimburse the foster parent for the replacement value of any property covered under and subject to the limitations of this chapter (see RCW 74.13.335).

(3) For occurrences before October 1, 1999, the department will reimburse the depreciated value of any property covered under and subject to the limitations of the this chapter.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0340, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0345 What are the eligibility requirements for reimbursements to foster parents for damages? Foster parents are eligible for reimbursement if the foster parents are:

(1) Licensed by DSHS or certified by a child-placing agency and licensed by the department under chapter 74.15 RCW; and

(2) Providing approved DSHS-funded foster care to children in the care, custody, and supervision of DSHS or a licensed child placing agency; or

(3) Providing department-approved and funded respite care to children.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0345, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0350 What are the department's reimbursement limitations? The following reimbursement limitations apply for claims:

(1) The **PER OCCURRENCE/TOTAL** amount the department will pay as the result of any one occurrence must not exceed:

(a) Five thousand dollars for all property damages and losses; or

(b) One thousand dollars for all personal bodily injuries regardless of the number of foster parents or their household members who sustain property damages, losses, or personal bodily injuries.

(2) **PROPERTY DAMAGE ITEMS** are limited to the repair/cleaning cost or the replacement value. The department pays replacement value if the item cannot be repaired or cleaned as substantiated by a detailed retailer estimate or if the repair cost goes over the replacement value of the item. The department may request the final repair bill from foster parents for payment made from estimates provided for purposes of recovery.

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(3) **PROPERTY LOSS ITEMS** are limited to the replacement value as substantiated by the original purchase receipt, if available, and two replacement estimates or replacement purchase receipt.

(4) **PERSONAL BODILY INJURY** claims are limited to the costs incurred for receiving emergency medical treatment services that is not payable or required to be provided under workmen's compensation, or disability benefits law, or under any similar law, or provided under a personal/business medical plan.

(5) For **POLICY DEDUCTIBLES**, foster parents must disclose if their property damages or losses were paid or will be paid under their homeowner, automobile, or other personal/business insurance policy. The department will then limit reimbursement to the policy deductible.

(6) **DENTAL EXPENSES** are limited to costs not payable under a dental plan. The department will pay comparable replacement of dental appliances up to the maximum per occurrence.

(7) **VISION EXPENSES** are limited to costs not payable under a medical plan.

(8) **LABOR EXPENSES** are limited to out-of-pocket costs (materials), incurred by foster parents and substantiated by a retailer. Items requiring installation are to be considered reimbursable expense.

(9) **VETERINARY EXPENSES** are limited to initial treatment expense incurred immediately following an occurrence up to five hundred dollars. Initial treatment expense is defined as emergent care and diagnosis. The department pays replacement value for a property loss sustained not to exceed the substantiated value of the animal or maximum per occurrence, whichever is less.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0350, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0355 What types of claims are specifically excluded from reimbursement? The department specifically excludes the following from reimbursement:

(1) Claims resulting from giving alcoholic beverage or other illegal substance, including tobacco products, to a foster child or respite care child for whatever reason.

(2) Claims resulting from violation of any statute, ordinance, or regulation by the foster child or respite care child.

(3) Claims resulting from failure of the foster parent to give directions, instructions, or to provide proper or adequate supervision to the foster child or respite care child.

(4) Claims resulting from the sexual abuse, or licentious, immoral, or other sexual behavior between foster children and/or respite care children or initiated by a foster parent.

(5) Follow-up medical treatment expenses incurred by foster parents or their household member for a personal bodily injury sustained as a result of an action of the foster/respite care child.

(6) Claims for items which belong to the foster child or respite care child.

(7) Claims resulting from acts of foster children that occur while the child is on a temporary planned, unplanned, or voluntary absence from the foster home.

(8) Claims for lost wages.

(9) Claims for property damages, losses, and emergency medical treatment costs arising out of an act of the fos-

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ter/respite child, with or without the permission of the foster parent, related to the ownership, operation, or maintenance of any owned motor vehicle, including surface, air, or water.

(10) Claims filed by any person other than the foster parent or their household member.

(11) Claims for unsubstantiated property damages or losses alleged to have been caused by the foster child or respite care child.

(12) Claims not received by the department's office of risk management (ORM) within a year after the date of occurrence, regardless of the reason for the delay in filing the claim.

(13) Property damages or loss of items that do not depreciate, including but not limited to antiques, heirlooms, jewelry, figurines, and coin collections.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0355, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0360 What is the procedure for filing a claim? (1) Within thirty days of an occurrence of property damage, loss, or emergency medical treatment, the foster parent must:

(a) Request from the child's social worker a Foster Parent Reimbursement Plan Claim, DSHS 18-400(X) (Rev. 6/96) to file a claim;

(b) Submit the completed claim with all requested information plus any required substantiating documentation;

(2) The claimant must include a statement documenting the reasons for the delay in filing the claim on claims filed more than thirty days after an occurrence.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0360, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0365 Which office within the department determines damage reimbursement? The department's office of risk management determines whether a claim will be paid.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0365, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0370 How are exception requests made? Written requests for exceptions to the terms, limitations, and exclusions specified in the foster parent reimbursement plan must be made to the ORM, Risk Management Administrator, P.O. Box 45844, Mailstop 45844, Olympia, WA 98504-5844. The request must include the justification for the request and alternatives explored. ORM staff will discuss and review requests for exceptions with the CA foster care program manager. Staff in the CA division of program and policy development make final decisions on exceptions.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0370, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0375 What claims may the department deny? The department must deny any claim in which any material fact or circumstance of a property damage, loss, or personal bodily injury is misrepresented or willfully concealed by the foster parent. The department is entitled to recover any payments made in these cases. Claims found to

be fraudulent involving theft or collusion are subject to criminal investigation.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0375, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0380 What must a foster parent do to have a denied claim reconsidered? The foster parent must submit a request for reconsideration in writing within thirty days of the previous decision to the claims program manager, DSHS Office of Risk Management (ORM), P.O. Box 45844, Mailstop 45844, Olympia, WA 98504-5844. The request must include information or documentation not previously provided. All determinations made by the risk management administrator are final and do not constitute a basis for requesting or obtaining an administrative fair hearing.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0380, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0385 Will the department investigate claims? The foster parent must permit the department, upon request, to inspect the damaged property. The department retains the authority to have an inspector of its choice make a damage estimate when, and as often, as the department may require.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0385, filed 3/30/01, effective 4/30/01.]

PART H: FOSTER PARENT TRAINING

WAC 388-25-0390 What are the training requirements for licensed foster parents? See chapter 388-148 WAC for required training for licensed foster parents.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0390, filed 3/30/01, effective 4/30/01.]

PART I: JUVENILE RECORDS

WAC 388-25-0395 What are the department's responsibilities for management of juvenile records? The department must comply with the requirements of chapter 13.50 RCW for management of juvenile records. The department's responsibilities for management of those records are:

- (1) To maintain accurate information and remove or correct false or inaccurate information;
- (2) To take reasonable steps to ensure the security of records and to prevent tampering;
- (3) To make every effort to ensure the completeness of records, including action taken by other agencies with respect to matters in its files; and
- (4) To facilitate inquiries concerning access to records.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0395, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0400 To whom may the department release records? Subject to review the department may release records to the following persons:

- (1) Other participants in the juvenile justice or care system only when an investigation or case involving the juvenile is being pursued by the other participants or when that participant is assigned the responsibility of supervising the juvenile. "Juvenile justice or care agency" means any of the fol-

lowing: Police, diversion units, court, prosecuting attorney, defense attorney, detention center, attorney general, the legislative children's oversight committee, the office of family and children's ombudsman, the department and its contracting agencies, schools; persons or public or private agencies having children committed to their custody; and any placement oversight committee created under RCW 72.05.415;

(2) A contracting agency or service provider of the department that provides counseling, psychological, psychiatric, or medical services may release to the office of the family and children's ombudsman information or records relating to the provision of services to a juvenile who is dependent under chapter 13.34 RCW. The department may provide these records without the consent of the parent or guardian of the juvenile, or of the juvenile if the juvenile is under the age of thirteen, unless otherwise prohibited by law;

(3) A juvenile, a juvenile's parents, the juvenile's attorney, and the juvenile's parent's attorney;

(4) Any person who has reasonable cause to believe information concerning that person is included in the record;

(5) A clinic, hospital, or agency which has the subject person under care or treatment;

(6) Individuals or agencies engaged in legitimate research for educational, scientific, or public purposes when permission is granted by the court.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0400, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0405 Under what circumstances may the department exclude or deny information from release unless authorized by law or court order? The department may withhold the following information unless authorized or ordered by the court:

(1) Information determined by the department to likely cause severe psychological or physical harm to the juvenile or the juvenile's parents;

(2) Information obtained in connection with provision of counseling, psychological, psychiatric, or medical services to the juvenile, when the services have been sought voluntarily by the juvenile, and the juvenile has a legal right to receive those services without the consent of any person or agency. Such information may not be disclosed to the juvenile's parents without the informed consent of the juvenile.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0405, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0410 What may a juvenile or the juvenile's parent do if the department denies access to information? (1) A juvenile or the juvenile's parent may file a motion in juvenile court requesting access to the records.

(2) The person making the motion must give reasonable notice of the motion to all parties.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0410, filed 3/30/01, effective 4/30/01.]

PART J: CHILD PLACING AGENCIES

WAC 388-25-0415 What are the department's expectations for child placing agencies (CPA) to which the department makes reimbursement for services or administrative costs? (1) The department requires that the child

placing agency (CPA) be licensed or certified under chapter 74.15 RCW and have a contract with the department for the provision of child placement and related services.

(2) The CPA must document the services provided in a format described by the department in the contract.

(3) When the department agrees to place a child with a CPA, the licensed or certified agency must maintain the license of the foster family home and provide support services to the foster parents. The department will only place and pay for services with an agency with which the department has a contract. The agency must provide payment to the foster family in accordance with this chapter.

(4) The department requires that private agencies bringing children from other countries for adoption remain financially responsible for the child's placement costs if the adoption is not finalized, disrupts prior to finalization, or until the child reaches age eighteen.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0415, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0420 What steps must the department take when a child whose case management responsibility remains with the department is placed in a home certified by a CPA? (1) The DCFS social worker follows regionally-designated procedures for accessing services and sharing responsibility for utilizing child placing agency foster homes.

(2) The CPA and the DCFS social worker must sign a DSHS Private Child Placing Agency Agreement/Child in Foster Care, DSHS 15-190(X). The agreement designates which agency is responsible for case management services, support activities, and specific parts of the service plan while the child is placed in the CPA foster home. The agency representative and the department social worker must review and revise the agreement by mutual agreement at the request of either party.

(3) The CPA must provide the assigned DCFS social worker with quarterly progress reports for each child placed in homes certified by the CPA.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0420, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0425 What activities must a child placing agency provide in order to receive payment from the department? The CPA must undertake the following activities to receive payment from the department:

(1) Accept referrals of children and families from the department and negotiate a child-specific written service agreement with the department;

(2) Provide child and family case management and support activities as agreed;

(3) Document the case management and support activities as described in the contract between the department and the CPA;

(4) Provide adequate quarterly progress reports to the assigned social worker for each child whose placement or other services the department financially supports.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0425, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0430 Under what conditions and how much will the department reimburse to child placing agencies licensed or certified under chapter 74.15 RCW to provide care to children? (1) The CPA representative must discuss with the department social worker for the child the roles of the agency and the department in the placement, permanency planning, and supervision of the child. The agency representative and the department social worker must also discuss services the department or the agency will provide to the child's parents and extended family.

(2) The CPA must maintain the documentation required by contract to demonstrate all services provided to children in care and for whom the department makes payment.

(3) The department will pay a monthly administrative fee to a CPA if the agency, in addition to supervision of the child, provides services to the child or the child's family.

(4) If the department wants to borrow a CPA-certified home for placement of a child, the department pays the agency for the use of the CPA's foster home with approval of the agency. The department pays the borrowed home fee described in the contract between the department and the agency.

(5) The department will pay a set monthly fee to a child placing agency for a borrowed home if the agency provides supervision services only to the child and no services to the child's family. The department pays this fee only to enable the agency to maintain the foster care license and to provide any related licensing training and support services. This activity includes maintenance of a foster care license for foster parent dependency guardianships in the agency-certified home. The following conditions also apply:

(a) The department may pay for a maximum of two borrowed beds in one foster home.

(b) If one CPA borrows a bed from another CPA, the department will pay only one service fee to one agency for the child. The two private agencies and the department will mutually identify and agree upon the agency the department will pay.

(6) The department may enter into contracts with CPAs to provide intensive treatment and supervision services to children with behavioral, emotional, medical, or developmental disabilities. The department will assess the needs of the child, assign a service level, and pay the rate provided in the contract.

(7) Before making payment for care of a child, the department must determine initial and ongoing eligibility for financial support, approve the placement, and approve the case plan for care of the child and services to the family. The department will document this approval through written agreements, documentary reports, and supervisory conferences with the CPA.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0430, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0435 What steps may the department take if a child placing agency does not meet the requirements of this chapter? (1) In addition to any sanctions included in the department's contract with the CPA, the DCFS social worker must stop payment of the agency administrative fees in accordance with department procedures if the

department does not receive the child's report in the time frame stipulated in WAC 388-25-0425.

(2) The DCFS social worker must inform the regional licenser and contracts coordinator when there are continuing problems with reports.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0435, filed 3/30/01, effective 4/30/01.]

PART K: INTERSTATE PLACEMENTS

WAC 388-25-0440 What are the department's obligations regarding children placed by the department between states? The department must comply with the interstate compact on the placement of children (ICPC) in the interstate placement of children (see chapter 26.34 RCW).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0440, filed 3/30/01, effective 4/30/01.]

PART L: RELATIVE PLACEMENT

WAC 388-25-0445 Under what circumstances does the department choose a relative as the placement for a child in need of out-of-home care? (1) When the department determines that a child needs to be placed outside the home, the department must search for appropriate relatives to care for the child before considering nonrelative placements. See RCW 74.15.020 for the definition of "relative."

(2) The department reviews and determines the following when selecting a relative placement:

(a) The child would be comfortable living with the relative;

(b) The relative has a potential relationship with the child;

(c) The relative is capable of caring for the child and is willing to cooperate with the permanency plan for the child;

(d) The relative is able to provide a safe home for the child;

(e) Each child has his or her own bed or crib if the child remains in the home beyond thirty days.

(3) The department may consider nonrelated family members as potential resources, if these family members become licensed to provide foster care (see RCW 74.15.030).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0445, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0450 Under what circumstances may a relative not be considered as a placement option for a child? The department may exclude relatives who have criminal histories as included in the Adoption and Safe Families Act (ASFA) regulations.

(1) If the department finds that, based on a criminal records check, a court of competent jurisdiction has determined that the relative or a member of the household has been convicted of a felony involving:

(a) Child abuse or neglect;

(b) Spousal abuse;

(c) A crime against a child or children (including child pornography); or

(d) Crimes involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery.

(2) The department may not approve a relative placement if the department finds the relative, or a member of the household, has, within the last five years, been convicted of a felony involving:

- (a) Physical assault;
- (b) Battery; or
- (c) A drug related offense.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0450, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0455 What sources of financial support are available to a relative caring for a child that the department has placed in the relative's home? (1) For relatives needing financial support to care for the child, the social worker may assist the family to apply for temporary assistance for needy families (TANF) through the department's local community services office (CSO).

(2) Relatives who are licensed as foster parents may choose to receive foster care payments. The relative must not receive TANF benefits in behalf of the child in care while at the same time receiving foster care payments (see RCW 74.15.030).

(3) A relative who is not a licensed foster parent at the time of placement may apply to become a foster parent as described in chapter 388-148 WAC.

(4) The relative caring for the child in out-of-home placement may apply to be the representative payee for Supplemental Security Income (SSI) or Social Security Administration benefits for the related child living with the relative. However, if the child is a dependent of the state of Washington with custody assigned to the department by the court, the department will usually remain the payee in behalf of the child until the dependency is dismissed.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0455, filed 3/30/01, effective 4/30/01.]

FAMILY SUPPORTS AND RELATIONSHIPS

WAC 388-25-0460 How does the department treat relatives of specified degree with legally free children? (1) The department acknowledges a continuing relationship between relatives of specified degree and children who are legally free where the relatives choose to continue a relationship with the child and the continuing relationship is in the best interest of the child (see RCW 74.15.020 for the definition of relative of specified degree).

(2) Relatives of specified degree remain legal relatives when a child becomes legally free if those relatives wish to maintain a relationship with the child and the assigned social worker determines the continuing relationship is in the best interest of the child.

(3) Department staff must treat relatives of specified degree as the department treats all relatives under the rules of ICPC and the foster care and foster family home licensing programs.

The rights of the affected relatives of specified degree do not extend beyond adoption of the child except through an open adoption agreement (see RCW 26.33.295).

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0460, filed 3/30/01, effective 4/30/01.]

[Title 388 WAC—p. 304]

STATE SUPPLEMENTARY PAYMENT PROGRAM

WAC 388-25-1000 What is the state supplementary payment (SSP) that is administered by the children's administration (CA)? The state supplementary payment (SSP) is a state-paid cash assistance program for specific eligible foster children with the children's administration.

[Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1000, filed 5/9/05, effective 6/9/05.]

WAC 388-25-1010 What are the eligibility requirements for the CA/SSP program? To be eligible to receive CA/SSP, you must be a child who has entered foster care (Title 45 CFR 1355.20) and is eligible for and receiving Supplemental Security Income (SSI), receiving behavior rehabilitation services (BRS) for out-of-home placement services for all or part of a month, and not be eligible for foster care reimbursement under Title IV-E of the Social Security Act (42 U.S.C. 670).

[Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1010, filed 5/9/05, effective 6/9/05.]

WAC 388-25-1020 When will my eligibility for CA/SSP be determined? The SSP eligibility verification and payment process is usually done two months following the month of your potential eligibility for an SSP payment. You will receive an SSP payment when all of the eligibility criteria (WAC 388-25-1010) have been verified.

[Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1020, filed 5/9/05, effective 6/9/05.]

WAC 388-25-1030 How will I know if I am eligible to receive a CA/SSP payment? Once you have been identified as eligible for a CA/SSP payment, CA will send out written notification to representative payees, legal guardians, and children age eighteen and above.

[Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1030, filed 5/9/05, effective 6/9/05.]

WAC 388-25-1040 Can I apply for the CA/SSP program if I am not identified by CA as eligible for the CA/SSP program? You can apply through children's administration to determine your eligibility for CA/SSP, but eligibility is limited to those meeting the eligibility requirements in WAC 388-25-1010.

[Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1040, filed 5/9/05, effective 6/9/05.]

WAC 388-25-1050 What are my appeal rights if CA determines that I am not eligible for CA/SSP? You have the right to appeal children's administration's denial, termination, or reduction of eligibility for the CA/SSP under RCW 74.13.045 and chapter 34.05 RCW and chapter 388-02 WAC.

[Statutory Authority: RCW 74.04.050, 2002 c 371, RCW 74.04.600 and 74.13.031. 05-11-016, § 388-25-1050, filed 5/9/05, effective 6/9/05.]

(2007 Ed.)

Chapter 388-27 WAC

CHILD WELFARE SERVICES—ADOPTION
SERVICES AND ADOPTION SUPPORT

WAC

ADOPTION SUPPORT PROGRAM

Adoption Services

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 388-27-0225 What are the current maximum rates available for basic adoption support monthly cash payments and special rate? [Statutory Authority: RCW 74.13.109, 74.13.112, 74.13.130, and 2002 c 371. 03-02-059, § 388-27-0225, filed 12/27/02, effective 1/27/03. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0225, filed 3/30/01, effective 4/30/01.] Repealed by 04-06-024, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675.
- 388-27-0235 How does the department evaluate a request for adoption support special rate cash payments? [Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0235, filed 3/30/01, effective 4/30/01.] Repealed by 04-06-024, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675.
- 388-27-0240 How does the department evaluate a request for adoption support supplemental cash payments? [Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0240, filed 3/30/01, effective 4/30/01.] Repealed by 04-06-024, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675.
- 388-27-0245 What specific department requirements apply to supplemental cash payments? [Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0245, filed 3/30/01, effective 4/30/01.] Repealed by 04-06-024, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675.
- 388-27-0270 What department requirements apply to child care services? [Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0270, filed 3/30/01, effective 4/30/01.] Repealed by 04-06-024, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675.

ADOPTION SUPPORT PROGRAM Adoption Services

WAC 388-27-0005 What is the legal basis for and purpose of the department's adoption program? (1) Adoption services are included in RCW 74.13.020 as a child welfare service.

(2) The purpose of the department's adoption program is to meet the permanency needs of children who are in the department's care and custody.

(a) The agency that has the responsibility for providing services to the family and makes permanent plans for children.

(b) The permanent plan must include a primary outcome and may also include alternate outcomes (see RCW 13.34.145). Possible permanent plans include:

- (i) Return home;
- (ii) Adoption;
- (iii) Guardianship;
- (iv) Permanent legal custody; or
- (v) Independent living if the child is over age sixteen.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0005, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0010 What definitions apply to the department's adoption program? "Agency" means any public or private association, corporation, or individual licensed or certified by the department as a child placing agency under chapter 74.15 RCW or as an adoption agency.

"Adoptee" means a person who is to be adopted or who has been adopted.

"Adoption" means the legal granting of the adoption decree consistent with chapter 26.33 RCW.

"Adoptive parent" refers to a person or persons who seeks to adopt or who has adopted.

"Alleged father" refers to a person whose parent-child relationship has not been terminated, who is not a presumed father under chapter 26.26 RCW, and who alleges himself or whom a party alleges to be the father of the child. It includes a person whose marriage to the mother was terminated more than three hundred days before the birth of the child or who was separated from the mother more than three hundred days before the birth of the child.

"Approved adoptive home" refers to any person or persons who has been approved for adoption in a preplacement report completed pursuant to RCW 26.33.190.

"Birth parent" means the biological mother or biological or alleged father of a child, including a presumed father under chapter 26.26 RCW, whether or not a court of competent jurisdiction has terminated the person's parent-child relationship.

"Child placing agency" means an agency licensed by the department to place children for temporary care, continued care, or adoption.

"Children's administration" (CA) means the cluster of programs within the department of social and health services responsible for the provision of child welfare, adoption, child protective, child care licensing, and other services to children and their families.

"Department" means the department of social and health services (DSHS).

"Department placement" refers to the placement of a child for whom the department has placement authority in an approved adoptive home.

"Division of children and family services" (DCFS) is the division of children's administration that provides child welfare, child protective, family reconciliation, and support services to children in need of protection and their families.

"Division of licensed resources" (DLR) is the division of children's administration responsible for licensing or certifying child care homes and facilities under the authority of chapter 74.15 RCW.

"Foster-adopt" refers to families that are interested in adoption who have an approved adoptive home study and who have also been granted a foster home license in accordance with chapter 388-148 WAC.

"Independent placement" refers to the placement of a child in an adoptive home by a doctor, attorney, or other individual acting as a facilitator.

"Inter-country placement" refers to the placement of a child for adoption who is not a resident and/or citizen of the United States.

"Relative" means a person related by blood, marriage, or legal adoption, as defined in RCW 74.15.020.

"Voluntary adoption plan" means an agreement by the birth parent(s) to the termination of parental rights with a specific proposal for adoptive placement for the child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0010, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0015 What are the eligibility criteria for the department's adoption program? (1) The department provides adoption services to any child in the department's care and custody:

- (a) With an identified permanent plan of adoption; or
- (b) When the department considers adoption as an alternate permanent plan; and
- (i) The child is in supervised out-of-home care; or
- (ii) The child's birth parent(s) requests adoption as a permanent plan prior to the child's placement in out-of-home care.

(2) The department considers families who apply for adoption services to be resources for children in the department's care and custody if the potential parent(s) is:

- (a) Legally competent;
- (b) Eighteen years of age or older; and
- (c) Has an approved adoptive home study.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0015, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0020 When does the department provide general adoption services? The department provides general adoption services throughout the case planning of any child with an identified primary or alternate permanent plan of adoption until:

- (1) Finalization of the adoption; or
- (2) Adoption is no longer the identified permanent plan.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0020, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0025 What general adoption services does the department provide? (1) The department provides the following general adoption services prior to the finalization of an adoption:

- (a) Social work services to birth parents and children to achieve a permanent family for each child;

(b) Use of the courts, legal counsel, and juvenile court specialists for termination of parental rights and granting of adoption petitions;

(c) Obtaining available child and family medical and social background information for disclosure to adoptive families;

(d) Recruitment, study, and approval of adoptive and foster-adopt families;

(e) Assessment of the child and the current caretaker to determine if the placement is an appropriate adoptive placement;

(f) Placement of children with waiting adoptive or foster-adopt family;

(g) Social work services and/or referral of children and families to services after placement to facilitate the adoption;

(h) Development of alternate plans when the planned adoptive placement is not in the best interest of the child and/or the adoptive family; and

(i) Location and exchange, on a state and national basis, of information about children and adoptive families.

(2) The department administers the state's adoption support program on behalf of eligible children adopted through the department or a private child-placing agency (see WAC 388-25-0120 and following).

(3) The department administers the interstate compact on the placement of children (ICPC) and the interstate compact on adoption and medical assistance (ICAMA) and cooperates, upon request, with other state and tribal child welfare agencies in adoptive planning for children.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0025, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0030 What procedures must the department follow for the interstate placement of children? (1) Washington state is a member of Interstate Compact on Placement of Children (ICPC) and Interstate Compact on Adoption and Medical Assistance (ICAMA) and must meet all compact requirements (see chapter 26.34 RCW).

(2) The rules of this chapter apply to accepted ICPC cases.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0030, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0035 What adoption services does the department provide for children in the department's care and custody? (1) The department's adoption services for children include:

(a) Social work services with birth parents focused on locating a permanent home for the children.

(b) Social work services with children focusing on the child's educational, medical, psychological, and developmental needs;

(c) Petitioning the court for termination of parental rights;

(d) Facilitating voluntary relinquishments when a voluntary adoption is in the child's best interests;

(e) Assessment of children to determine their medical and social needs including, as needed:

- (i) Psychiatric evaluations;
- (ii) Psychological evaluations;

- (iii) Educational evaluations; and
- (iv) Medical evaluations;
- (f) Evaluating prospective adoptive families through the use of the adoptive home study, also known as the preplacement report, to determine appropriateness for adoption generally and to determine What specific child characteristics or needs that the family will best be able to meet.
- (g) Making adoptive placements that are best able to meet a child's needs, from available resources;
- (h) Social work services and/or referral of children and families to services after placement;
- (i) The department social worker assigned to finalizing the adoption will assist families complete the adoption support program application for children who may be eligible for the adoption support program;
- (j) Provision of post-placement reports and other documents required for finalization to the court for a child when the department:
 - (i) Conducts the post-placement reports and other documents required for finalization to the court for a child when the department:
 - (ii) Has custody of the child;
 - (k) Provision of the consent to the adoption of a child in the department's custody.
- (2) Every six months, the department must review and adjust the case plan for children continuing in foster care under department care and supervision. The CA social worker must develop the case plan in accordance with chapter 13.34 RCW to achieve the permanency planning goals for the child.
- (3) The department may utilize the following methods to locate an adoptive resource for a child until the child has been placed with an adoptive family:
 - (a) Ask birth parents to identify a potential adoptive family;
 - (b) The department prefers to place a child for adoption with a fit and willing relative who is known to the child and with whom the child is comfortable:
 - (i) Conduct searches for relatives who are fit and willing to adopt the child, who are known to the child and with whom the child is comfortable;
 - (ii) Ask the relatives to be considered as a potential adoptive family;
 - (c) Ask current and past foster parents if they wish to be considered as a potential adoptive family;
 - (d) Consider families that have an approved adoptive home study; and/or
 - (e) Conduct individualized child specific family recruitment.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0035, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0040 What adoption services does the department provide for prospective and approved adoptive families? (1) For department placements, the department:

- (a) Accepts applications from families residing in the state of Washington that are interested in adopting a child who is in the care and custody of the department. Children in the care and custody of the department may have special needs.

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(b) Initiates an adoptive home study and achieves one of the following outcomes:

- (i) Approves the family for an adoptive placement and registers the family with the contracted adoption resource exchange unless a placement decision has already been made;
- (ii) Denies the application to adopt; or
- (iii) The family withdraws the application to adopt.
- (c) Searches for an appropriate placement for families with an approved adoptive home study;
- (d) Obtains the prospective adoptive child's available medical and family background information and discloses the available information to the adoptive family;
- (e) Removes a family from the contracted adoption resource exchange for any of the following reasons:
 - (i) A child has been placed with the family;
 - (ii) The family decides to receive adoption services through a private agency or an independent placement;
 - (iii) The department receives additional information that causes the department to revoke the approved status of a family;
 - (iv) The family and/or social worker determines that adoption is no longer an appropriate plan for the family; and/or
 - (v) The family relocates its residence to another state.
- (f) Reevaluates a family's situation at the time of reapplication if a family was removed from the exchange registry and reapplies for adoption services;
- (g) Informs families in writing of action the department has taken, according to the rules of this chapter;
- (2) The department does not provide adoption or adoption-related services for inter-country adoptions or for independent adoptions.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0040, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0045 When may the department place a dependent child (not legally free) into an adoptive home? The department may place a child into a foster-adopt home under the following conditions:

- (1) When the identified family has been granted a foster home license in accordance with chapter 388-148 WAC; and
- (2) When the identified family has an approved adoptive home study that has been filed with the court in compliance with RCW 26.33.190.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0045, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0050 When may a legally free child be placed into an adoptive home? The department may place a child into an adoptive home under the following conditions:

- (1) When the identified prospective adoptive family has an approved adoptive home study; and
- (2) The adoptive home study has been filed with the court in compliance with RCW 26.33.190.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0050, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0055 What is a voluntary adoption plan? A voluntary adoption plan (VAP) occurs when a par-

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ent(s) has agreed to the termination of parental rights and has proposed a specific adoptive placement for the child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0055, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0060 When must the department follow a voluntary adoption plan? The department must follow the voluntary plan for adoption if:

(1) The prospective adoptive parents chosen by the parent are properly qualified to adopt in compliance with chapter 26.33 RCW or WAC 388-25-0025; and

(2) The court determines that this adoption is in the best interest of the child; and

(3) The VAP is proposed to the department before a petition for termination of the parent-child relationship has been filed.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0060, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0065 Will the department consider a proposed voluntary adoption plan if a termination petition has already been filed at the request of the department? If the attorney general's office has filed a termination petition at the request of the department, the department must consider, but is not required to support, an adoptive resource proposed by the parent.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0065, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0070 What will the department do to implement a voluntary adoption plan? The department must take the following actions to implement a VAP:

(1) The assigned CA social worker must work with the parent to determine whether the parent will identify a preferred adoptive placement by name.

(2) If a parent identifies a preferred placement, the assigned social worker must advise the parent and the proposed adoptive parent(s) that an adoption home study must be completed. CA, a private agency, or a qualified individual may complete the adoptive home study (see RCW 26.33.-190).

(3) If the proposed adoptive parent chooses to have an adoptive home study completed by a private agency or qualified individual, CA retains the right to do its own home study if CA has concerns regarding the recommendations contained in the nondepartmental home study.

(4) Using approved procedures for determining suitability to be an adoptive resource, the child's social worker and the social worker for the adoptive family must determine:

(a) That the preplacement investigation and report, as described in RCW 26.33.190, on the proposed family results in approval of the adoptive placement; and

(b) That this placement is in the best interest of the child.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0070, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0075 What must the department do to maintain confidentiality of adoption records? (1) In accordance with chapter 26.33 RCW all records and information

the department obtains in providing adoption services are confidential.

(2) To ensure that the department case file of an adopted child remains confidential, the CA local office must send the child's case file to CA headquarters for archiving upon the issuance of the decree of adoption.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0075, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0080 Under what conditions may the department reveal identifying information about the birth parent? When providing reports or information on the adoptive child to the prospective or actual adoptive parents, the department must not reveal the identity of the birth parents of the child, unless:

(1) There is a written open communication agreement where the identity of the birth parent(s) is known;

(2) The birth parent is already known to the adoptive family; or

(3) The birth parent has selected the adoptive family, and the birth parent's identity has already been established.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0080, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0085 What must the department, private practitioner, or child placing agency do to locate records and information relating to the birth parents and the child? (1) The social worker, child placing agency, or another assigned worker must make the following efforts to locate records and information relating to the birth parent and the child:

(a) Ask the birth parents, the child, and relatives, when available, for names of all:

(i) Physicians;

(ii) Treatment agencies for medical, psychological, or educational services that have seen the parent or child for examination, evaluation, or treatment; and

(iii) Schools attended by the child and the parent.

(2) The social worker, contractor, or another assigned worker must contact the children's administration Supplemental Security Income (SSI) facilitator to obtain medical, psychological, or social information gathered during any SSI screen or application process.

(3) The social worker, contractor, or another assigned worker must document efforts, including unsuccessful efforts, made to obtain information by:

(a) Placing the gathered records in the child's case file;

(b) Documenting the information on the child's health and education record;

(c) Documenting on the health and education passport in CAMIS;

(d) Maintaining copies of written requests to service providers for records in the child's case file;

(e) Documenting efforts on the Child's Medical and Family Background Report, DSHS 13-041(X), unless the information is already documented on the health and education passport in CAMIS.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0085, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0090 What information must the department or child placing agency provide to prospective adoptive parents about the child that is being considered for adoption? (1) The department or the child placing agency must provide a medical report containing all known and available information concerning the mental, physical, and sensory handicaps of an adopted child, or a child placed for adoption, to the adoptive or prospective adoptive parents under the authority of RCW 26.33.020, 26.33.340, 26.33.343 and 26.33.350.

(2) The department or the child placing agency worker must provide the Child's Medical and Family Background Report, DSHS 13-041(X), to the prospective adoptive parents. This report must include documentation of efforts made to obtain medical and social information on the child and birth parents.

(3) The department must provide a social history report on the child and birth family that includes, at a minimum in accordance with RCW 26.33.380:

- (a) Circumstances of the child's birth;
- (b) Chronological report of how the child came to be available for adoption;
- (c) The child's placement history;
- (d) All court reports pertaining to the dependency and custody of the child;
- (e) The child's education history, including school reports and records; and
- (f) The child's psychological and psychiatric reports and recommendations.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0090, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0100 What information must the department or child placing agency provide to prospective adoptive parents about the birth parent(s) of a child being considered for adoption? The department or the child placing agency must provide a nonidentifying report on the birth parent(s) that includes any known and available social and medical information on the child's birth parent(s) in accordance with RCW 26.33.380. This information regarding the birth parent(s) must include but is not limited to:

- (1) First names only;
- (2) Current age of parent(s);
- (3) Heritage, including nationality, ethnic background, and race;
- (4) General physical appearance, including height, weight, color of hair, eyes, and skin or other information of a similar nature;
- (5) Education, including the number of years of school completed at the time of the adoption, and school report (if still attending), but not the name or location of the school;
- (6) Religion or religious heritage;
- (7) Occupation, but no specific titles or places of employment;
- (8) Talents, hobbies, and special interests;
- (9) Family history and circumstances leading to the adoption;
- (10) Medical and genetic history including:
 - (a) Available psychiatric, psychological, and substance abuse reports;

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(b) Available medical history including any acute or chronic conditions;

(c) Available medical history of the birth and pregnancy, including any known substance abuse by the birth mother while pregnant.

(11) First names other children of birth parents by age and sex;

(12) Available medical histories of other children;

(13) Extended family of birth parents by age and sex;

(14) Medical histories of extended family members, if known;

(15) The fact of the death, age at death, and cause, if known, of a birth parent;

(16) Photographs of child and birth family, if available; and

(17) Name of agency or individual that facilitated the adoption.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0100, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0105 When will the department, private practitioner, or child placing agency disclose required information? The department, private practitioner, or child placing agency must disclose available child and birth family medical and social background information prior to the finalization of an adoption. Disclosure may occur:

(1) Prior to the placement of a child into an adoptive home; or

(2) At the time when a placement is identified as an adoptive placement.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0105, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0110 How does an adoptee, adoptive parent, or birth parent obtain nonidentifying information from an archived adoptive record? (1) Nonidentifying information about the birth parents, adoptee, or adoptive parent may be shared with persons identified in RCW 26.33.020 and 26.33.340.

(2) If the adoption was facilitated through the department, a request for information must be made in writing to the state office of Children's Administration, P.O. Box 45713, Olympia WA 98504-5713. The state office is the sole source for releasing information from an archived record.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0110, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0115 What is the department response to requests for public disclosure of an adoptive record? The department complies with the requirements for disclosure of public records in RCW 26.33.340.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-27-0115, filed 3/30/01, effective 4/30/01.]

Part A: General

WAC 388-27-0120 What is the legal basis of the department's adoption support program? The legal authorities for the program are:

(1) Revised Code of Washington (RCW) 74.13.100 through 74.13.159;

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(2) Chapter 42 United States Code (U.S.C.) 671-675; and

(3) The U.S. Department of Health and Human Services (DHHS) policy guidelines for states to use in determining a child's eligibility for Title IV-E adoption assistance (contained in DHHS Policy Manual).

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0120, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0120, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0125 What is the purpose of the adoption support program? The adoption support program encourages the adoption of special needs children in the legal custody of public or private nonprofit child care agencies who would not be adopted if support for the child was not available.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0125, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0130 What definitions apply to the adoption support program? The following definitions apply to this chapter:

"Adoption" means the granting of an adoption decree consistent with chapter 26.33 RCW.

"Adoption support agreement" means a written contract between the adoptive parent(s) and the department that identifies the specific support available to the adoptive parent(s) and other terms and conditions of the agreement.

"Adoption support cash payment" means negotiated monthly cash payments paid pursuant to an agreement between the adoptive parent(s) and the department after the child's adoption.

"Applicant" means a person or couple applying for adoption support on behalf of a child the person or couple plans to adopt.

"Child placing agency" means a private nonprofit agency licensed by the department under chapter 74.15 RCW to place children for adoption or foster care.

"Department" means the department of social and health services.

"Extenuating circumstances" means a finding by an administrative law judge or a review judge that one or more certain qualifying conditions or events prevented an otherwise eligible child from being placed on the adoption support program prior to adoption.

"Medical services" means services covered by Medicaid (and administered by the medical assistance administration) unless defined differently in the adoption support agreement.

"Negotiation" means the process of working toward an agreement between the department and the adoptive parent on the terms of the adoption support agreement, including any amount of monthly cash payment.

"Nonrecurring costs" means reasonable, necessary, and directly related adoption fees, court costs, attorney fees, and other expenses the adoptive parent incurs when finalizing the adoption of a special needs child. Total reimbursement from the department may not exceed one thousand five hundred dollars.

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"Placing agency" means the agency that has the legal authority to place the child for adoption. This may be the department or a private nonprofit child placing agency.

"Program" means the department's adoption support program.

"Reconsideration" means the limited state-funded support available to an eligible child whose adoption was finalized without a valid adoption support agreement in place.

"Resident state" (for purposes of the child's Medicaid eligibility) means the state in which the child physically resides. In some cases this may be different from the state of the parent's legal residence.

"Special needs" means the specific factors or conditions that apply to the child and that may prevent the child from being adopted unless the department provides adoption support services. See WAC 388-27-0140 for a detailed description of the factors or conditions.

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0130, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0130, filed 3/30/01, effective 4/30/01.]

Part B: Eligibility

WAC 388-27-0135 What are the eligibility criteria for the adoption support program? For a child to be eligible for participation in the adoption support program, the department must first determine that adoption is the most appropriate plan for the child. If the department determines that adoption is in the child's best interest, the child must:

(1) Be less than eighteen years old when the department and the adoptive parents sign the adoption support agreement;

(2) Be legally free for adoption;

(3) Have a "special needs" factor or condition according to the definition in this rule (see WAC 388-27-0140); and

(4) Meet at least one of the following criteria:

(a) Is in state-funded foster care or child caring institution or was determined by the department to be eligible for and likely to be so placed (For a child to be considered "eligible for and likely to be placed in foster care" the department must have opened a case and determined that removal from the home was in the child's best interest.); or

(b) Is eligible for federally funded adoption assistance as defined in Title IV-E of the Social Security Act, the Code of Federal Regulations, the U.S. Department of Health and Human Services establishing guidelines for states to use in determining a child's eligibility for Title IV-E adoption assistance.

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0135, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0135, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0140 What constitutes a "special needs"? To be considered a child with special needs the following three statements must be true:

(1) One or more of the following factors or conditions must exist:

(a) The child is of a minority ethnic background;

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(b) The child is six years of age or older at the time of application for adoption support;

(c) The child is a member of a sibling group of three or more or of a sibling group in which one or more siblings meets the definition of special needs;

(d) The child is diagnosed with a physical, mental, developmental, cognitive or emotional disability; or

(e) The child is at risk for a diagnosis of a physical, mental, developmental, cognitive or emotional disability due to prenatal exposure to toxins, a history of serious abuse or neglect, or genetic history.

(2) The state has determined that the child cannot or should not be returned to the home of the biological parent; and

(3) The department or child placing agency that placed the child for adoption must document that except where it would be against the best interests of the child the department or child placing agency had made a reasonable but unsuccessful effort to place the child for adoption without adoption support.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0140, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0145 What constitutes a reasonable effort to place a child for adoption without adoption support? Reasonable effort to place a child without adoption support includes:

(1) A child registered for three months with the Washington adoption resource exchange (WARE) without finding an adoptive family; or

(2) A child for whom a documented, formal agency search was conducted for three months, without finding a family who would adopt the child without adoption support services; or

(3) A child for whom the placing agency's selected prospective adoptive family is unable to adopt the child without assistance from the adoption support program.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0145, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0150 Under what circumstances would it be against the best interest of the child to search for a family that could adopt the child without adoption support? Searching for a family that could adopt the child without adoption support is against the best interest of the child when:

(1) A foster parent desires to adopt a child who:

(a) Has been in the foster parent's home for six months or more before that child becomes legally free for adoption; and

(b) The child has close emotional ties to the current foster parent which, if severed, may cause emotional damage to the child; and

(c) The foster parent is identified as the adoptive parent of choice by the department or agency staff having responsibility for the child (RCW 26.33.190 and 74.13.109(4)); or

(2) The adoptive parent is a relative of specified degree as defined in RCW 74.15.020 (4)(a) and has an approved adoptive home study per RCW 26.33.109 and 74.13.109(4).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0150, filed 3/30/01, effective 4/30/01.]

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WAC 388-27-0155 Are there other factors affecting a child's eligibility for adoption support? (1) A child is not eligible for adoption support program services and payments if the adopting parent is the birth parent or stepparent of the child.

(2) The department must not use the adoptive parents' income as a basis for determining the child's eligibility for the adoption support program, however, the department must consider income and other financial circumstances of the adopting family as one factor in determining the amount of any adoption support cash payments to be made. (See WAC 388-27-0230.)

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0155, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0155, filed 3/30/01, effective 4/30/01.]

Part C: Application

WAC 388-27-0160 How does a prospective adoptive parent apply for adoption support services? There are two ways a prospective adoptive parent (applicant) may apply for adoption support services:

(1) An applicant may apply through the social worker of the child to be adopted. The social worker must:

(a) Register the child with the adoption support program; and

(b) Submit the applicant's completed program application along with a completed worksheet used to assist the family and the department in determining services and amount of monthly cash payment, if needed, based on the needs of the child and family circumstances.

(2) An applicant may also apply directly to the adoption support program for adoption support services if:

(a) The child does not have an assigned social worker; or

(b) The applicant and the social worker have a dispute regarding the content of the program application.

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0160, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0160, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0165 What requirements apply to an application for ongoing adoption support? (1) The application must include a copy of the child's medical and family background report signed by the adoptive parent(s) (DSHS 13-041 minus the attachments). It must also include copies of medical and/or therapist reports that document the child's physical, mental, developmental, cognitive or emotional disability or risk of any such disability.

(2) If the applicant is requesting a cash payment, the applicant and the department must mutually determine both the type and amount according to the requirements of WAC 388-27-0230.

(3) If the applicant is requesting reimbursement of non-recurring costs, the applicant must include this request in the application. (See WAC 388-27-0380 and 388-27-0385 for the type and amount of expenses the department may reimburse.)

(4) The applicant must furnish a copy of the applicant's most recently filed federal income tax return. If the applicant is not required to file a federal income tax return, the appli-

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cant must submit a financial statement with the applicant's adoption support application.

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675, 04-06-024, § 388-27-0165, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0165, filed 3/30/01, effective 4/30/01.]

Part D: Agreement

WAC 388-27-0170 What is the nature and purpose of an adoption support agreement? The adoption support agreement is a binding contract between the adoptive parent(s) and the department that identifies the terms and conditions that both parties must follow.

[Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0170, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0175 What must be included in an adoption support agreement? The adoption support agreement must:

(1) State the amount of cash payments (if any) the department must make to the adoptive parent(s) on behalf of the child;

(2) Include an itemized list of the additional services (including Title XIX Medicaid and Title XX social services) for which the child is eligible;

(3) Contain statements that:

(a) Assure that participation in the adoption support program must continue, as long as the child is eligible, regardless of where the adoptive family resides;

(b) Inform the adoptive parent(s) of specific circumstances that may warrant further renegotiation and adjustment of the payment as agreed to by the adoptive parents and the department;

(c) Inform the adoptive parent(s) that the agreement must be reviewed every five years. Terms of the agreement may be modified according to WAC 388-27-0200;

(d) Inform the adoptive parent(s) that the department may suspend a child from the program within thirty days of any changes in circumstances (of the child or family) that affect the child's eligibility for program payments if the adoptive parent has failed to notify the department of the changes; and

(e) Define the circumstances under which the agreement may be terminated.

(4) Be signed by all relevant parties before the final adoption decree is issued (45 C.F.R. Sec. 1356.40).

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675, 04-06-024, § 388-27-0175, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0175, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0180 If the adoptive family resides in or moves to another state, how is the child's participation in the adoption support services affected? If the adoptive family resides in or moves to another state the child's participation in the adoption support program is affected as follows:

(1) Social services (Title XX) become the responsibility of the new state of residence.

(2) Medical benefits (Title XIX Medicaid) remain the responsibility of Washington state if the child is not eligible

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for federal Title IV-E adoption assistance. However, Washington state is no longer responsible if the child becomes eligible for the resident state's Title XIX program through the Interstate Compact on Adoption and medical assistance or other eligibility factors.

(3) Title XIX Medicaid benefits become the responsibility of the resident state if the child receives Title IV-E adoption assistance.

(4) Medicaid benefits included in Washington state's Medicaid plan, but not included in the resident state's plan, must remain the responsibility of Washington state and subject to Washington state plan limits.

(5) Washington state remains responsible for any cash payments made to the adoptive parent(s) on behalf of the child or any non-Medicaid counseling that has been preauthorized by the adoption support program per WAC 388-27-0245.

[Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0180, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0185 When does the adoption support agreement become effective? (1) Unless otherwise stated in the adoption support agreement, an adoption support agreement takes effect on the first day of the month following the month in which the court finalizes the adoption.

(2) If the child to be adopted needs support benefits prior to finalization, the assigned regional adoption support program manager may arrange an early effective date. To be eligible for an early effective date, the applicant must:

(a) Have an adoption support agreement signed by all parties;

(b) Sign the child's medical and family background report (DSHS 13-041) and a statement of the applicant's intention to adopt; and

(c) Have the department's designee sign "an exception to policy" statement.

[Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0185, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0190 If the department implements adoption support services prior to the adoption, may the adoptive parent(s) continue to receive department-funded foster care payments while also receiving adoption support payments? (1) The adoptive parent(s) may not continue to receive department-funded foster care payments for a child while also receiving adoption support payments for the same child.

(2) If the adoptive parent(s) receives department-funded foster care for the child to be adopted, the department's social worker assigned to the child must terminate that coverage on the last day of the month preceding the month in which the adoption support becomes effective.

(3) Foster care payments are paid after the month of service. Adoption Support payments are paid prior to the month.

(4) The adoptive parent(s) may not receive foster care payments and adoption support cash payments for the same child for the same month.

(5) If the adoptive parent is adopting a relative child and has been receiving a nonneedy relative grant the adoptive parent must notify the community services office financial services specialist that the adoption has been finalized. The

adoptive parent may not receive both the grant and adoption support payments for the same month for the same child.

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0190, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0190, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0195 May the adoptive parent(s) change the benefits contained in the adoption support program? The adoptive parent may submit a written request asking that the department renegotiate the benefits offered in the adoption support agreement whenever either the family's economic circumstances or the condition of the child changes.

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0195, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0195, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0200 When may the department modify the terms of the adoption support agreement? The department's adoption support program may modify the terms of an adoption support agreement:

- (1) At the request of the adoptive parent(s);
- (2) When specific circumstances warrant renegotiation and adjustment of monthly cash payment as agreed to by the adoptive parents and the department;
- (3) When the department loses contact with the adoptive parent(s);
- (4) When the child is placed outside of the adoptive parents' home at department expense;
- (5) If the adoptive parent is no longer providing for the child's daily care and living expenses; or
- (6) If the adoptive parent fails to notify the department's adoption support program within thirty days of a change of circumstance which affects the adopted child's continuing eligibility for adoption support program cash payments or services.

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0200, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0200, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0205 Does the adoptive parent need to let the department know if the family's circumstances change? The adoptive parent must inform the department's adoption support program of circumstances that might make the parent and the adoptive child either ineligible for adoption assistance payments or benefits or eligible for adoption assistance payments or benefits in different amounts. Such changes include but are not limited to:

- (1) A significant change in the child's condition;
- (2) A change in the marital status of the adoptive parent(s);
- (3) A change in the legal or physical custody of the child; or
- (4) A change in the adoptive family's mailing address.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0205, filed 3/30/01, effective 4/30/01.]

[Title 388 WAC—p. 314]

WAC 388-27-0210 Under what circumstances would the adoption support agreement be terminated? The adoption support agreement is terminated according to the terms of the agreement or if any one of the following events occurs:

(1) The child reaches eighteen years of age; (if a child is at least eighteen but less than twenty-one years old and is a full-time high school student or working full time toward the completion of a GED (high school equivalency) certificate and continues to receive financial support from the adoptive parent(s), the department may extend the terms of the adoption support agreement until the child completes high school or achieves a GED. Under no circumstances may the department extend the agreement beyond the child's twenty first birthday.) Adoption support benefits will automatically stop on the child's eighteenth birthday unless the parent(s) requests continuation per this rule and have provided documentation of the child's continuation in school. To prevent disruption in services the parent should contact the adoption support program at least ninety days prior to the child's eighteenth birthday if continued services are to be requested.

(2) The adoptive parents no longer have legal responsibility for the child;

(3) The adoptive parents are no longer providing financial support for the child;

(4) The child dies; or

(5) The adoptive parents die. (A child who met federal Title IV-E eligibility criteria for adoption assistance will be eligible for adoption assistance in a subsequent adoption.)

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0210, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0210, filed 3/30/01, effective 4/30/01.]

Part E: Services

WAC 388-27-0215 What benefits may the adoptive parent or child receive from the adoption support program? The adoption support program may provide one or more of the following benefits:

(1) Reimbursement for nonrecurring adoption finalization costs;

(2) Cash payments;

(3) Payment for counseling services as preauthorized (see WAC 388-27-0255 for conditions and terms); or

(4) Medical services through the department's Medicaid program.

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675. 04-06-024, § 388-27-0215, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0215, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0220 What factors affect the amount of adoption support benefits a child receives? The department bases the amount of support it provides on the child's needs and the family's circumstances, but limits the cash payment to an amount that does not exceed the foster care maintenance rate the child would receive if the child was in a foster family home. Specific circumstances as agreed to by the adoptive parent and the department in the agreement, may warrant future renegotiation and adjustment of the payment determined in an assessment of the child.

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[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675, 04-06-024, § 388-27-0220, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0220, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0230 How does the department evaluate a request for adoption support monthly cash payments? (1) The amount of the adoption support monthly cash payment is determined through the discussion and negotiation process between the adoptive parents and representatives of the department based upon the needs of the child and the circumstances of the family. The payment that is agreed upon should combine with the parents' resources to cover the ordinary and special needs of the child projected over an extended period of time. Anticipation and discussion of these needs are part of the negotiation of the amount of the adoption assistance payment.

(2) Family circumstances to be considered include:

(a) Size, including the adopted child;

(b) Normal living expenses, including education and childcare expenses;

(c) Exceptional circumstances of any family member;

(d) Income;

(e) Resources and savings plans;

(f) Medical care and hospitalization needs;

(g) Ability to purchase or otherwise obtain medical care; and

(h) Additional miscellaneous expenses related to the adopted child.

(3) The department and the adoptive parents will jointly determine the level of adoption support cash payments needed to meet the basic needs of the child without creating a hardship on the family.

(4) Under no circumstances may the amount of the adoption support monthly cash payment the department pays for the child exceed the amount of foster care maintenance payment that would be paid if the child were in a foster family home.

[Statutory Authority: RCW 74.13.109, 74.13.031, 2002 c 371 § 202(8), 42 U.S.C. 671-675, 04-06-024, § 388-27-0230, filed 2/23/04, effective 3/25/04. Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0230, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0250 What specific department requirements apply to medical services? (1) While an adoption support agreement remains in effect, the department's medical program rules apply to the adopted child.

(2) The department must make all medical payments according to established department procedures and directly to the child's physician(s) or service provider(s).

[Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0250, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0255 What specific department requirements apply to outpatient counseling and/or mental health services not covered by Medicaid? When the department's adoption support program directly pays for a child's counseling and/or mental health services, the following conditions apply:

(1) The adoptive parent must obtain written authorization from the department's adoption support program before the service is rendered;

(2) The adoptive parents' primary health care coverage must be billed prior to billing the department's adoption support program;

(3) The department will pay the adoption support program's authorized rate minus any payment made by the primary (and other) insurer;

(4) The department may grant verbal authorization for no more than three counseling sessions prior to providing the required written authorization;

(5) The child's therapist or other treatment provider must submit a written treatment plan prior to authorization for continued treatment;

(6) The department may authorize counseling as follows:

(a) Up to six hours of outpatient counseling per month for up to twelve months; or

(b) Up to a total of twenty hours per quarter when critical need warrants;

(7) The department may extend the authorization for counseling (beyond the initial time period authorized) upon receipt of an updated treatment plan and documentation supporting the need for additional treatment from the treatment provider and a parent's request for continuing counseling (DSHS 10-214);

(8) The department may authorize this service for only one provider at a time unless a second provider is required for a different service.

(9) The department encourages adoptive parents to seek an annual assessment of the functioning of the adoptive child within the family to determine if there are mental health services needed to help maintain and/or strengthen the adoptive placement.

[Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0255, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0260 If the adoptive parent requests residential placement services for the parent's adopted child, what department requirements apply? (1) The adoption support program must not pay for residential treatment placements. See RCW 74.13.080 and WAC 388-25-0025.

(2) If the adoptive parent requests residential treatment services for a child:

(a) For treatment of a mental illness, the department must refer the family to the local regional support network (RSN);

(b) If a diagnosis of physical, mental, developmental, cognitive or emotional disability is present, department staff must refer the child to the division of developmental disabilities (DDD) to determine eligibility of services for which the child might be eligible; or

(c) For reasons other than treatment of mental illness or developmental disabilities, department staff must refer the adoptive parent to the child welfare services intake at the local office of the division of children and family services (DCFS).

(3) The adoption support program manager may assist the adoptive parent in arranging residential service for the child but must not be responsible for the child's placement or for the payment of the residential service.

[Statutory Authority: RCW 74.13.031, 01-08-045, § 388-27-0260, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0265 What are the consequences of the department placing the adopted child in foster care, group care, or residential treatment? (1) If a child is on active status with Washington state's adoption support program and the department places the child in foster care, group care, or residential treatment, the department may report to the division of child support that good cause exists for not pursuing collection of support payments.

(2) The department must review the adoption support agreement and must discontinue any cash payments to the adoptive parent during the child's out-of-home placement unless the adoptive parent(s) documents continuing expenses directly related to the child's needs.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0265, filed 3/30/01, effective 4/30/01.]

Part F: Review

WAC 388-27-0275 When does the department review an adoption support agreement? (1) The adoption support program must review an agreement:

- (a) At least once every five years; or
- (b) When the adoptive parents request a change in the terms of the agreement.

(2) The department may review an adoption support agreement:

- (a) Whenever variations in medical opinions, prognosis, or costs warrant a review; or
- (b) At the department's request.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0275, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0280 What is involved in the review process? (1) The review process provides an opportunity for the adoptive parent to describe any changes in family circumstances or the child's condition and request a change in the terms of the adoption support agreement.

(2) The adoptive parent must provide supporting documentation upon department request.

(3) The department may request a copy of the adoptive parents' most recently filed IRS form 1040. If not required to file a federal tax return the adoptive parent(s) must submit a financial statement upon department request.

(4) The adoptive parent must request that the child's medical provider complete an EPSDT (early periodic screening, diagnosis and treatment) exam and submit a report of the results to the adoption support program.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0280, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0285 What is the department's responsibility when the adoptive parent(s) requests a review of the adoption support agreement? The adoption support program must initiate a review of the adoption support agreement no later than thirty days after receiving the adoptive parents' request for review of the agreement.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0285, filed 3/30/01, effective 4/30/01.]

[Title 388 WAC—p. 316]

WAC 388-27-0290 What if the department does not respond to a request for a review of an adoption support agreement within thirty days? If the department does not respond to an adoptive parent's request for a review of an adoption support agreement within thirty days, the adoptive parent has the right to an administrative hearing (see RCW 74.13.127).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0290, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0295 What requirements apply to the review of a support agreement? (1) The adoptive parent and the department must negotiate any changes in the agreement that result from a review;

(2) Changes in the terms of the agreement may be retroactive to the date the department received the written request; and

(3) If the department modifies the terms of the agreement, the adoptive parent and the department must sign a new agreement.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0295, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0300 After a review, what if the department and the adoptive parent cannot agree on the terms of the adoption support agreement? If the department proposes service changes without the adoptive parent's consent, the department must give written notification of those changes. In that notice, the department must clearly state the department's reasons for the proposed changes and inform the adoptive parent of the adoptive parent's right to an administrative hearing.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0300, filed 3/30/01, effective 4/30/01.]

Part G: Post-Finalization Requests for Assistance

WAC 388-27-0305 May an adoptive parent apply for adoption support services after the adoption has been finalized? Federal and state laws and rules require that a prospective adoptive parent must apply for adoption assistance prior to adopting a special needs child and that the prospective adoptive parent must have a valid adoption support agreement, signed by all parties, before the adoption is finalized.

However, both state and federal governments have recognized that in some situations there may have been extenuating circumstances that prevented the child from being placed on the adoption support program prior to adoption. For these situations separate remedies have been created depending on which eligibility criteria are met by the child.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0305, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0310 If a child met federal Title IV-E eligibility for adoption assistance before the adoption, but was not placed on the adoptive support program, what may the adoptive parent do after adoption finalization to obtain adoption support services for the adopted child? For a child who met the Title IV-E eligibility criteria for adoption assistance prior to adoption, federal rules allow for

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a possible finding of extenuating circumstances through an administrative hearing process. In these situations the adoptive parent must request a review by an administrative law judge or a review judge to obtain an order authorizing the department to enter into a post-adoption agreement to provide adoption support services to a special needs child.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0310, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0315 What constitutes "extenuating circumstances"? An administrative law judge or a review judge may make a finding of extenuating circumstances if one or more of the following situations exist:

(1) Relevant facts regarding the child, the biological family or child's background were known by the agency placing the child for adoption and not presented to the adoptive parents prior to the legalization of the adoption;

(2) The department denied adoption assistance based upon a means test of the adoptive family;

(3) Erroneous determination or advice by the department or private child placing agency that a child is ineligible for adoption assistance; or

(4) Failure by the placing agency to advise adoptive parents of the availability of adoption assistance.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0315, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0320 What is the effective date of an adoption support agreement that results from a finding of extenuating circumstances? The effective date of an adoption support agreement the department and the adoptive parent have entered into as a result of a finding of extenuating circumstances may not be before the date the department received the written request from the adoptive parent for participation in the adoption support program. Under no circumstances may the department back date an adoption support agreement more than two years from the date of an order of an administrative law judge or review judge authorizing the department to enter an adoption support agreement after finalization of the adoption.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0320, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0325 If a child did not meet federal Title IV-E eligibility for adoption assistance before the adoption, what may the adoptive parent do after adoption finalization to obtain adoption support services for the adopted child? For children ineligible for federal Title IV-E Adoption Assistance, the department may provide limited support through the state-funded adoption support reconsideration program.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0325, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0330 What is the adoption support reconsideration program? (1) The adoption support reconsideration program allows the department to register an eligible adopted child for limited state-funded support (see RCW 74.13.150).

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(2) The reconsideration program provides for payment of medical and counseling services to address the physical, mental, developmental, cognitive, or emotional disability of the child that resulted in the child's eligibility for the program.

(3) There is a twenty thousand dollar per child lifetime cap on this program.

(4) The program requires the adoptive parent and the department to sign an adoption support reconsideration agreement specifying the terms, conditions, and length of time the child will receive limited support.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0330, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0335 How does a child qualify for the adoption support reconsideration program? To be eligible for the adoption support reconsideration program, a child must:

(1) Have resided, immediately prior to adoption finalization, in a department funded pre-adoptive placement or in department funded foster care;

(2) Have a physical or mental handicap or emotional disturbance that existed and was documented before adoption or was at high risk for future physical or mental handicap or emotional disturbance due to conditions to which the child was exposed before adoption;

(3) Reside in Washington state with an adoptive parent who lacks the financial resources to care for the child's special needs; and

(4) Be covered by a primary basic health insurance program.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0335, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0340 How does an adoptive parent apply for the adoption support reconsideration program? To apply, the adoptive parent must complete an application for adoption support reconsideration and attach:

(1) A written cost estimate of the child's proposed corrective-rehabilitative services;

(2) A current medical evaluation of the child including the cause(s) of the condition requiring corrective-rehabilitative services;

(3) A written statement explaining the child's current medical and counseling needs;

(4) A written statement giving the department permission to request and review pre-adoption information held by the adoption agency facilitating the child's adoption; and

(5) A copy of the adoptive parents' most recently filed IRS 1040 federal income tax form.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0340, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0345 What types of services does the department provide through the adoption support reconsideration program? The reconsideration program provides some support for counseling and medical services needed to treat the child's qualifying condition.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0345, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0350 What department requirements apply to adoption support reconsideration services? (1) The department must authorize, in writing, any services paid by the adoption support reconsideration program before the services are provided.

(2) The department must base the authorized level of service on the child's needs and must limit the level of service to established program rates.

(3) The department must limit medical services to those services that would be available to the child if the child were eligible for Medicaid coverage.

(4) The department must make no cash payments to the family.

(5) The department must make payment directly to the provider of the authorized service.

(6) The adoptive parents' basic health insurance must provide primary coverage and must be used before billing the reconsideration program. The adoption support reconsideration program must be the secondary insurer.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0350, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0355 Under what conditions or circumstances would a child become ineligible for the adoption support reconsideration program? (1) Eligibility for adoption support reconsideration services ends according to the terms of the adoption support reconsideration agreement or when the child:

(a) Reaches eighteen years of age;

(b) Is eligible for the federal Title IV-E adoption assistance program and has been placed on that program;

(c) Has received twenty thousand dollars in department paid medical, dental, and/or counseling services; or

(d) Is no longer the financial responsibility of the adoptive parent(s).

(2) If the parent dies, the reconsideration agreement becomes invalid. Neither the agreement nor the child's eligibility for the program are transferable to a subsequent adoption.

(3) The department may suspend services when the child:

(a) Resides outside the adoptive parents' home for more than thirty continuous days; or

(b) Is no longer covered by primary basic health insurance.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0355, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0360 What happens if the state no longer funds the adoption support reconsideration program? If the department no longer has funds available for the program, a child's participation in the program will cease. The department will terminate the adoption support reconsideration agreement.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0360, filed 3/30/01, effective 4/30/01.]

Part H: Appeal Rights

WAC 388-27-0365 Does an adoptive parent have the right to appeal department decisions regarding adoption

[Title 388 WAC—p. 318]

support issues? (1) An adoptive parent has the right to an administrative hearing to contest the following department actions:

(a) Denial of a child's initial eligibility for the adoption support program or the adoption support reconsideration program;

(b) Failure to respond with reasonable promptness to a written application or request for services;

(c) Denial of a written request to modify the level of payment or service in the agreement;

(d) A decision to increase or decrease the level of the child's adoption support payments without the concurrence of the adoptive parent(s);

(e) Denial of a request for nonrecurring adoption expenses; or

(f) Termination from the program.

(2) The adoptive parent must submit a request for an administrative hearing to the office of administrative hearings within ninety days of receipt of the department's decision to deny a request or failure to respond to a request.

(3) The office of administrative hearings must apply the rules in WAC 388-27-0120 through 388-27-0390 as they pertain to the issues being contested.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0365, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0370 What information about adoption support agreements may be used in an administrative hearing? Adoption and adoption support files are confidential, and information contained in those files may not be disclosed without the consent of the person who is the subject of the file. By requesting an administrative hearing to challenge a department decision relating to adoption support the adoptive parent is agreeing that the department may release factual information about the case during the course of the proceedings. Actions taken by the department and decisions by administrative law judges or review judges in adoption support cases which do not directly involve the case being heard may not be cited or relied upon in any administrative proceeding (RCW 26.33.340 and 74.04.060).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0370, filed 3/30/01, effective 4/30/01.]

Part I: Nonrecurring Costs

WAC 388-27-0375 Will the department reimburse an adoptive parent for nonrecurring adoption expenses? The department will agree to reimburse some or all of an adoptive parent's nonrecurring adoption expenses if:

(1) The child has a qualifying factor or condition identified in WAC 388-27-0140(1);

(2) Washington state has determined that the child cannot or should not be returned to the home of the child's biological parent; and

(3) Except where it would be against the best interest of the child, the department or a child placing agency has made a reasonable but unsuccessful effort to place the child with appropriate adoptive parents without the benefit of adoption assistance; and

(4) The child has been placed for adoption according to applicable state and local laws or Tribal laws.

[Statutory Authority: RCW 74.13.109, 74.13.112, 74.13.130, and 2002 c 371. 03-02-059, § 388-27-0375, filed 12/27/02, effective 1/27/03. Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0375, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0380 What types of nonrecurring adoption expenses will the department reimburse? The department may reimburse:

- (1) Court costs directly related to finalizing an adoption;
- (2) Reasonable and necessary adoption fees;
- (3) Reasonable and necessary attorney fees directly related to finalizing an adoption; and
- (4) Costs associated with an adoption home study, including:
 - (a) Health and psychological examination;
 - (b) Placement supervision before adoption;
 - (c) Transportation, lodging, and food costs incurred by the adoptive parent(s) and child during pre-placement visits; and
 - (d) Other costs directly related to finalizing the legal adoption of the child.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0380, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0385 Is there a limit to the amount of nonrecurring adoption expenses that the department will reimburse? Department reimbursement of nonrecurring adoption expenses must not exceed one thousand five hundred dollars per child.

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0385, filed 3/30/01, effective 4/30/01.]

WAC 388-27-0390 How does an adoptive parent get reimbursed for nonrecurring adoption expenses? (1) Before the adoption is finalized, the adoptive parent must sign an agreement with the department specifying the nature and amount of nonrecurring adoption expenses. This agreement may be part of an adoption support agreement or it may be a separate agreement specific to the reimbursement for nonrecurring adoption finalization costs. The department will make no reimbursement payments unless such an agreement exists.

(2) Upon finalization of the adoption, the adoptive parent may request reimbursement. A copy of the adoption decree and documentation supporting actual costs incurred must accompany the request for reimbursement.

(3) The department must reimburse documented actual costs or the amount specified in the signed agreement, whichever is less.

(4) The department will not reimburse nonrecurring adoption expenses that are reimbursable from other sources (for example: IRS, military, or the adoptive parent's employer).

[Statutory Authority: RCW 74.13.031. 01-08-045, § 388-27-0390, filed 3/30/01, effective 4/30/01.]

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Chapter 388-32 WAC

CHILD WELFARE SERVICES TO PREVENT OUT-OF-HOME PLACEMENT AND ACHIEVE FAMILY RECONCILIATION

WAC

HOME SUPPORT SERVICES BY CHILDREN'S ADMINISTRATION

- 388-32-0005 What are home support services?
388-32-0010 What are the eligibility criteria for HSS?

HOME BASED SERVICES BY COMMUNITY PROVIDERS

- 388-32-0015 What are home based services and under what circumstances may the department provide the services to the child's parent or relative caregiver?

FAMILY RECONCILIATION SERVICES

- 388-32-0020 What is the purpose of the family reconciliation services program?
388-32-0025 Who may receive FRS services?
388-32-0030 What FRS services does the department provide?

HOME SUPPORT SERVICES BY CHILDREN'S ADMINISTRATION

WAC 388-32-0005 What are home support services?

The department's children's administration (CA) offers home support services (HSS), within available funds, to provide supportive, culturally appropriate, skill-building services in partnership with CA's client families. Only CA staff may provide the services in the family home or other appropriate setting and must provide the services as part of a comprehensive case plan. The department does not contract for this service.

(1) CA typically offers HSS during the normal work week but may provide HSS on weekends and beyond normal working hours.

(2) Child and family resource specialists (CFRS) have primary responsibility to provide HSS, which may include the following services:

(a) Teach and demonstrate basic physical and emotional care of children, including child development and developmentally appropriate child discipline;

(b) Teach homemaking and other life skills, including housekeeping, nutrition and food preparation, personal hygiene, financial budgeting, time management and home organization, with consideration given to the family's cultural environment;

(c) Help families obtain basic needs by networking families with appropriate supportive community resources; e.g., housing, clothing and food banks, health care services, and educational and employment services;

(d) Provide emotional support to families and build self-esteem in family members; aid family members in developing appropriate interpersonal and social skills;

(e) Provide client transportation/supervision of visits on a nonroutine, short-term basis;

(f) Observe family functioning, assisting the social worker to identify family strengths as well as areas needing intervention or improvement, providing reports and assessments to the assigned social worker on the family's progress in skill-building, family functioning, and other areas defined in the case plan;

(g) Participate in child protection teams, multidisciplinary teams, interagency case staffings, and family intervention meetings;

(h) Provide court testimony when requested by the attorney representing DSHS or when subpoenaed.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0005, filed 3/30/01, effective 4/30/01.]

WAC 388-32-0010 What are the eligibility criteria for HSS? Children's administration uses the following criteria to determine eligibility for HSS, within available funding:

(1) The family must be a current recipient of CA services.

(2) The case plan for the family must document the need for teaching, skill-building, community networking, or visitation.

(3) HSS does not provide long-term maintenance for a family, is not a housekeeping service, and is not interchangeable with CHORE services, which are provided by the department's aging and adult services administration.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0010, filed 3/30/01, effective 4/30/01.]

HOME BASED SERVICES BY COMMUNITY PROVIDERS

WAC 388-32-0015 What are home based services and under what circumstances may the department provide the services to the child's parent or relative caregiver? (1) Home based services (HBS) are designed to prevent or improve conditions that may result in out-of-home placement. Children's administration (CA) provides these services in the context of a comprehensive case plan. CA purchases services from community providers within available funds for this purpose. Services may include:

(a) Basic goods and services; e.g., food, clothing, shelter, furniture, health care, utilities, transportation

(b) Paraprofessional services; e.g., parent aides;

(c) Parent training;

(e) In-home counseling or assistance to prevent out-of-home placement.

(2) For a family or individual to receive HBS, the following conditions must be met:

(a) The client has a case open for child protective services (CPS), child welfare services (CWS), or family reconciliation services (FRS);

(b) The department may provide services to the family of origin, relatives, or foster families when the intent of HBS is to maintain or reunify a permanent or long-term stable home for the child;

(c) The family is willing and able to cooperate with HBS services; and

(d) In the assigned social worker's judgment, the child may be safely maintained in the home or be safely returned to the home within the next three months with provision of HBS.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0015, filed 3/30/01, effective 4/30/01.]

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FAMILY RECONCILIATION SERVICES

WAC 388-32-0020 What is the purpose of the family reconciliation services program? (1) The purpose of family reconciliation services (FRS) is to achieve reconciliation between the parent and child, to reunify the family, and to maintain and strengthen the family unit to avoid the necessity of out-of-home placement of children.

(2) The department provides these services, within available funds, to:

(a) Alleviate personal or family situations that present a serious and imminent threat to the health or stability of the child or family and that do not meet the definition of child abuse or neglect; and

(b) Maintain families intact whenever possible.

[Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0020, filed 3/30/01, effective 4/30/01.]

WAC 388-32-0025 Who may receive FRS services?

(1) CA provides FRS to adolescents, thirteen through seventeen years of age, and their families, in instances where the adolescent has runaway and/or is in conflict with his/her family. These populations are defined as follows:

"Families in conflict" means families in which personal or family situations present a serious and imminent threat to the health or stability of the child, which may include an at-risk youth, or family.

"Runaways" means youths who are absent from home for a period of time without parental permission. Services are to actual runaways and not to threatened runaways, unless the threatened runaways meet the definition of families in conflict.

(2) FRS is not provided for any of the following situations, unless the family is seeking an at-risk youth or a child-in-need-of-services (CHINS) family assessment:

(a) The identified youth has not reached his/her thirteenth birthday, or the youth is eighteen years of age or older;

(b) Chronic or long-term multiproblem situations requiring long-term interventions;

(c) Custody and marital disputes unless the dispute creates a conflict between the child and parent with physical custody;

(d) Families currently receiving counseling services related to the parent-child conflict/relationship from other agencies;

(e) Child abuse and neglect cases, unless those cases meet the definition of family in conflict; or

(f) Youth receiving foster care or group care services or follow up to those services.

[Statutory Authority: Chapter 13.32A RCW, RCW 74.08.090, 74.13.031, 2002 c 371. 03-19-051, § 388-32-0025, filed 9/11/03, effective 9/11/03. Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0025, filed 3/30/01, effective 4/30/01.]

WAC 388-32-0030 What FRS services does the department provide? The assigned social worker provides services to develop skills and supports within families to resolve family conflicts, achieve a reconciliation between parent and child, and to avoid out-of-home placement. The services may include, but are not limited to, referral to services for suicide prevention, psychiatric or other medical

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care, or psychological, financial, legal, educational, or other social services, as appropriate to the needs of the child and family. Typically FRS is limited to a ninety-day period. Children's administration (CA) provides intake/assessment services (IAS).

(1) Youth and/or their families who call or self-present at children's administration central intake or a local office requesting FRS services must be provided assistance in contacting the appropriate children's administration's intake services to make a formal request for FRS services.

(a) The FRS social worker must contact the family within twenty-four hours of their assignment to the case, to schedule an appointment to begin the phase I family interview process. These FRS phase I sessions are intended to defuse the immediate potential for violence, assess problems, and explore options leading to problem resolution.

(b) CA or its contractors may provide FRS phase II crisis counseling services.

(2) Families eligible for FRS phase II crisis counseling are those who, in the opinion of the family and the CA social worker, require more intensive services than those provided through phase I services.

(a) Families must make a commitment to participate in the FRS phase II crisis counseling service and must not concurrently be receiving similar counseling services through other agencies or practitioners. At a minimum, there must be a parent and a child willing to participate. FRS phase II crisis counseling assists the family to develop skills and supports in order to resolve conflicts.

(b) FRS phase II crisis counseling services may not exceed twelve hours within forty-five days unless it is provided using a CA approved model that is based on research demonstrating effectiveness.

(c) The assigned counselor helps the family develop skills and supports to resolve conflicts. The counselor may refer to resources including medical, legal, ongoing counseling and CPS for problem resolution.

(d) FRS phase II crisis counseling services are available a maximum of twice in a lifetime for any one family. The family must include a parent/guardian who has legal custody of the youth.

[Statutory Authority: RCW 13.32A.040, 74.13.031, and 74.08.090. 06-11-080, § 388-32-0030, filed 5/16/06, effective 6/16/06. Statutory Authority: Chapter 13.32A RCW, RCW 74.08.090, 74.13.031, 2002 c 371. 03-19-051, § 388-32-0030, filed 9/11/03, effective 9/11/03. Statutory Authority: RCW 74.13.031. 01-08-047, § 388-32-0030, filed 3/30/01, effective 4/30/01.]

Chapter 388-39A WAC

CHILD WELFARE SERVICES—COMPLAINT RESOLUTION

WAC

388-39A-010	What definitions apply to the department's child welfare services complaint resolution process?
388-39A-030	How does the children's administration resolve complaints?
388-39A-035	What is the process for resolving complaints?
388-39A-040	What happens if the complaint is not resolved at the regional level?
388-39A-045	Does the complaint resolution process apply to all complaints?
388-39A-050	Is the complaint resolution process the only way to resolve a complaint?
388-39A-055	What rights do complainants have under the complaint resolution process?

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388-39A-060

Do constituent relations staff only handle complaints?

WAC 388-39A-010 What definitions apply to the department's child welfare services complaint resolution process? "Children's administration" (CA) means the cluster of programs within the department of social and health services responsible for the provision of child welfare, child protective, child care licensing, and other services to children and their families.

"Complaints office" or "constituent relations" means the office within the children's administration responsible for handling complaints regarding child welfare services.

"Division of children and family services" (DCFS) means the division within the children's administration responsible for administering child welfare services programs.

"Division of licensed resources" (DLR) means the division within the children's administration responsible for licensing or certifying child care homes and facilities under the authority of chapter 74.15 RCW.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-010, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-030 How does the children's administration resolve complaints? Constituent relations staff assist clients, foster parents, and other affected individuals in resolving complaints and grievances regarding children's administration (CA) policies and procedures, or the application of a policy or procedure related to CA programs. Under RCW 74.13.045, constituent relations staff may inquire into, determine fact, and facilitate the resolution of disputes and complaints.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-030, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-035 What is the process for resolving complaints? (1) After making a reasonable effort to resolve a complaint with a social worker or licensor, a client, foster parent, or community member may contact the CA constituent relations office to request assistance.

(2) Constituent relations staff will assist the complainant in reviewing the complaint with the assigned social worker or licensor to arrive at a resolution.

(3) If the complaint cannot be resolved with the social worker or licensor, constituent relations staff will assist the complainant in reviewing it with the supervisor of the social worker or licensor for resolution.

(4) If the complaint cannot be resolved with the supervisor, constituent relations staff will assist the complainant in reviewing the complaint with the supervisor's area manager or regional manager for resolution.

(5) If the complaint cannot be resolved with the area manager or regional manager, constituent relations staff will assist the complainant in reviewing it with the area manager's regional administrator or the regional manager's office chief.

(6) If CA constituent relations staff determines at any time during the complaint resolution process that the administration's actions were consistent with agency policy and procedures based on complete and correct information regarding the complainant's situation, the constituent rela-

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tions staff will terminate the resolution process and will close the complaint.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-035, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-040 What happens if the complaint is not resolved at the regional level? (1) When constituent relations staff and local CA staff have made a reasonable attempt to resolve the complaint, the regional administrator, the office chief, or the constituent relations supervisor may convene a panel to review the complaint and make recommendations to the CA assistant secretary for resolution.

(2) The regional administrator or office chief and the constituent relations supervisor will determine the membership of the panel.

(3) The panel must consist of the following members:

(a) The regional administrator's or office chief's designee who must not be from the administrative unit where the complaint originated;

(b) A constituent relations staff person;

(c) A person who is not a CA employee; and

(d) If the complainant is a foster parent, a foster parent who is not involved in the complaint.

(4) The panel may examine the complaint, the complainant's file, and any additional relevant information, including information from the complainant, CA staff, or others.

(5) The panel must submit written findings and recommendations to the CA assistant secretary who will issue a final, written decision.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-040, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-045 Does the complaint resolution process apply to all complaints? (1) The complaint resolution process does not apply to complaints for which the complainant has the right to seek resolution through judicial review or an adjudicative proceeding under Title 13, 26, or 74 RCW.

(2) The process also does not apply to contract rate setting, contested rate payments, exceptional cost rates, disputes or decisions regarding written personal service contracts, or financial agreements.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-045, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-050 Is the complaint resolution process the only way to resolve a complaint? Participation in the complaint resolution process does not affect the right of any person to seek other remedies.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-050, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-055 What rights do complainants have under the complaint resolution process? (1) Under RCW 74.13.045, the complaint resolution process does not create substantive or procedural rights for any person.

(2) Participation in the complaint resolution process does not entitle any person to an adjudicative proceeding under chapter 34.05 RCW or to superior court review.

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[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-055, filed 3/5/01, effective 4/5/01.]

WAC 388-39A-060 Do constituent relations staff only handle complaints? In addition to complaint resolution, CA constituent relations staff also provide information about children's administration programs, policies, and procedures and information about other complaint resolution resources, including the office of the family and children's ombudsman.

[Statutory Authority: RCW 74.13.045. 01-06-041, § 388-39A-060, filed 3/5/01, effective 4/5/01.]

Chapter 388-60 WAC

DOMESTIC VIOLENCE PERPETRATOR TREATMENT PROGRAM STANDARDS

WAC

DEFINITIONS

388-60-0015 What definitions apply to this chapter?

PURPOSE

388-60-0025 What is the purpose of this chapter?

388-60-0035 Must domestic violence perpetrator treatment programs be certified?

388-60-0045 What must be the focus of a domestic violence perpetrator treatment program?

388-60-0055 What must be a treatment program's primary goal?

REQUIRED PROGRAM POLICIES AND PROCEDURES

388-60-0065 What steps must a treatment program take to address victim safety?

388-60-0075 What must a treatment program require of its participants?

388-60-0085 What requirements apply to group treatment sessions?

388-60-0095 May a participant be involved in more than one type of treatment while enrolled in a domestic violence perpetrator treatment program?

388-60-0105 What requirements does the department have for treatment programs regarding nondiscrimination?

388-60-0115 Does a program have the authority to screen referrals?

388-60-0125 What rights do participants in a treatment program have?

CONFIDENTIALITY

388-60-0135 What information about the participant must the treatment program keep confidential?

388-60-0145 What releases must a program require a participant to sign?

388-60-0155 Must a treatment program keep information provided by or about the victim confidential?

388-60-0165 What information must the treatment program collect and discuss with the client during the intake process or assessment interview?

388-60-0175 Who may complete the intake process or conduct the assessment interview?

388-60-0185 Must the program compile a written document based on information gathered in the intake/assessment process?

388-60-0195 Must the treatment program develop an individual treatment plan for each participant?

388-60-0205 What must a treatment program consider when developing an individual treatment plan for a participant?

388-60-0215 Must a program require a participant to sign a contract for services with the treatment program?

388-60-0225 What must the treatment program include in the contract for each participant's treatment?

388-60-0235 Must a treatment program follow an educational curriculum for each participant?

388-60-0245 What topics must the treatment program include in the educational curriculum?

388-60-0255 What is the minimum treatment period for program participants?

388-60-0265 What criteria must be satisfied for completion of treatment?

- 388-60-0275 What must the treatment program do when a participant satisfactorily completes treatment?
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- 388-60-0325 Must a program notify the department when new direct treatment staff are added?
- 388-60-0335 Who is considered a trainee for domestic violence perpetrator treatment programs?
- 388-60-0345 May a trainee provide direct treatment services to participants?
- 388-60-0355 Do treatment programs need a supervisor?
- 388-60-0365 Who may provide supervision of direct treatment staff in a domestic violence perpetrator treatment program?
- 388-60-0375 Must a supervisor always be on the premises of the treatment program?
- 388-60-0385 Must the treatment program have staff supervision policies?
- 388-60-0395 What are the requirements for staff orientation?
- 388-60-0405 What are the continuing professional education requirements for all direct treatment program staff?
- 388-60-0415 Is a treatment program required to cooperate with local domestic violence victim programs?
- 388-60-0425 Does a treatment program need knowledge of the domestic violence laws and justice system practices?

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- 388-60-0435 What is the process to apply for certification of a treatment program?
- 388-60-0445 What is the application fee for certification?
- 388-60-0455 What documentation must a program submit before the department may certify the program?
- 388-60-0465 What happens after a program turns in an application to the department?
- 388-60-0475 Will a certificate be issued if the treatment program meets the standards?
- 388-60-0485 What happens if a treatment program does not meet the standards?
- 388-60-0495 What records must the department keep regarding certified domestic violence perpetrator programs?

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- 388-60-0505 How often must a domestic violence perpetrator treatment program reapply for certification?
- 388-60-0515 What must a program do to apply for recertification of their domestic violence perpetrator treatment program?
- 388-60-0525 What must the application packet for renewal of the certification of a domestic violence perpetrator program include?
- 388-60-0535 How does the department decide that a program should continue to be certified?
- 388-60-0545 Is there a formal process if a treatment program wishes to appeal a denial of certification or recertification?

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- 388-60-0555 Does the department have an advisory committee for domestic violence perpetrator treatment?
- 388-60-0565 What is the role of the advisory committee?
- 388-60-0575 Who are the advisory committee members and how are they chosen?
- 388-60-0585 How long is the appointed term for an advisory committee member?
- 388-60-0595 May advisory committee members be replaced before their term expires?
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COMPLAINTS AND THE INVESTIGATION OF COMPLAINTS

- 388-60-0615 Does the department investigate complaints about domestic violence perpetrator treatment programs?
- 388-60-0625 Who may request an investigation of a certified domestic violence perpetrator treatment program?

- 388-60-0635 Does the department notify a treatment program that the department has received a complaint?
- 388-60-0645 May DSHS begin an investigation of a treatment program without receiving a complaint?
- 388-60-0655 What is included in an investigation?
- 388-60-0665 Is there a time limit for the department to complete its investigation of a complaint?

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- 388-60-0675 Does the department put the results of the investigation in writing?
- 388-60-0685 What action may the department take regarding a program's certification if a complaint is founded?
- 388-60-0695 Does DSHS notify a treatment program of its decision to take corrective action?
- 388-60-0705 What information must the department give a program if it takes action that affects the program's certification status?
- 388-60-0715 What happens if a treatment program refuses to remedy the problems outlined in the complaint findings?
- 388-60-0725 What if the director of a domestic violence perpetrator treatment program disagrees with the corrective action decision?

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- 388-60-0735 Does the department notify the person that made the complaint of the results of the investigation?
- 388-60-0745 What must the treatment program do after notification that its certification has been suspended or revoked?
- 388-60-0755 What happens if the program has other licenses or certificates?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 388-60-005 Scope. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-005, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-005, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-120 Treatment focus. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-120, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-120, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-130 Treatment modality. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-130, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-130, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-140 Program policies and procedures. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-140, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-140, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-150 Treatment staff qualifications. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-150, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-150, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-160 Orientation and continuing professional education requirements. [Statutory Authority: RCW 26.50.150. 97-02-035, § 388-60-160, filed 12/24/96, effective 1/24/97. Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-160, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-170 Cooperation with domestic violence victim programs. [Statutory Authority: 1992 HB 1884. 93-10-024 (Order 3539), § 388-60-170, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-180 Knowledge of law and justice system practices. [Statutory Authority: 1992 HB 1884. 93-10-024 (Order

- 3539), § 388-60-180, filed 4/28/93, effective 5/29/93.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-190 Program certification process. [Statutory Authority: RCW 26.50.150, 97-02-035, § 388-60-190, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-200 Certification maintenance. [Statutory Authority: RCW 26.50.150, 97-02-035, § 388-60-200, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-210 Advisory committee. [Statutory Authority: RCW 26.50.150, 97-02-035, § 388-60-210, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-220 Complaint. [Statutory Authority: RCW 26.50.150, 97-02-035, § 388-60-220, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-230 Investigation. [Statutory Authority: RCW 26.50.150, 97-02-035, § 388-60-230, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-240 Results of investigation. [Statutory Authority: RCW 26.50.150, 97-02-035, § 388-60-240, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-250 Notification of results. [Statutory Authority: RCW 26.50.150, 97-02-035, § 388-60-250, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.
- 388-60-260 Appeal. [Statutory Authority: RCW 26.50.150, 97-02-035, § 388-60-260, filed 12/24/96, effective 1/24/97.] Repealed by 01-08-046, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 26.50.150.

DEFINITIONS

WAC 388-60-0015 What definitions apply to this chapter? The following definitions are important to understand these rules:

"Corrective action" means the denial or suspension or revocation of certification, or the issuance of a written warning.

"Department" or **"DSHS"** means the department of social and health services.

"Participant" or **"perpetrator"** means the client enrolled in the domestic violence perpetrator treatment program. This client may be court-ordered to attend treatment or someone who chooses to voluntarily attend treatment.

"Program" or **"treatment program"** means a domestic violence perpetrator treatment program.

[Statutory Authority: RCW 26.50.150, 01-08-046, § 388-60-0015, filed 3/30/01, effective 4/30/01.]

PURPOSE

WAC 388-60-0025 What is the purpose of this chapter? (1) This chapter establishes minimum standards for programs that treat perpetrators of domestic violence.

(2) These standards apply to any program that:

(a) Advertises that it provides domestic violence perpetrator treatment; or

(b) Defines its services as meeting court orders that require enrollment in and/or completion of domestic violence perpetrator treatment.

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(3) These programs provide treatment only to perpetrators of domestic violence, including clients who are self-referred or those who are court-ordered to attend treatment.

(4) An agency may administer other service programs in addition to domestic violence perpetrator treatment services; however, the domestic violence perpetrator treatment program must be considered a separate and distinct program from all other services the agency provides.

[Statutory Authority: RCW 26.50.150, 01-08-046, § 388-60-0025, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0035 Must domestic violence perpetrator treatment programs be certified? All programs providing domestic violence perpetrator treatment services must:

(1) Be certified by the department; and

(2) Comply with the standards outlined in this chapter.

[Statutory Authority: RCW 26.50.150, 01-08-046, § 388-60-0035, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0045 What must be the focus of a domestic violence perpetrator treatment program? (1) A domestic violence perpetrator treatment program must focus treatment primarily on ending the participant's physical, sexual, and psychological abuse.

(2) The program must hold the participant accountable for:

(a) The abuse that occurred; and

(b) Changing the participant's violent and abusive behaviors.

(3) The program must base all treatment on strategies and philosophies that do not blame the victim or imply that the victim shares any responsibility for the abuse which occurred.

[Statutory Authority: RCW 26.50.150, 01-08-046, § 388-60-0045, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0055 What must be a treatment program's primary goal? The primary goal of a domestic violence perpetrator treatment program must be to increase the victim's safety by:

(1) Facilitating change in the participant's abusive behavior; and

(2) Holding the participant accountable for changing the participant's patterns of behaviors, thinking, and beliefs.

[Statutory Authority: RCW 26.50.150, 01-08-046, § 388-60-0055, filed 3/30/01, effective 4/30/01.]

REQUIRED PROGRAM POLICIES AND PROCEDURES

WAC 388-60-0065 What steps must a treatment program take to address victim safety? (1) Each treatment program must have written policies and procedures that adequately assess the safety of the victims of the perpetrators enrolled in the treatment program.

(2) The treatment program must take the following steps to protect victims:

(a) Notify the victim of each program participant within fourteen days of the participant being accepted or denied entrance to the program that the participant has enrolled in or has been rejected for treatment services;

(b) Inform victims of specific outreach, advocacy, emergency and safety planning services offered by a domestic violence victim program in the victim's community;

(c) Encourage victims to make plans to protect themselves and their children;

(d) Give victims a brief description of the domestic violence perpetrator treatment program, including the fact that the victim is not expected to do anything to help the perpetrator complete any treatment program requirements; and

(e) Inform victims of the limitations of perpetrator treatment.

(3) The program must document in writing the program's efforts to notify the victim of the above requirements.

(4) The program cannot invite or require the victims of participants to attend perpetrator treatment program counseling sessions or education groups which the program requires participants to attend as a condition of their contracts.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0065, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0075 What must a treatment program require of its participants? (1) All participants must attend consecutive, weekly group treatment sessions. A program may develop policies which allow excused absences to be made up with the program director's approval.

Exception: Another type of intervention may be approved for certain documented clinical reasons, such as psychosis or other conditions that make the individual not amenable to treatment in a group setting.

(2) The program must assign each participant to a home group and the participant must be required to attend the same scheduled group each week. The program's director must authorize any exceptions to this requirement and document the reason for the exception.

(3) Each participant must sign all releases of information required by the treatment program, including those specified in WAC 388-60-0145.

(4) Each participant must sign a contract for services with the treatment program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0075, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0085 What requirements apply to group treatment sessions? (1) The group sessions must be single gender.

(2) The group size is limited to a maximum of twelve participants, and a minimum of two participants.

(3) Group sessions must be at least ninety minutes in length.

(4) Group sessions must be closed to all persons other than participants, group facilitators, and others specifically invited by the group leaders. Others specifically invited by group leaders may include:

(a) Professionals in related fields;

(b) Persons offering interpretation services for the deaf and/or hearing impaired or language translation/interpretation; and

(c) Others bringing specific information critical to the group.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0085, filed 3/30/01, effective 4/30/01.]

(2007 Ed.)

WAC 388-60-0095 May a participant be involved in more than one type of treatment while enrolled in a domestic violence perpetrator treatment program? (1) A program may allow a client to participate in other types of therapy during the same period the client is participating in the required weekly group treatment sessions.

(2) Any other type of therapy must support the goal of victim safety by facilitating change in the participant's abusive behavior without blaming the victim for the perpetrator's abuse.

(3) The program must determine that the participant is stable in the participant's other treatments before allowing the participant to participate in treatment for domestic violence.

(4) Other therapies including the following list may not be substituted for the required domestic violence perpetrator treatment sessions:

(a) Individual therapy;

(b) Marital or couples' therapy;

(c) Family therapy;

(d) Substance abuse evaluations or treatment; or

(e) Anger management.

(5) A program may recommend marital or couples' therapy only after:

(a) The participant has completed at least six months of domestic violence perpetrator treatment services; and

(b) The victim has reported that the participant has ceased engaging in violent and/or controlling behaviors. However, this therapy may not take the place of domestic violence perpetrator treatment session.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0095, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0105 What requirements does the department have for treatment programs regarding non-discrimination? (1) A domestic violence perpetrator treatment program may not discriminate against any participant based on:

(a) Race;

(b) Age;

(c) Gender;

(d) Disability;

(e) Religion;

(f) Marital status or living arrangements;

(g) Political affiliation;

(h) Educational attainment;

(i) Socio-economic status;

(j) Ethnicity;

(k) National origin; or

(l) Sexual orientation.

(2) Program materials, publications, and audio-visual materials must be culturally sensitive and nondiscriminatory.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0105, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0115 Does a program have the authority to screen referrals? (1) A treatment program has the authority to accept or reject any referral for its program.

(2) The program must base acceptance and rejection of a client on written criteria the program has developed to screen potential participants.

(3) A treatment program may impose any conditions on participants that the program deems appropriate for the success of treatment.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0115, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0125 What rights do participants in a treatment program have? (1) A treatment program must provide each participant with the highest quality of service.

(2) Treatment program staff must establish a climate where all relationships with colleagues and participants are respectful.

(3) Each participant enrolled in a program must have the assurance that the program staff will conduct themselves professionally, as specified in RCW 18.130.180.

(4) Staff, board members, and volunteers working for a treatment program must not engage in or tolerate sexual harassment or exploitation of an employee, a program participant, or a victim of any program participant.

(5) Each participant must have a written contract signed by the participant and the treatment program staff which specifies the participant's rights and responsibilities while enrolled in the program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0125, filed 3/30/01, effective 4/30/01.]

CONFIDENTIALITY

WAC 388-60-0135 What information about the participant must the treatment program keep confidential?

(1) Treatment programs must follow the confidentiality requirements contained in chapter 18.19 RCW for registered counselors and certified professionals.

(2) All program participants and guests must agree in writing not to disclose the identity of group participants or personal information about the participants.

(3) A treatment program must keep all communications between the participant and direct treatment staff confidential unless:

(a) The participant has signed a release of information; or

(b) The program is legally required to release the information.

(4) The treatment program may audio or video tape group sessions only when all participants grant written consent that gives details about the specific uses for the tape. The program must obtain an additional consent statement from each participant to permit use of the tape for any purpose other than the purposes specified in the original consent.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0135, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0145 What releases must a program require a participant to sign? For a treatment program to conduct case monitoring and periodic safety checks, the program must require all participants to sign the following releases which must remain in effect for the duration of the client's treatment:

(1) A release allowing the treatment program to notify the victim and/or the victim's community and/or legal advo-

cates that the perpetrator has been accepted or rejected for treatment;

(2) A release allowing the program to provide the victim with periodic reports about the perpetrator's participation in the program;

(3) A release allowing the current domestic violence perpetrator treatment program access to information held by all prior and concurrent treatment agencies, including domestic violence perpetrator treatment programs, mental health agencies, and drug and alcohol treatment programs;

(4) A release allowing the treatment program to provide relevant information regarding the participant to each of the following entities:

(a) Lawyers, including prosecutors;

(b) Courts;

(c) Parole officers;

(d) Probation officers;

(e) Child protective services, child welfare services, and other DSHS programs;

(f) Court-appointed guardians ad litem;

(g) DSHS certifying authorities; and

(h) Former treatment programs that the participant has attended.

(5) A release for the program to notify any person whose safety appears to be at risk due to the participant's potential for violence and lethality. This includes, but is not limited to:

(a) The victim;

(b) Any children;

(c) Significant others;

(d) The victim's community and legal advocates; or

(e) Police.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0145, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0155 Must a treatment program keep information provided by or about the victim confidential?

(1) A treatment program must treat all information the victim provides to the program as confidential unless the victim gives written permission for the program to release the information.

(2) Information must be kept separate from any files for perpetrators.

(3) If a victim tells the treatment program that the participant has committed a new offense, the treatment program must encourage the victim to contact:

(a) Appropriate law enforcement agency; and

(b) The local domestic violence victim's program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0155, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0165 What information must the treatment program collect and discuss with the client during the intake process or assessment interview? (1) Treatment programs must conduct an individual, complete clinical intake and assessment interview with each perpetrator who has been accepted into the treatment program. The program staff must meet face-to-face with the program participant to conduct this intake and interview.

(2) During the intake interview, program staff must obtain the following information, at a minimum:

(a) Current and past violence history;

- (b) A complete diagnostic evaluation;
- (c) A substance abuse screening;
- (d) History of treatment from past domestic violence perpetrator treatment programs;
- (e) History of threats of homicide or suicide;
- (f) History of ideation of homicide or suicide;
- (g) History of stalking;
- (h) Data to develop a lethality risk assessment;
- (i) Possession of, access to, plans to obtain, or a history of use of weapons;
- (j) Degree of obsessiveness and dependency on the perpetrator's victim;
- (k) History of episodes of rage;
- (l) History of depression and other mental health problems;
- (m) History of having sexually abused the battered victim or others;
- (n) History of the perpetrator's domestic violence victimization and/or sexual abuse victimization;
- (o) Access to the battered victim;
- (p) Criminal history and law enforcement incident reports;
- (q) Reports of abuse of children, elderly persons, or animals;
- (r) Assessment of cultural issues;
- (s) Assessment of learning disabilities, literacy, and special language needs; and
- (t) Review of other diagnostic evaluations of the participant.

(3) If the program cannot obtain the above information, the program client file must include documentation of the program's reasonable efforts to obtain the information.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0165, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0175 Who may complete the intake process or conduct the assessment interview? (1) Only treatment staff who meet the minimum qualifications for direct treatment staff stated in chapter 388-60 WAC may complete the intake process or conduct the assessment interview.

(2) A trainee may not have sole responsibility for conducting an intake or assessment. If the staff conducting the intake/assessment is a trainee, the trainee must work in conjunction with additional staff in their program, and the trainee's program supervisor must review and sign off on the trainee's work.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0175, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0185 Must the program compile a written document based on information gathered in the intake/assessment process? The program must compile a written document, which includes the information required to be gathered in the intake/assessment process.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0185, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0195 Must the treatment program develop an individual treatment plan for each participant? (2007 Ed.)

pant? (1) The treatment program must develop a written treatment plan for each participant who is accepted into the domestic perpetrator treatment program.

(2) The treatment program must base the participant's treatment on the clinical intake/assessment which the program completed for the client.

(3) The treatment plan must adequately and appropriately address the needs of the individual participant.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0195, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0205 What must a treatment program consider when developing an individual treatment plan for a participant? (1) A treatment program must:

(a) Assess whether a participant should be required to engage in drug and alcohol, mental health, or other treatment services while they are participating in the treatment program;

(b) Decide which treatment gets priority for the participant if more than one treatment service is recommended;

(c) Determine the sequence of other services if concurrent treatment is not clinically appropriate; and

(d) Make appropriate referrals to outside agencies.

(2) A treatment program must consider issues relating to a participant's prior victimization when designing each treatment plan.

The program must consider the appropriateness of domestic violence victim services in lieu of perpetrator treatment for a participant who presents an extensive history of prior victimization.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0205, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0215 Must a program require a participant to sign a contract for services with the treatment program? A treatment program must require each participant to sign a formal contract for services.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0215, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0225 What must the treatment program include in the contract for each participant's treatment? The contract between each participant and the treatment program must include the following elements:

(1) A statement regarding the treatment program's philosophy that:

(a) The victim may not be blamed for the participant's abuse;

(b) The perpetrator must stop all forms of abuse;

(c) An abuser is to be held accountable for the abusers actions; and

(d) The program's primary concern is for the safety of victims.

(2) A statement requiring the participant to:

(a) Cooperate with all program rules;

(b) Stop violent and threatening behaviors;

(c) Be nonabusive and noncontrolling in relationships;

(d) Develop and adhere to a responsibility plan;

(e) Comply with all court orders;

(f) Cooperate with the rules for group participation; and

- (g) Sign all required releases of information.
- (3) A policy on attendance and consequences for inadequate attendance;
- (4) A requirement that the perpetrator must actively participate in treatment, including sharing personal experiences, values, and attitudes, as well as completing all group activities and assignments;
- (5) A policy regarding other program expectations, such as completion of written exams, concurrent treatment requirements, and possession of weapons as described under chapters 388-861 and 388-875 WAC;
- (6) Written criteria for completion of treatment;
- (7) A statement that group members must honor the confidentiality of all participants;
- (8) A statement that the treatment program has the duty to warn and protect victims, law enforcement, and third parties of any risk of serious harm the program determines the participant poses to them;
- (9) Requirements that the participant must either:
 - (a) Provide the program with the participant's arrest records, criminal history, and any information regarding treatment services previously received; or
 - (b) Identify the existence of and location of all service records, and authorize release of all such records to the domestic violence treatment program.
- (10) The program's policy regarding the use of drugs and alcohol, including a provision that the participant must attend treatment sessions free of drugs and alcohol; and
- (11) Fees and methods of payment for treatment.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0225, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0235 Must a treatment program follow an educational curriculum for each participant? A treatment program must follow a specific educational curriculum for all participants in the program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0235, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0245 What topics must the treatment program include in the educational curriculum? The curriculum of the treatment program must include the following topics:

- (1) Belief systems that allow and support violence against women;
- (2) Belief systems that allow and/or support the use or threat of violence to establish power and control over an intimate partner;
- (3) Definitions of abuse, battering, and domestic violence;
- (4) Forms of abuse, including:
 - (a) Physical abuse;
 - (b) Emotional and sexual abuse;
 - (c) Economic manipulation or domination;
 - (d) Physical force against property or pets;
 - (e) Stalking;
 - (f) Terrorizing someone or threatening him or her; and
 - (g) Acts that put the safety of battered partners, children, pets, other family members, or friends at risk.

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(5) The impact of abuse and battering on children and the incompatibility of domestic violence and abuse with responsible parenting;

(6) The fact that a participant is solely responsible for the participant's violent behavior, and must acknowledge this fact;

(7) The need to avoid blaming a victim for the participant's abusive behavior;

(8) Techniques to be nonabusive and noncontrolling;

(9) Negative legal and social consequences for someone who commits domestic violence;

(10) Why it is necessary to meet financial and legal obligations to family members;

(11) Opportunities for a participant to develop a responsibility plan:

(a) The treatment program may assist the participant in developing the plan.

(b) In the plan, the participant must make a commitment to giving up power and control over the victim.

(12) Education regarding individual cultural and family dynamics of domestic violence; and

(13) Washington state laws and practices regarding domestic violence, as described in chapters 10.31, 10.99, and 26.50 RCW.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0245, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0255 What is the minimum treatment period for program participants? (1) The minimum treatment period is the time required for the participant to fulfill all conditions of treatment set by the treatment program. Satisfactory completion of treatment is not based solely on a perpetrator participating in the treatment program for a certain period of time or attending a certain number of sessions.

(2) The program must require participants to attend treatment and satisfy all treatment program requirements for at least twelve consecutive months.

(3) The program must require the participant to attend:

(a) A minimum of twenty-six consecutive weekly same gender group sessions, followed by:

(b) Monthly sessions with the treatment provider until the twelve-month period is complete. These sessions must be conducted face-to-face with the participant by program staff who meet the minimum qualifications set forth in this chapter.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0255, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0265 What criteria must be satisfied for completion of treatment? (1) A treatment program must have written criteria for satisfactory completion of treatment.

(2) A program must require a participant to meet all of the following conditions in order for the program to state that the participant has completed treatment:

(a) Attend treatment sessions for the minimum treatment period;

(b) Attend all other sessions required by the program;

(c) Cooperate with all group rules and program requirements throughout the duration of treatment services;

(d) Stop the use of all violent acts or threats of violence;

(e) Stop using abusive and controlling behavior;

(2007 Ed.)

- (f) Adhere to the participant's responsibility plan;
- (g) Comply with court orders; and
- (h) Comply with other conditions of the contract for treatment services, such as chemical dependency treatment.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0265, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0275 What must the treatment program do when a participant satisfactorily completes treatment? (1) A treatment program must notify the following people when a participant satisfactorily completes treatment:

- (a) The court having jurisdiction, if the participant has been court-mandated to attend treatment; and
- (b) The victim, if feasible.
- (2) The program must document in writing its efforts to contact the victim.
- (3) The program may specify only that the perpetrator has completed treatment based on adequate compliance with the participant's contract with the treatment program and any court order.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0275, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0285 Must a treatment program have policies regarding any reoffenses during treatment? A treatment program must establish and implement written policies that include consequences if a perpetrator reoffends during treatment or does not comply with program requirements.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0285, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0295 Does a program need guidelines for discharging participants who do not complete treatment? (1) A treatment program must have guidelines for discharging participants who do not satisfactorily complete the program.

- (a) Discharge decisions must be uniform and predictable.
- (b) Discrimination may not occur against any participant.
- (2) A program may terminate a participant from treatment prior to completion of the program if the participant has not complied with the requirements set forth in the participant's contract with the program.
- (3) If a program discharges a participant who does not complete treatment, the treatment program must document in writing that the participant has not complied with:
 - (a) The participant's contract with the treatment program;
 - (b) A court order;
 - (c) A probation agreement; or
 - (d) Group rules.
- (4) If a program chooses not to discharge a participant who has reoffended, committed other acts of violence or abuse, or has not complied with any of subsection (3)(a) through (d) of this section, the program must note the reoffense and/or noncompliance in the client's progress notes, reports to the court, and reports to the victim (if feasible).

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(5) The program must state in the client's record the program's rationale for not terminating the participant, and state what corrective action was taken.

(6) A program may discharge a participant if the treatment program cannot provide adequate treatment services to the participant because of the treatment program's current development.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0295, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0305 Who must the program notify when the program discharges a participant because of failure to complete treatment? A treatment program must notify the following parties in writing when the program discharges a participant from the program because of failure to complete treatment:

- (1) The court having jurisdiction, if the participant has been court-mandated to attend treatment;
- (2) The participant's probation officer, if any;
- (3) The victim of the participant, if feasible; and
- (4) The program must notify the above parties within three days of terminating the client.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0305, filed 3/30/01, effective 4/30/01.]

TREATMENT STAFF QUALIFICATIONS

WAC 388-60-0315 What are the minimum qualifications for all direct treatment staff? (1) All staff with direct treatment contact with participants must be:

- (a) Registered as counselors or certified as mental health professionals as required under chapter 18.19 RCW; and
- (b) Free of criminal convictions involving moral turpitude.

(2) Each staff person providing direct treatment services to a participant must have a bachelor's degree.

(a) The department will review requests for an exception to this requirement on a case-by-case basis.

(b) In order to qualify for an exception, the employee must possess year-for-year professional level experience equivalent to a bachelor's degree. The department determines this equivalency at the discretion of the DSHS program manager responsible for monitoring domestic violence perpetrator treatment programs.

(3) Prior to providing any direct treatment services to program participants, each direct treatment staff person must have completed:

(a) A minimum of thirty hours of training about domestic violence from an established domestic violence victim program; and

(b) A minimum of thirty hours of training from an established domestic violence perpetrator treatment services program.

(i) If located within Washington state, the domestic violence perpetrator treatment program must be certified and meet the standards as outlined in this chapter.

(ii) If located out-of-state, the domestic violence perpetrator treatment program must meet the standards outlined in this chapter as well as chapter 26.50 RCW.

(4) All employees must complete all sixty hours of required training before the employee may begin to provide

any direct services to group participants. Any work experience accrued prior to completion of the sixty hours of training will not count toward any requirement for work experience.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0315, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0325 Must a program notify the department when new direct treatment staff are added?

(1) At the time that the program adds new direct treatment staff, the program must submit documentation to DSHS which proves that the staff meets the minimum qualifications for all treatment staff stated in WAC 388-60-0315.

(2) Direct treatment staff may not provide services to perpetrators until the treatment staff's qualifications have been reviewed and approved by the DSHS program manager responsible for certification of domestic violence perpetrator treatment programs.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0325, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0335 Who is considered a trainee for domestic violence perpetrator treatment programs?

A trainee is a direct treatment staff person who has not accrued at least two hundred fifty hours of experience providing services to domestic violence perpetrators and domestic violence victims.

(1) At least one hundred twenty-five hours of this requirement must have been provision of supervised, direct treatment services to domestic violence perpetrators.

(2) The remainder of this requirement must have been provision of domestic violence victim advocacy services.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0335, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0345 May a trainee provide direct treatment services to participants?

(1) A trainee may serve as a co-facilitator of groups, but may not have sole responsibility for the group at any time.

(2) A trainee may not have sole responsibility for conducting an intake or assessment, or for terminating a participant from treatment.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0345, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0355 Do treatment programs need a supervisor?

Each treatment program must have at least one person providing supervision to paid and volunteer direct treatment staff.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0355, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0365 Who may provide supervision of direct treatment staff in a domestic violence perpetrator treatment program?

(1) In addition to possessing the basic qualifications required for all direct treatment staff, a program's supervisor must meet all of the following requirements:

(a) Have a minimum of three years of experience providing direct treatment services to perpetrators of domestic violence;

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(b) Have a minimum of one year of experience providing victim advocacy services to domestic violence victims (this may be concurrent with (a) of this subsection);

(c) Have a minimum of one year of experience in facilitating domestic violence perpetrator treatment groups;

(d) Has completed at least five hundred hours of supervised direct treatment contact with both perpetrators and domestic violence victims:

(i) At least three hundred hours of this requirement must have been the provision of supervised, direct treatment services to domestic violence perpetrators.

(ii) The remainder of this requirement must have been the provision of domestic violence victim advocacy services.

(2) Each staff person providing supervision to direct treatment staff within a program must have a master's degree.

(a) The department's program manger [manager] will review requests for an exception to this requirement on a case-by-case basis.

(b) In order to qualify for an exception, the employee must possess year-for-year professional level experience equivalent to a master's degree. The department determines this equivalency at the discretion of the DSHS program manager responsible for monitoring domestic violence perpetrator treatment programs.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0365, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0375 Must a supervisor always be on the premises of the treatment program?

A supervisor may be located either on or off-site unless direct treatment services are being provided only by employees who are considered trainees, as defined in these rules. If no other direct treatment staff besides the supervisor possesses at least two hundred fifty hours of experience providing direct treatment services to perpetrators, the supervisor must be present at all times that direct treatment services are being provided.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0375, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0385 Must the treatment program have staff supervision policies?

A treatment program must develop and follow policies, procedures, and supervision schedules that provide adequate supervision for all treatment staff.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0385, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0395 What are the requirements for staff orientation?

(1) A treatment program must have an orientation for any new staff, whether the staff are paid or volunteer.

(2) The purpose of the orientation must be to provide the staff with the program's philosophy, organization, curriculum, policies, procedures, and goals.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0395, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0405 What are the continuing professional education requirements for all direct treatment program staff?

(1) All staff having direct treatment contact

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with participants must complete a minimum of twenty hours of continuing professional education each year after the program is certified, or each year after the staff person is added to the staff list. No more than five of those hours may be obtained by attending "in-house" training.

(2) Each staff person's continuing professional education must include four or more hours of training per year on issues of sexism, racism, and homophobia and their relationship to domestic violence.

(3) Continuing education training may be in the fields of alcohol/drug abuse, mental health, or other issues but all training must be related to the treatment of domestic violence perpetrators.

(4) The treatment staff may obtain continuing professional education through classes, seminars, workshops, video or audiotapes, or other self-study programs when approved in writing by the program supervisor. No more than five hours of video, audiotapes, or self-study program may be used toward the requirement of twenty hours of continuing education requirement. This includes correspondence courses.

(5) The staff must document all continuing education hours on DSHS approved forms.

(a) The form must be accompanied by completion certificates, course/workshop outline, and supervisor signature.

(b) The program must submit the form and documentation to the department at the time the program applies for recertification.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0405, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0415 Is a treatment program required to cooperate with local domestic violence victim programs? A treatment program must establish and maintain cooperative relationships with domestic violence victim services programs located in their community.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0415, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0425 Does a treatment program need knowledge of the domestic violence laws and justice system practices? A treatment program must show evidence of an understanding of the laws pertaining to domestic violence and the operation of the justice system. At a minimum, a program must be familiar with:

(1) State laws regulating the response to domestic violence by the criminal justice system;

(2) Relief available to victims of domestic violence offered by:

(a) Washington domestic violence law and civil protection orders;

(b) Criminal no-contact orders; and

(c) Civil restraining orders.

(3) Local law enforcement, prosecution, and court and probation policies regarding domestic violence cases.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0425, filed 3/30/01, effective 4/30/01.]

CERTIFICATION PROCESS

WAC 388-60-0435 What is the process to apply for certification of a treatment program? (1) Any program

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wishing to provide treatment to perpetrators of domestic violence must request certification by completing an application available from the department. To request an application by mail, write to:

Domestic Violence Perpetrator Treatment Program
Department of Social and Health Services (DSHS)
Children's Administration
P.O. Box 45710
Olympia, Washington 98504-5710.

(2) The program must submit the application, application fee, and all documentation needed to prove that the program meets the requirements set forth in these standards.

(3) A program may not provide direct treatment services to domestic violence perpetrators without being certified by the department.

(4) If approved, the department grants certification for a two year period.

(5) The department considers each geographical location of a program an individual program, and must certify each program separately.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0435, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0445 What is the application fee for certification? (1) Application fee for either initial certification or recertification of a domestic violence perpetrator treatment program is one hundred dollars.

(2) The department publishes the application fee for certification of domestic violence perpetrator treatment programs in the application packet.

(3) If there is any change in the fee, the update will be done in July of each year.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0445, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0455 What documentation must a program submit before the department may certify the program? The program's director must submit the following documentation with the program's application:

(1) A written statement signed by the director that the program complies with the standards contained in this chapter;

(2) Results of current criminal history background checks conducted by the Washington state patrol for all current direct treatment program staff;

(3) A statement for each current paid or volunteer staff person whether or not the staff person has ever been a party to any civil proceedings involving domestic violence;

(4) Proof that each direct treatment staff is registered as a counselor or certified as a mental health professional with the department of health;

(5) Evidence that the program maintains cooperative relationships with agencies providing services related to domestic violence.

(a) This evidence must include, at a minimum:

(i) Three items of evidence that they have established and continue to maintain cooperative relationships with local domestic violence victim programs and other local agencies involved with domestic violence intervention.

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(ii) Documentation that they have established a referral process between their program and the local domestic violence victim services programs.

(iii) Proof that they participate in a local domestic violence task force, intervention committee or workgroup if one exists in their community.

(b) The program may also submit evidence of the following:

(i) Participation in public awareness activities sponsored by the local domestic violence victim services agency.

(ii) Service agreements between the local domestic violence victim services agency(ies) and the treatment program.

(iii) Letters of support for the program from other agencies or parties involved in domestic violence intervention.

(6) Evidence that the program maintains cooperative relationships with agencies involved in domestic violence intervention.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0455, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0465 What happens after a program turns in an application to the department? (1) The department will review a certification application within thirty days after the application is received to decide if the domestic violence perpetrator program meets the program standards in this chapter.

(2) The department must notify the applicant whether or not the program meets these standards.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0465, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0475 Will a certificate be issued if the treatment program meets the standards? If a program meets the standards in this chapter, the department will issue the program a certificate of compliance.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0475, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0485 What happens if a treatment program does not meet the standards? (1) If a program does not meet the standards for certification or recertification, the department will provide the program with:

(a) A copy of the standards;

(b) A written notice containing the reasons for the determination of noncompliance; and

(c) The program standards relied upon for making the decision.

(2) Treatment programs have the right to a hearing if the program is denied certification under this chapter (chapter 388-02 WAC).

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0485, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0495 What records must the department keep regarding certified domestic violence perpetrator programs? The department must maintain the following information:

(1) A current record of all certified domestic violence perpetrator programs.

(2) A current record of programs that:

(a) Are in the process of applying for certification;

(b) Have been denied certification;

(c) Have been notified that the department is revoking or suspending certification;

(d) Have had their certification revoked; and

(e) Are being investigated.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0495, filed 3/30/01, effective 4/30/01.]

RECERTIFICATION

WAC 388-60-0505 How often must a domestic violence perpetrator treatment program reapply for certification? Each program certified under this chapter must reapply for certification every two years.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0505, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0515 What must a program do to apply for recertification of their domestic violence perpetrator treatment program? In order to be recertified, a program must submit a completed application packet to the department at least forty-five days prior to the expiration date of the previous certification period.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0515, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0525 What must the application packet for renewal of the certification of a domestic violence perpetrator program include? The packet must include the following:

(1) A completed application form signed by the program director;

(2) Payment of the application fee;

(3) A listing of all direct treatment staff;

(4) A statement of qualifications for any staff added since the last certification period;

(5) Current results of criminal history background checks conducted by the Washington state patrol, and a statement regarding any involvement in civil proceedings involving domestic violence for each employee providing direct treatment services;

(6) An update of continuing professional education hours for each direct treatment staff;

(7) Evidence that the program maintains cooperative relationships with agencies providing services related to domestic violence.

(a) This evidence must include, at a minimum:

(i) Three items of evidence that they have established and continue to maintain cooperative relationships with local domestic violence victim programs and other local agencies involved with domestic violence intervention.

(ii) Documentation that they have established a referral process between their program and the local domestic violence victim services programs.

(iii) Proof that they participate in a local domestic violence task force, intervention committee or workgroup if one exists in their community.

(b) The program may also submit evidence of the following:

(i) Participation in public awareness activities sponsored by the local domestic violence victim services agency.

(ii) Service agreements between the local domestic violence victim services agency(ies) and the treatment program.

(iii) Letters of support for the program from other agencies or parties involved in domestic violence intervention.

(8) Evidence that the program maintains cooperative relationships with agencies involved in domestic violence intervention; and

(9) All documentation needed to prove that the program continues to meet the standards for certification.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0525, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0535 How does the department decide that a program should continue to be certified? The department will continue to certify a program, or will review its certification, if:

(1) The department determines, based on the completed application, that the program continues to meet the standards and qualifications as outlined in this chapter; and

(2) The department determines that any complaint investigations from the previous certification period have been satisfactorily resolved.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0535, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0545 Is there a formal process if a treatment program wishes to appeal a denial of certification or recertification? If the department denies certification or recertification, the domestic violence perpetrator treatment program has a right to an administrative hearing under chapter 388-08 WAC.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0545, filed 3/30/01, effective 4/30/01.]

ADVISORY COMMITTEE

WAC 388-60-0555 Does the department have an advisory committee for domestic violence perpetrator treatment? The department will establish and appoint a volunteer group to serve as the Washington domestic violence perpetrator treatment program standards advisory committee.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0555, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0565 What is the role of the advisory committee? The role of the advisory committee is to:

(1) Advise the department regarding recommended changes to the program standards; and

(2) Provide technical assistance on program standards, implementation, and certification and recertification criteria.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0565, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0575 Who are the advisory committee members and how are they chosen? The advisory committee must include the following members:

(1) Four persons representing the perspective of victims of domestic violence. They will be chosen with input from

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the Washington State Coalition Against Domestic Violence (WSCADV);

(2) Four persons representing the perspective of state-certified domestic violence perpetrator treatment programs. They will be chosen with input from the Washington Association of Domestic Violence Intervention Professionals (WADVIP);

(3) Four persons representing the perspective of adult misdemeanor probation and Washington state courts of limited jurisdiction. They will be chosen with input from the Misdemeanor Corrections Association and the Washington State District and Municipal Court Judges Association;

(4) One person representing the department of corrections; and

(5) One person representing the office of the administrator for the courts.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0575, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0585 How long is the appointed term for an advisory committee member? Advisory committee members are appointed for two-year terms.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0585, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0595 May advisory committee members be replaced before their term expires? The department may replace committee members if the member misses two consecutive committee meetings.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0595, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0605 Are expenses for advisory committee members reimbursed? (1) If funds are available, the department will reimburse advisory committee members for travel and meal expenses related to service on the committee.

(2) Advisory committee members may not receive any other compensation for service on the committee.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0605, filed 3/30/01, effective 4/30/01.]

COMPLAINTS AND THE INVESTIGATION OF COMPLAINTS

WAC 388-60-0615 Does the department investigate complaints about domestic violence perpetrator treatment programs? DSHS investigates complaints regarding domestic violence perpetrator treatment programs.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0615, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0625 Who may request an investigation of a certified domestic violence perpetrator treatment program? Any person may submit a written complaint to DSHS if the person has the following concerns about a certified program:

(1) The program has acted in a way that places victims at risk; or

(2) The program has failed to follow standards in this chapter.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0625, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0635 Does the department notify a treatment program that the department has received a complaint? Once it receives a complaint about a certified program, the department will:

- (1) Determine that the complaint includes sufficient information to be deemed valid;
- (2) Notify the program within fourteen days of the complaint being determined valid that the department has received a complaint about the program; and
- (3) Notify the program that an investigation has been initiated.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0635, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0645 May DSHS begin an investigation of a treatment program without receiving a complaint? DSHS may begin an investigation of a domestic violence perpetrator treatment program without a written complaint if the department believes that the program:

- (1) Has placed victims at risk; or
- (2) Failed to follow the standards outlined in this chapter.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0645, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0655 What is included in an investigation? The investigation of a complaint against a domestic violence perpetrator treatment program may include:

- (1) Contact with:
 - (a) The person making the complaint;
 - (b) Other persons involved in the complaint; or
 - (c) The treatment program.
- (2) A request for written documentation of evidence; and/or
- (3) An on-site visit to the program to interview program staff.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0655, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0665 Is there a time limit for the department to complete its investigation of a complaint? The department must complete its investigation within forty-five days of beginning the investigation, unless circumstances warrant a longer period of time.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0665, filed 3/30/01, effective 4/30/01.]

RESULTS OF INVESTIGATIONS

WAC 388-60-0675 Does the department put the results of the investigation in writing? (1) The department will prepare written results of the complaint investigation.

(2) If the department decides that the treatment program behaved in a way that placed victims at risk or failed to meet the standards outlined in this chapter, the written results must include a decision regarding the status of the program's certification.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0675, filed 3/30/01, effective 4/30/01.]

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WAC 388-60-0685 What action may the department take regarding a program's certification if a complaint is founded? If the department determines that a complaint against a domestic violence perpetrator treatment program is founded, the department may:

- (1) Revoke the treatment program's certification;
- (2) Suspend the treatment program's certification; or
- (3) Send a written warning to the treatment program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0685, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0695 Does DSHS notify a treatment program of its decision to take corrective action? DSHS must send the written results of its investigation to the program by certified mail, return receipt requested, within twenty days after completing the investigation.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0695, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0705 What information must the department give a program if it takes action that affects the program's certification status? (1) If DSHS revokes a program's certification, the department must provide the program with:

- (a) The specific reasons for the revocation;
- (b) The WAC standards the revocation is based on; and
- (c) The effective date of the revocation.
- (2) If DSHS suspends a treatment program's certification, DSHS must provide the treatment program with:
 - (a) The specific reasons for the corrective action;
 - (b) The WAC standards that the suspension is based on;
 - (c) The effective date of the suspension;
 - (d) Any remedial steps which the program must complete to the satisfaction of the department before the department will reinstate the program's certification and lift the suspension; and
 - (e) The deadline for completion of any remedial steps.
- (3) If DSHS issues a written warning to a program, DSHS must provide the treatment program with:
 - (a) The specific reasons for the written warning;
 - (b) The WAC standards that the written warning is based on; and
 - (c) Any remedial steps which the program must complete to the satisfaction of the department.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0705, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0715 What happens if a treatment program refuses to remedy the problems outlined in the complaint findings? If the treatment program refuses or fails to remedy the problems outlined in the written warning, DSHS may revoke or suspend the certification of the program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0715, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0725 What if the director of a domestic violence perpetrator treatment program disagrees with the corrective action decision? (1) When DSHS revokes or suspends a program's certification, issues a written warning, or imposes corrective action, the department will notify the

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program director in writing of the program's right to request a hearing.

(2) The program director may request an administrative hearing from the office of administrative hearings pursuant to chapter 388-02 WAC.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0725, filed 3/30/01, effective 4/30/01.]

NOTIFICATION OF RESULTS OF AN INVESTIGATION

WAC 388-60-0735 Does the department notify the person that made the complaint of the results of the investigation? DSHS will mail a copy of the written results of the investigation to the person who made the complaint against the domestic violence perpetrator treatment program.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0735, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0745 What must the treatment program do after notification that its certification has been suspended or revoked? If DSHS revokes or suspends a program's certification, the program must:

(1) Take immediate steps to notify and refer current clients to other certified domestic violence perpetrator treatment programs;

Note: This must be done prior to the effective date of revocation or suspension.

(2) Cease accepting perpetrators of domestic violence into its treatment program;

(3) Notify victims, current partners of the participants, and any relevant agencies about the client referral; and

(4) Notify, in writing, the presiding judge and chief probation officer of each judicial district from which the treatment program receives court referrals.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0745, filed 3/30/01, effective 4/30/01.]

WAC 388-60-0755 What happens if the program has other licenses or certificates? If a program also holds a license or certification from the state of Washington for other treatment modalities, DSHS may notify the appropriate licensing or certifying authority that the program's certification has been suspended or revoked.

[Statutory Authority: RCW 26.50.150. 01-08-046, § 388-60-0755, filed 3/30/01, effective 4/30/01.]

Chapter 388-61 WAC FAMILY VIOLENCE

WAC

388-61-001 How does the Family Violence Amendment affect me if I am getting TANF/SFA?

WAC 388-61-001 How does the Family Violence Amendment affect me if I am getting TANF/SFA? The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), also known as the Welfare Reform Act, allowed every state to create a program addressing family violence for temporary assistance for needy families (TANF) recipients.

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(1) For TANF/state funded assistance (SFA), family violence is when a recipient, or family member or household member has been subjected by another family member or household member as defined in RCW 26.50.010(2) to any of the following:

(a) Physical acts that resulted in, or threatened to result in, physical injury;

(b) Sexual abuse;

(c) Sexual activity involving a dependent child;

(d) Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities;

(e) Threats of or attempts at, physical sexual abuse;

(f) Mental abuse;

(g) Neglect or deprivation of medical care; or

(h) Stalking.

(2) DSHS must:

(a) Screen and identify adults, minor teen parents, or emancipated teens getting TANF/SFA for a history of family violence;

(b) Notify in writing and verbally adults, minor teen parents, or emancipated teens getting TANF/SFA about the Family Violence Amendment;

(c) Maintain confidentiality as stated in RCW 74.04.060;

(d) Refer individuals needing counseling to supportive services;

(e) Waive WorkFirst requirements in cases where the requirements would make it more difficult to escape family violence, unfairly penalize victims of family violence or place victims at further risk of family violence. This may include:

(i) Time limits for TANF/SFA recipients, for as long as necessary (after fifty-two months of receiving TANF/SFA);

(ii) Cooperation with the division of child support.

(f) Develop specialized work activities for family violence clients, as defined in subsection (1) of this section if participation in work activities would place the recipients at further risk of family violence.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.08A.010. 04-21-028, § 388-61-001, filed 10/13/04, effective 12/1/04. Statutory Authority: Public Law 104-193, Section 103, Subsection 408 (a)(7)(c)(iii), HB 3901, section 103(4), RCW 74.08A.010, 74.04.050 and 74.08.090. 98-07-040, § 388-61-001, filed 3/12/98, effective 4/12/98. Statutory Authority: RCW 74.04.050, 74.08.090 and 74.04.057. 97-20-124, § 388-61-001, filed 10/1/97, effective 11/1/97.]

Chapter 388-61A WAC SHELTERS FOR VICTIMS OF DOMESTIC VIOLENCE

(Formerly chapter 284-554 WAC)

WAC

PURPOSE

- 388-61A-0005 What is the legal basis for the domestic violence shelter program?
- 388-61A-0010 What is the purpose of having minimum standards for domestic violence shelters and services?
- 388-61A-0015 Is DSHS required to provide funding to any domestic violence service that requests funding?
- 388-61A-0020 What are the facility and service requirements for domestic violence services?
- 388-61A-0025 What definitions apply to domestic violence shelters and services?

GENERAL FACILITY REQUIREMENTS

388-61A-0030	What safety requirements is the shelter required to meet?
388-61A-0035	What are the general requirements for bedrooms?
388-61A-0040	What kind of diaper changing area must I provide?
388-61A-0045	What are the kitchen requirements?
388-61A-0050	Are there any restrictions on food preparation?
388-61A-0055	What are the requirements for providing food and clothing to shelter residents?
388-61A-0060	What are the requirements for toilets, sinks, and bathing facilities?
388-61A-0065	What types of linen do I need to provide to clients?
388-61A-0070	What are the requirements for laundry facilities?
388-61A-0075	Are there requirements for drinking water?
388-61A-0080	What are the requirements for sewage and liquid wastes?
388-61A-0085	What kind of heating system is required?
388-61A-0090	How must I ventilate the shelter?
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388-61A-0100	Are there any requirements about pets in the shelter?
388-61A-0105	What first-aid supplies must I provide?
388-61A-0110	What are the requirements for storing medications?
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388-61A-0125	Where do I keep firearms and other dangerous weapons?

ADDITIONAL REQUIREMENTS FOR SAFE HOMES

388-61A-0130	What are the additional requirements for a safe home?
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ADDITIONAL REQUIREMENTS FOR SHELTER HOMES

388-61A-0135	What are the additional requirements for a shelter home?
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SUPPORTIVE SERVICES

388-61A-0140	What supportive services am I required to provide to clients?
388-61A-0145	What is advocacy-based counseling?
388-61A-0150	What type of training is required for staff of the domestic violence service?
388-61A-0155	Must supervisors of domestic violence service staff have specific experience and training?
388-61A-0160	What written policies and procedures do you need to have?

COMPLIANCE WITH STANDARDS

388-61A-0165	Will DSHS do an evaluation of the domestic violence service?
388-61A-0170	What will happen if I am out of compliance with my contract?
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APPEAL PROCESS

388-61A-0185	What are my rights if DSHS suspends, revokes, or denies funding?
388-61A-0190	Will I be notified if my funding has been suspended, revoked, or denied?
388-61A-0195	How do I request an agency hearing?

PURPOSE

WAC 388-61A-0005 What is the legal basis for the domestic violence shelter program? Chapter 70.123 RCW authorizes us to establish minimum standards for agencies that receive funding from the department of social and health services (DSHS) to provide domestic violence shelter and services.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0005, filed 3/16/01, effective 4/16/01.]

[Title 388 WAC—p. 336]

WAC 388-61A-0010 What is the purpose of having minimum standards for domestic violence shelters and services? The purpose of these rules is to have uniform state-wide standards for domestic violence shelters and services funded by us. Minimum standards are necessary to provide rules for agencies that contract with us to provide shelter and services for domestic violence victims. These standards address issues such as adequate food, clothing, housing, safety, security, advocacy, and counseling for victims.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0010, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0015 Is DSHS required to provide funding to any domestic violence service that requests funding? We are not obligated to disburse funds to all domestic violence services that may comply with the minimum standards set forth in this chapter. The goal of this program is to provide funding and support for the statewide development, stability, and expansion of shelter and services for victims of domestic violence. In support of that goal, if an agency applies to receive funding we will consider such things as:

- (1) Geographic location;
- (2) Population ratios;
- (3) Population need for services;
- (4) An agency's ability to provide services that comply with these minimum standards;
- (5) The availability of other domestic violence services in a community; and
- (6) The amount of funding we have available to support domestic violence services.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0015, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0020 What are the facility and service requirements for domestic violence services? In order for us to contract with an agency for domestic violence services, the agency must provide shelter and supportive services to victims of domestic violence. The agency must comply with the:

- (1) General facility requirements for shelters; and
- (2) Specific additional requirements for safe homes; or
- (3) Specific additional requirements for shelter homes; and
- (4) Requirements for supportive services and agency administration.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0020, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0025 What definitions apply to domestic violence shelters and services? "Advocacy-based counseling" means that the client is involved with an advocate counselor in individual, family, or group sessions with the primary focus on safety planning, empowerment, and education of the client through reinforcing the client's autonomy and self-determination.

"Advocate counselor" means a trained staff person who works in a domestic violence service and provides advocacy-based counseling, counseling, and supportive temporary shelter services to clients.

"Client" means a victim of domestic violence or dependent child of the victim.

"Cohabitant" means a person who is married or is living with a person as a husband or wife at the present time or at some time in the past. Any person who has one or more children in common with another person, regardless of whether they have been married or have lived together at any time, is considered a cohabitant.

"Department" means the department of social and health services (DSHS).

"Domestic violence" includes, but is not limited to, the criminal offenses defined in RCW 10.99.020 when committed by one cohabitant against another.

"Domestic violence service" means an agency that provides shelter, advocacy, and counseling for domestic violence clients in a safe, supportive environment.

"Lodging unit" means one or more rooms used for a victim of domestic violence including rooms used for sleeping or sitting.

"Program" means the DSHS domestic violence program.

"Safe home" means a shelter that has two or less lodging units and has a written working agreement with a domestic violence service.

"Secretary" means the DSHS secretary or the secretary's designee.

"Shelter" means a safe home or shelter home that provides temporary refuge and adequate food and clothing offered on a twenty-four hour, seven-day-per-week basis to victims of domestic violence and their children.

"Shelter home" means a shelter that has three or more lodging units and either is a component of or has a written working agreement with a domestic violence service.

"Staff" means persons who are paid or who volunteer services and are a part of a domestic violence service.

"Victim" means a cohabitant who has been subjected to domestic violence.

"We, us and our" refers to the department of social and health services and its employees.

"You, I and your" refers to the domestic violence service or shelter.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0025, filed 3/16/01, effective 4/16/01.]

GENERAL FACILITY REQUIREMENTS

WAC 388-61A-0030 What safety requirements is the shelter required to meet? You must keep your equipment and the physical structures in the shelter safe and clean for the clients you serve. You must:

(1) Maintain the shelter, premises, equipment, and supplies in a clean, safe and sanitary condition, free of hazards, and in good repair;

(2) Provide guard or handrails, as necessary, for stairways, porches and balconies used by clients;

(3) Maintain swimming pools, wading pools, bathtubs, hot tubs, spas, and bathing beaches in a safe manner and in such a way that does not present a health hazard, safety problem, or nuisance;

(4) Have a method for securing all windows, doors, and other building accesses to prevent the entry of intruders;

(2007 Ed.)

(5) Provide a way for staff to enter any area occupied by clients should there be an emergency; and

(6) Secure all unused refrigerators and freezers accessible to children in such a way that prevents them from climbing in and becoming trapped.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0030, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0035 What are the general requirements for bedrooms? Shelters must meet the following requirements for bedrooms:

(1) You must provide a bed in good condition, with a clean and comfortable mattress to shelter residents.

(2) If the shelter provides cribs or bassinets for infants, the shelter must follow each of these requirements:

(a) Cribs and bassinets must have clean, firm mattresses covered with waterproof material that is easily sanitized;

(b) Crib mattresses must fit snugly to prevent the infant from being caught between the mattress and crib side rails;

(c) Cribs must be made of wood, metal, or approved plastic with secure latching devices;

(d) Cribs must have no more than two and three-eighths inches space between vertical slats when used for infants under six months of age; and

(e) Bumper pad ties must be no longer than twelve inches in length.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0035, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0040 What kind of diaper changing area must I provide? You must provide a sanitary diaper changing area. In addition, you must develop and provide to clients, hygiene procedures for handling and storing diapers and sanitizing the changing area.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0040, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0045 What are the kitchen requirements? The following are the minimum general requirements for kitchen facilities:

(1) A sink for dishwashing;

(2) A refrigerator or other storage equipment capable of maintaining a temperature of forty-five degrees Fahrenheit or lower;

(3) A range, stove, or hot plate;

(4) Covered garbage container;

(5) Eating and cooking utensils that are clean and in good repair; and

(6) Counter surfaces that are clean and resistant to moisture.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0045, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0050 Are there any restrictions on food preparation? Food and beverages prepared by and for clients must be prepared, served and stored safely and in a sanitary manner. You must not serve home-canned, low-acid foods (e.g., meats and vegetables) to clients residing in a shelter.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0050, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0055 What are the requirements for providing food and clothing to shelter residents? (1) The domestic violence service must provide appropriate food and beverages for the basic sustenance of shelter residents, unless other resources are immediately available.

(2) You should store appropriate food, including infant formula, at the shelter to provide to residents when other resources are not immediately available.

(3) Whenever possible, the shelter should provide food that is culturally appropriate.

(4) You must provide shelter residents with access to clean, adequate clothing. Clothing that you provide must be clean and have been stored in a sanitary manner.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0055, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0060 What are the requirements for toilets, sinks, and bathing facilities? You must meet these requirements for toilets, sinks, and bathing facilities.

(1) You must provide at least one indoor flush-type toilet, one nearby hand-washing sink with hot and cold running water, and a bathtub or shower facility. These facilities must be located within the shelter building premises.

(2) You must comply with all of the following requirements for toilet and bathing facilities:

(a) Toilet and bathing facilities must allow for privacy of shelter residents.

(b) Toilets, urinals, and hand-washing sinks must be the appropriate height for the children served, or have a safe and easily cleaned step stool or platform that is water resistant.

(c) Hand-washing and bathing facilities must be provided with hot and cold running water; the hot water must not exceed one hundred twenty degrees.

(d) Potty chairs and toilet training equipment for toddlers must be regularly maintained and kept in a sanitary condition. You must put potty chairs, when in use, on washable, water resistant surfaces.

(e) You must provide soap and clean washcloths and towels, disposable towels or other approved hand-drying devices to residents.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0060, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0065 What types of linen do I need to provide to clients? (1) You must provide the following to clients residing in shelter:

(a) Bed linen, towels and washcloths that are clean and in good repair. After use by a client, bed linen, towels and washcloths must be laundered prior to use by another client.

(b) A clean liner for a sleeping bag unless the bag is cleaned between use by different clients.

(2) Clients residing in shelter must be provided with changes of clean bed linen, towels and washcloths upon their request.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0065, filed 3/16/01, effective 4/16/01.]

[Title 388 WAC—p. 338]

WAC 388-61A-0070 What are the requirements for laundry facilities? We have specific requirements for laundry facilities at your shelter.

(1) You must provide adequate laundry and drying equipment, or make other arrangements for getting laundry done on a regular basis.

(2) You must handle and store laundry in a sanitary manner.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0070, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0075 Are there requirements for drinking water? Water supplies to be used for human consumption must be from an approved public water system. If it is an individual system, the local health department must approve it as safe for human consumption.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0075, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0080 What are the requirements for sewage and liquid wastes? You must discharge sewage and liquid wastes into a public sewer system or into a functioning septic system, approved by the local health authority or department.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0080, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0085 What kind of heating system is required? (1) Rooms used by clients in a shelter must be equipped with a safe and adequate source of heat that can keep the room at a healthful temperature during the time the room is occupied.

(2) Gas-fired or oil-fired space heaters and water heaters must be safely vented to the outside.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0085, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0090 How must I ventilate the shelter? (1) You must ensure that your shelter is ventilated for the health and comfort of the shelter residents. A mechanical exhaust to the outside must ventilate toilets and bathrooms that do not have windows opening to the outside.

(2) Bedrooms and communal living areas must have a window or opening to the outdoors that can be locked or secured from the inside.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0090, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0095 How much lighting is required in the shelter? You must locate light fixtures and provide lighting that promotes good visibility and comfort for shelter residents.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0095, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0100 Are there any requirements about pets in the shelter? Pets are prohibited from the kitchen during food preparation.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0100, filed 3/16/01, effective 4/16/01.]

(2007 Ed.)

WAC 388-61A-0105 What first-aid supplies must I provide? You must keep first-aid supplies on hand for immediate use, including unexpired syrup of ipecac that is to be used only when advised by the poison control center. First-aid supplies must include at least the following: First-aid manual, band-aids, gauze, and adhesive tape.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0105, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0110 What are the requirements for storing medications? (1) All medications, including pet medications and herbal remedies, must be stored in a way that is inaccessible to children.

(2) Pet and human medications must be stored separately.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0110, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0115 What measures must I take for pest control? You must make reasonable attempts to keep the shelter free from pests, such as rodents, flies, cockroaches, fleas and other insects.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0115, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0120 What are the requirements for labeling and storing chemicals and toxic materials? (1) Containers of chemical cleaning agents and other toxic materials must:

(a) Be clearly labeled with the contents; and
(b) Bear the manufacturer's instructions and precautions for use.

(2) You must store the following items in a place that is not accessible to children:

- (a) Chemical cleaning supplies;
- (b) Toxic substances;
- (c) Poisons;
- (d) Aerosols; and
- (e) Items with warning labels.

(3) You must store chemical cleaning supplies and toxic substances separately from food items, clothing, and bedding in order to prevent contamination.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0120, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0125 Where do I keep firearms and other dangerous weapons? (1) You must keep firearms and other dangerous weapons in a locked storage container, gun safe, or another storage area made of strong, unbreakable material.

(2) If the storage cabinet has a glass or another breakable front, you must secure the firearms with a locked cable or chain placed through the trigger guards.

(3) You must store ammunition in a place that is separate from the firearms or locked in a gun safe.

(4) You must allow access to firearms, weapons and ammunition only to authorized persons.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0125, filed 3/16/01, effective 4/16/01.]

(2007 Ed.)

ADDITIONAL REQUIREMENTS FOR SAFE HOMES

WAC 388-61A-0130 What are the additional requirements for a safe home? Safe homes must meet the following additional requirements in order for a domestic violence service to contract with us:

(1) A safe home must complete a written application to a domestic violence service. The domestic violence service must approve the application and give training to the safe home staff before the home may receive clients.

(2) The domestic violence service must maintain a written record of all safe homes. The record must include:

(a) The name and address of the person operating the safe home or an identification code for the safe home;

(b) A written safe home application;

(c) Documentation that the safe home complies with the general facility and additional requirements for safe homes; and

(d) Verification that safe home staff received initial basic training as outlined in this WAC by the domestic violence service.

(3) You must have at least one telephone at the safe home for incoming and outgoing calls. You must provide the following information to residents:

(a) Emergency telephone numbers; and

(b) Instructions on how residents can access domestic violence service staff.

(4) When clients are residing in a safe home at least one domestic violence service staff member must be on-call to go to the safe home twenty-four-hours a day, seven-days-per-week.

(5) Safe homes must comply with the following general fire safety requirements:

(a) Every room used by children in the safe home must have easy entry and exit, including one of these features:

(i) Two separate doors;

(ii) One door leading directly to the outside; or

(iii) A window that opens to the outside and is large enough for emergency escape or rescue.

(b) Every occupied area must have access to at least one exit that does not pass through rooms or spaces the can be locked or blocked from the opposite side.

(c) No space may be lived in by a client that is accessible only by a ladder, folding stairs, or a trap door.

(d) Every bathroom door used by clients must be designed to permit the opening of the locked door from the outside.

(e) Every closet door latch must be designed to be opened from the inside.

(f) Stoves or heaters must not block escape or exit routes.

(g) Flammable, combustible, or poisonous material must be stored away from exits and away from areas that are accessible to children.

(h) Open-flame devices and fireplaces, heating and cooking appliances, and products capable of igniting clothing must not be left unattended or used incorrectly.

(i) Fireplaces, wood stoves and other heating systems that have a surface hot enough to cause harm must have gates or protectors around them when in use.

(j) Multilevel dwellings must have a means of escape from an upper floor. If a fire ladder is needed to escape from

an upper story window, it must be stored in a location that is easily accessible to the clients who may need it.

(k) You must place a smoke detector in good working condition in each bedroom or in areas close to where children sleep, such as a hallway. If the smoke detector is mounted on the wall, it must be twelve inches from the ceiling and a corner.

(l) If questions arise concerning fire danger, the local fire protection authority must be consulted.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0130, filed 3/16/01, effective 4/16/01.]

ADDITIONAL REQUIREMENTS FOR SHELTER HOMES

WAC 388-61A-0135 What are the additional requirements for a shelter home? Shelter homes must meet the following additional requirements in order for a domestic violence service to contract with us:

(1) When a shelter home is not a component of a domestic violence service, the shelter home and domestic violence service must have a written working agreement before the shelter home receives clients from the domestic violence service. The written working agreement must include:

(a) Confirmation that the domestic violence service has inspected the shelter home and that the shelter home complies with the general facility and additional requirements for shelter homes;

(b) How the domestic violence service will provide supportive services to shelter home residents; and

(c) Verification that shelter home staff received initial basic training as outlined in this rule by the domestic violence service.

(2) Shelter homes must provide at least one toilet, sink, and bathing facility for each fifteen clients or fraction of this number. The floors of all toilet and bathing facilities must be resistant to moisture.

(3) You must have at least one telephone at the shelter for incoming and outgoing calls. Next to the telephone in shelter homes you must post:

(a) Emergency telephone numbers; and

(b) Instructions on how residents can access domestic violence service staff.

(4) In shelter homes all bathrooms, toilet rooms, laundry rooms, and janitor closets containing wet mops and brushes must have natural or mechanical ventilation in order to prevent objectionable odors and condensation.

(5) When staff serve food to clients in shelter homes, the staff must prepare the food in compliance with WAC 246-215-190, Temporary food service establishment.

(6) Shelter homes must develop and post hygiene procedures for handling and storing diapers and sanitizing the changing area.

(7) Shelter homes must comply with the fire and life safety requirements as outlined in chapter 51-40 WAC.

(8) Shelter homes must meet the following requirements for bedrooms:

(a) Bedrooms must have a minimum ceiling height of seven and half feet;

(b) Bedrooms must provide at least fifty square feet of usable floor area per bed; and

(c) Floor area where the ceiling height is less than five feet cannot be considered as usable floor area.

(9) When clients are residing in a shelter home at least one domestic violence service staff member must be present or on-call to go to the shelter home twenty-four-hours a day, seven-days-per-week.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0135, filed 3/16/01, effective 4/16/01.]

SUPPORTIVE SERVICES

WAC 388-61A-0140 What supportive services are required to provide to clients? You must give clients an opportunity to receive supportive services and assistance during their stay in the shelter. Clients are not required to participate in these services as a condition of residing in the shelter. Supportive services must include:

(1) Twenty-four-hour, seven-day-per-week access to advocacy-based counseling;

(2) A safe, supportive environment that offers clients the opportunity to examine the events that led to the need for domestic violence services;

(3) A private area for counseling;

(4) Advocacy-based counseling with, and on behalf of, the client;

(5) Safety planning, problem solving and crisis intervention;

(6) Assistance with child care during individual and group counseling sessions;

(7) A minimum ratio of one group facilitator to eight group participants;

(8) Planned activities for children who are residents of the shelter;

(9) A day program or drop-in center to assist victims of domestic violence who have found other shelter but who have a need for supportive services; and

(10) Referrals to other appropriate services or domestic violence services when:

(a) Shelter homes or safe homes are full;

(b) A client must be transferred to another domestic violence service for reasons of safety of the client; or

(c) An inappropriate referral has been made to a domestic violence service; or

(d) The client has problems that require services of another agency or agencies before receiving domestic violence services.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0140, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0145 What is advocacy-based counseling? Advocacy-based counseling means the involvement of a client with an advocate counselor in an individual, family, or group session with the primary focus on safety planning and on empowerment of the client through reinforcing the client's autonomy and self-determination. Advocacy-based counseling uses nonvictim blaming problem-solving methods that include:

(1) Identifying the barriers to safety;

(2) Developing safety checking and planning skills;

(3) Clarifying issues;

(4) Providing options;

- (5) Solving problems;
- (6) Increasing self-esteem and self-awareness; and
- (7) Improving and implementing skills in decision making, parenting, self-help, and self-care.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0145, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0150 What type of training is required for staff of the domestic violence service? All staff providing direct services to domestic violence clients, and supervisors of direct service staff, must meet the following minimum training requirements.

(1) A minimum of twenty hours of initial basic training that covers at least the following topics:

- (a) Theory and implementation of advocacy-based counseling;
- (b) The history of domestic violence;
- (c) Legal, medical, social service, and systems advocacy;
- (d) Confidentiality and ethics;
- (e) Client safety assessment;
- (f) Planning, problem-solving, and crisis intervention;
- (g) Providing services and advocacy to individuals from diverse communities;
- (h) Policies and procedures of the domestic violence service; and
- (i) Referrals and shelter resident transfers.

(2) In the year following the year in which they received their initial basic training, and every year thereafter, staff providing direct services, and supervisors of direct service staff, must attend a minimum of thirty hours of continuing education as follows:

(a) At least fifteen hours of continuing education must be training on advocacy-based counseling directly related to serving victims of domestic violence and their children.

(b) At least five hours of continuing education must be training on services and advocacy to individuals from diverse communities.

(c) Staff must devote not more than ten hours to video, audiotapes, or self-study as part of the overall thirty-hour continuing education requirement.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0150, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0155 Must supervisors of domestic violence service staff have specific experience and training? Supervisors of staff providing direct services to domestic violence clients must meet the following minimum experience and training requirements.

(1) At least two years' counseling experience with a domestic violence service; and

(2) Fifty hours of training on domestic violence issues and advocacy-based counseling within three years prior to providing staff supervision.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0155, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0160 What written policies and procedures do you need to have? The domestic violence service must have written policies and procedures that cover the following issues:

- (1) Victims in immediate danger or at risk will receive first priority for shelter;
- (2) Confidentiality of client records and communication;
- (3) Nondiscrimination relating to staff, clients, and provision of services;
- (4) The provision of bilingual and interpreter services to clients;
- (5) Recruitment, hiring, periodic performance evaluation, promotion and termination of staff. Agencies must recruit, to the extent feasible, persons who are former victims of domestic violence to work as paid or volunteer staff;
- (6) Job descriptions for all staff positions including volunteers;
- (7) Reporting of child abuse as legally mandated;
- (8) Clients access to their files;
- (9) Grievance procedures for staff and clients;
- (10) Procedures for making referrals to other community resources such as medical, community service offices, pastoral care, legal representation, and client transfers to another domestic violence service for reasons of safety of the client;
- (11) Emergency procedures for fire, disaster, first aid, medical and police intervention;
- (12) Appropriate documentation of domestic violence services and client files;
- (13) Protection of agency and client records;
- (14) Records retention;
- (15) Appropriate accounting procedures;
- (16) Personnel policies and procedures; and
- (17) Administrative policies and procedures.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0160, filed 3/16/01, effective 4/16/01.]

COMPLIANCE WITH STANDARDS

WAC 388-61A-0165 Will DSHS do an evaluation of the domestic violence service? (1) To measure compliance with our requirements we will conduct a biennial evaluation of each agency under contract with us to provide domestic violence service.

(2) We will inspect a random number of safe homes during biennial evaluations of domestic violence services to measure compliance with our requirements.

(3) If a lodging unit is occupied at the time of an evaluation, the domestic violence service must give the client an opportunity to leave the unit.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0165, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0170 What will happen if I am out of compliance with my contract? (1) If we find that the domestic violence service, safe home, or shelter home is out of compliance with the standards specified in this chapter or the contract, we will give you written notice of the deficiencies. You must correct the deficiencies according to a plan of correction we approve.

(2) We may suspend or revoke the funding of a domestic violence service where a safe home, shelter home, or the domestic violence service itself is out of compliance with this chapter or the DSHS contract.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0170, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0175 What will happen if there is a complaint to DSHS about the domestic violence service?

(1) If we receive a complaint that your domestic violence service is out of compliance with this chapter or the DSHS contract, we will notify you and we will initiate an investigation.

(2) If the investigation requires that we be on-site at your domestic violence service, you must give clients residing in lodging units an opportunity to leave the unit during the inspection.

(3) If we find that the domestic violence service, safe home, or shelter home has not complied with the standards specified in this chapter or the terms of the DSHS contract, we will give you written notice of the deficiencies. You must correct the deficiencies according to a plan of correction we approve.

(4) We may suspend or revoke the funding of a domestic violence service where a safe home, shelter home, or the service itself is out of compliance with this chapter or the DSHS contract.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0175, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0180 Can DSHS waive any of the minimum standards of this chapter? Under certain conditions we may waive some of the rules contained in this chapter if you submit a written request that satisfactorily demonstrates that:

(1) The waiver will not place the client's safety or health in jeopardy and that:

(a) The domestic violence service is unable to meet the requirements of this chapter without the waiver; or

(b) The absence of the waiver will have a detrimental effect on the provision of services.

(2) Any substitutions of procedures, materials, or equipment from those specified in this chapter are at least equivalent to those required.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0180, filed 3/16/01, effective 4/16/01.]

APPEAL PROCESS

WAC 388-61A-0185 What are my rights if DSHS suspends, revokes, or denies funding? If we suspend, revoke or deny funding you may request an agency hearing.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0185, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0190 Will I be notified if my funding has been suspended, revoked, or denied? We will notify you in writing if:

(1) Your funding has been suspended or revoked and we will state our reasons for making that decision; or

(2) Your request for funding has been denied and we will state our reasons for making that decision.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0190, filed 3/16/01, effective 4/16/01.]

WAC 388-61A-0195 How do I request an agency hearing? In order to request an agency hearing you must:

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(1) Notify the office of administrative hearings within twenty-eight days from the date of the letter that notified you of our decision;

(2) Include in your letter a statement of your reasons why you disagree with our decision; and

(3) Attach a copy of our letter to your request for an agency hearing.

[Statutory Authority: Chapter 70.123 RCW. 01-07-053, § 388-61A-0195, filed 3/16/01, effective 4/16/01.]

Chapter 388-70 WAC**CHILD WELFARE SERVICES—FOSTER CARE—ADOPTION SERVICES—SERVICES TO UNMARRIED PARENTS****WAC**

388-70-091	Foster care planning for Indian children—Definitions.
388-70-092	Foster care for Indian children—Tribal sovereignty.
388-70-093	Foster care for Indian children—Services.
388-70-095	Foster care for Indian children—Serious injury, death, abandonment, child abuse, neglect, incarceration.
388-70-450	Adoptive planning for Indian children by department staff.
388-70-600	Local Indian child welfare advisory committee—Purpose.
388-70-610	Local Indian child welfare advisory committee—Membership.
388-70-615	Local Indian child welfare advisory committee—Subcommittees.
388-70-620	Local Indian child welfare advisory committee—Functions.
388-70-630	Local Indian child welfare advisory committee—Meetings.
388-70-640	Local Indian child welfare advisory committee—Confidentiality.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-70-010	Foster care—Legal basis. [Statutory Authority: 1982 c 118, 82-23-006 (Order 1901), § 388-70-010, filed 11/4/82. Statutory Authority: RCW 74.08.090, 78-09-098 (Order 1335), § 388-70-010, filed 9/1/78; Order 965, § 388-70-010, filed 8/29/74; Order 913, § 388-70-010, filed 3/1/74; Order 623, § 388-70-010, filed 10/27/71; Regulation 70.010, filed 3/22/60.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-012	Foster care—Definitions. [Statutory Authority: RCW 74.08.090, 78-09-098 (Order 1335), § 388-70-012, filed 9/1/78; Order 1123, § 388-70-012, filed 6/7/76; Order 913, § 388-70-012, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-013	Authorization for foster care placement. [Statutory Authority: RCW 74.08.090, 88-17-059 (Order 2669), § 388-70-013, filed 8/17/88; 86-04-030 (Order 2337), § 388-70-013, filed 1/29/86. Statutory Authority: RCW 74.12.340, 82-16-064 (Order 1849), § 388-70-013, filed 7/30/82. Statutory Authority: RCW 74.08.090, 82-06-001 (Order 1764), § 388-70-013, filed 2/18/82. Statutory Authority: RCW 74.13.109 and 74.08.090, 81-18-031 (Order 1686), § 388-70-013, filed 8/27/81. Statutory Authority: RCW 74.08.090 and 1979 c 155, 79-10-026 (Order 1431), § 388-70-013, filed 9/10/79. Statutory Authority: RCW 74.08.090, 78-09-098 (Order 1335), § 388-70-013, filed 9/1/78; Order 1186, § 388-70-013, filed 2/3/77; Order 1123, § 388-70-013, filed 6/7/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-014	Eligibility for foster care—Need. [Order 1123, § 388-70-014, filed 6/7/76; Order 1040, § 388-70-014, filed 8/7/75; Order 965, § 388-70-014, filed 8/29/74; Order 913, § 388-70-014, filed 3/1/74.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.

388-70-015	Foster care—Definition. [Order 623, § 388-70-015, filed 10/27/71.] Repealed by Order 913, filed 3/1/74.	388-70-041	Payment standards—Foster family care. [Order 913, § 388-70-041, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-016	Placement of child in foster care. [Order 1138, § 388-70-016, filed 7/29/76; Order 1123, § 388-70-016, filed 6/7/76; Order 965, § 388-70-016, filed 8/29/74; Order 913, § 388-70-016, filed 3/1/74.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-042	Payment standards—Regular foster family care. [Statutory Authority: RCW 74.08.090. 86-04-030 (Order 2337), § 388-70-042, filed 1/29/86; 85-13-062 (Order 2242), § 388-70-042, filed 6/18/85; 81-09-042 (Order 1634), § 388-70-042, filed 4/15/81; 79-11-085 (Order 1445), § 388-70-042, filed 10/24/79; Order 1260, § 388-70-042, filed 12/29/77, effective 2/1/78; Order 1149, § 388-70-042, filed 8/26/76; Order 1052, § 388-70-042, filed 9/10/75; Order 963, § 388-70-042, filed 8/19/74; Order 913, § 388-70-042, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-017	Rights of natural parents of child. [Order 1123, § 388-70-017, filed 6/7/76; Order 913, § 388-70-017, filed 3/1/74.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-043	Foster care—Authorization for placement. [Order 763, § 388-70-043, filed 1/10/73; Order 623, § 388-70-043, filed 10/27/71.] Repealed by Order 913, filed 3/1/74.
388-70-018	Foster care—Duration of service. [Order 623, § 388-70-018, filed 10/27/71.] Repealed by Order 913, filed 3/1/74.	388-70-044	Payment standards—Receiving home care—Standards for using. [Statutory Authority: RCW 74.08.090. 86-04-030 (Order 2337), § 388-70-044, filed 1/29/86; 85-13-062 (Order 2242), § 388-70-044, filed 6/18/85; 81-09-042 (Order 1634), § 388-70-044, filed 4/15/81; 79-11-085 (Order 1445), § 388-70-044, filed 10/24/79; 78-09-098 (Order 1335), § 388-70-044, filed 9/1/78; Order 1260, § 388-70-044, filed 12/29/77, effective 2/1/78; Order 1208, § 388-70-044, filed 4/29/77; Order 1149, § 388-70-044, filed 8/26/76; Order 1052, § 388-70-044, filed 9/10/75; Order 963, § 388-70-044, filed 8/19/74; Order 913, § 388-70-044, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-019	Responsibility of foster parents. [Order 913, § 388-70-019, filed 3/1/74.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-046	Foster care—Rights of natural parents of child. [Order 623, § 388-70-046, filed 10/27/71.] Repealed by Order 913, filed 3/1/74.
388-70-020	Services offered. [Regulation 70.020, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.	388-70-047	Emergency foster care assistance. [Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-047, filed 9/1/78; Order 1052, § 388-70-047, filed 9/10/75.] Repealed by 85-13-062 (Order 2242), filed 6/18/85. Statutory Authority: RCW 74.08.090.
388-70-022	Payment of foster care. [Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-70-022, filed 9/10/79. Statutory Authority: RCW 74.08.090. 79-04-062 (Order 1384), § 388-70-022, filed 3/28/79; 78-09-098 (Order 1335), § 388-70-022, filed 9/1/78; Order 1260, § 388-70-022, filed 12/29/77, effective 2/1/78; Order 1123, § 388-70-022, filed 6/7/76; Order 913, § 388-70-022, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-048	Payment standards—Specialized rate foster family care—Child with special needs. [Statutory Authority: RCW 74.08.090. 86-04-030 (Order 2337), § 388-70-048, filed 1/29/86; 85-13-062 (Order 2242), § 388-70-048, filed 6/18/85; 81-09-042 (Order 1634), § 388-70-048, filed 4/15/81; 79-11-085 (Order 1445), § 388-70-048, filed 10/24/79; 78-09-098 (Order 1335), § 388-70-048, filed 9/1/78; Order 1149, § 388-70-048, filed 8/26/76; Order 1052, § 388-70-048, filed 9/10/75; Order 963, § 388-70-048, filed 8/19/74; Order 913, § 388-70-048, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-024	Payment of foster care—Effective date. [Statutory Authority: RCW 74.12.340. 82-16-064 (Order 1849), § 388-70-024, filed 7/30/82. Statutory Authority: RCW 74.08.090. 82-04-070 (Order 1753), § 388-70-024, filed 2/3/82; 78-09-098 (Order 1335), § 388-70-024, filed 9/1/78; Order 1123, § 388-70-024, filed 6/7/76; Order 1040, § 388-70-024, filed 8/7/75; Order 1020, § 388-70-024, filed 4/29/75; Order 913, § 388-70-024, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-049	Payment standards—Foster care in boarding school. [Order 913, § 388-70-049, filed 3/1/74.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.
388-70-025	Foster care—Eligibility. [Order 623, § 388-70-025, filed 10/27/71.] Repealed by Order 913, filed 3/1/74.	388-70-050	Requests from parents. [Regulation 70.050, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.
388-70-030	Application and requests for child welfare services. [Regulation 70.030, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.	388-70-051	Education related foster care. [Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-051, filed 9/1/78; Order 924, § 388-70-051, filed 4/15/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-031	Foster parent liability fund. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-031, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-052	Overpayments of foster care. [Order 913, § 388-70-052, filed 3/1/74.] Repealed by Order 1186, filed 2/3/77.
388-70-032	Period of coverage. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-032, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-053	Payment standards—Incentive plan. [Statutory Authority: RCW 74.08.090. 80-12-005 (Order 1534), § 388-70-053, filed 8/22/80.] Repealed by 85-13-062 (Order 2242), filed 6/18/85. Statutory Authority: RCW 74.08.090.
388-70-033	Persons eligible for coverage. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-033, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-054	Temporary absence of child from foster care. [Statutory Authority: RCW 74.08.090. 85-13-062 (Order 2242), § 388-70-054, filed 6/18/85; 79-11-105 (Order 1449), § 388-70-054, filed 10/31/79; Order 1123, § 388-70-054, filed 6/7/76; Order 965, § 388-70-054, filed 8/29/74; Order 913, § 388-70-054, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-034	Limits of coverage. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-034, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-055	Foster care—Responsibility of foster parents. [Order 623, § 388-70-055, filed 10/27/71.] Repealed by Order 913, filed 3/1/74.
388-70-035	Exclusions. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-035, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.		
388-70-036	Subrogation. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-036, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.		
388-70-037	Investigation of claims. [Statutory Authority: RCW 74.08.090. 91-24-044 (Order 3297), § 388-70-037, filed 11/27/91, effective 12/28/91.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.		
388-70-040	Foster care—Request for services. [Order 623, § 388-70-040, filed 10/27/71; Regulation 70.040, filed 3/22/60.] Repealed by Order 913, filed 3/1/74.		

388-70-056	Transportation and other expenses—Reimbursement. [Statutory Authority: RCW 74.08.090. 85-13-062 (Order 2242), § 388-70-056, filed 6/18/85; 78-09-098 (Order 1335), § 388-70-056, filed 9/1/78; Order 1123, § 388-70-056, filed 6/7/76; Order 965, § 388-70-056, filed 8/29/74; Order 913, § 388-70-056, filed 3/1/74.] Repealed by 87-09-027 (Order 2481), filed 4/9/87. Statutory Authority: Chapter 74.13 RCW.	388-70-090	Payment for foster care. [Regulation 70.090, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.
388-70-058	Reimbursement for damage or loss caused by child in foster family care. [Statutory Authority: RCW 74.08.090. 85-13-062 (Order 2242), § 388-70-058, filed 6/18/85; 80-04-055 (Order 1495), § 388-70-058, filed 3/21/80.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-100	Adoption services. [Regulation 70.100, filed 3/22/60.] Repealed by Order 1167, filed 10/27/76.
388-70-060	Services to the child in his own home. [Regulation 70.060, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.	388-70-110	Services to unmarried parents. [Order 1020, § 388-70-110, filed 4/29/75; Order 689, § 388-70-110, filed 6/15/72; Regulation 70.110, filed 3/22/60.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.
388-70-062	Payment for foster care to family receiving public assistance. [Order 913, § 388-70-062, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-111	Services to unmarried parents—Duration of service. [Order 689, § 388-70-111, filed 6/15/72.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.
388-70-064	Payment for foster care to relative. [Statutory Authority: RCW 74.08.090. 82-24-068 (Order 1915), § 388-70-064, filed 12/1/82; 80-06-069 (Order 1504), § 388-70-064, filed 5/22/80; Order 913, § 388-70-064, filed 3/1/74.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.	388-70-112	Services to unmarried parents—Persons eligible. [Order 1020, § 388-70-112, filed 4/29/75; Order 689, § 388-70-112, filed 6/15/72.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.
388-70-065	Foster care—Payment. [Order 623, § 388-70-065, filed 10/27/71.] Repealed by Order 825, filed 7/26/73.	388-70-114	Services to unmarried parents—Payment. [Order 689, § 388-70-114, filed 6/15/72.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.
388-70-066	Foster care out-of-state—Authorization—Payment. [Statutory Authority: RCW 74.08.090. 85-13-062 (Order 2242), § 388-70-066, filed 6/18/85; 78-09-098 (Order 1335), § 388-70-066, filed 9/1/78; Order 913, § 388-70-066, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-116	Services to unmarried parents—Parents' responsibility. [Order 689, § 388-70-116, filed 6/15/72.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.
388-70-068	Earnings of foster child. [Statutory Authority: RCW 74.08.090. 83-04-061 (Order 1943), § 388-70-068, filed 2/2/83; Order 913, § 388-70-068, filed 3/1/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-118	Services to unmarried parents—Services available. [Order 689, § 388-70-118, filed 6/15/72.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.
388-70-069	Resources and unearned income of foster child. [Statutory Authority: RCW 74.08.090. 83-04-061 (Order 1943), § 388-70-069, filed 2/2/83; Order 1123, § 388-70-069, filed 6/7/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-120	Medical care. [Regulation 70.120, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.
388-70-070	Referrals to juvenile court. [Regulation 70.070, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.	388-70-130	Foster homes. [Regulation 70.130, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.
388-70-075	Parents' obligation to support child in foster care. [Order 1123, § 388-70-075, filed 6/7/76; Order 918, § 388-70-075, filed 3/14/74; Order 623, § 388-70-075, filed 10/27/71.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-140	Interstate movement of children. [Regulation 70.140, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.
388-70-078	Standards for parental participation in cost of foster care—Minimum scale recommended to court. [Order 1123, § 388-70-078, filed 6/7/76; Order 918, § 388-70-078, filed 3/14/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-150	Adoption studies for the superior court. [Regulation 70.150, filed 3/22/60.] Repealed by Order 1167, filed 10/27/76.
388-70-080	Referral of child in foster care to department's office of support enforcement. [Statutory Authority: RCW 74.08.090. 83-17-003 (Order 1992), § 388-70-080, filed 8/5/83; Order 1123, § 388-70-080, filed 6/7/76; Order 1048, § 388-70-080, filed 8/29/75; Order 1016, § 388-70-080, filed 4/1/75; Order 918, § 388-70-080, filed 3/14/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-160	Guardianship of estate of child. [Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-160, filed 9/1/78; Order 965, § 388-70-160, filed 8/29/74; Order 913, § 388-70-160, filed 3/1/74; Regulation 70.160, filed 3/22/60.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
388-70-080	Foster care. [Regulation 70.080, filed 3/22/60.] Repealed by Order 623, filed 10/27/71.	388-70-170	Veterans' benefits. [Order 913, § 388-70-170, filed 3/1/74; Regulation 70.170, filed 3/22/60.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-082	Parents' foster care payments to be remitted to department. [Order 1123, § 388-70-082, filed 6/7/76; Order 918, § 388-70-082, filed 3/14/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-175	Veterans' benefits—Types of care. [Order 623, § 388-70-175, filed 10/27/71.] Repealed by Order 825, filed 7/26/73.
388-70-084	Assignment of child support judgment and limited power of attorney. [Order 1123, § 388-70-084, filed 6/7/76; Order 918, § 388-70-084, filed 3/14/74.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.	388-70-180	Foster family care—Standards for payment. [Order 825, § 388-70-180, filed 7/26/73; Order 763, § 388-70-180, filed 1/10/73; Order 654, § 388-70-180, filed 2/9/72; Order 623, § 388-70-180, filed 10/27/71; Order 554, § 388-70-180, filed 4/1/71; Order 418, § 388-70-180, filed 12/31/69; Regulation 70.180, filed 7/27/67; Regulation 70.180, filed 2/23/67, 12/28/66, 10/13/66, 3/31/66, 6/24/64, 9/26/63, 6/30/60, 3/22/60.] Repealed by Order 913, filed 3/1/74.
388-70-085	Foster care—Determination of parents' financial ability to support child. [Order 623, § 388-70-085, filed 10/27/71.] Repealed by Order 918, filed 3/14/74.	388-70-183	Payment standards for regular foster family care. [Order 825, § 388-70-183, filed 7/26/73.] Repealed by Order 913, filed 3/1/74.
		388-70-185	Payment standards for receiving home care. [Order 825, § 388-70-185, filed 7/26/73.] Repealed by Order 913, filed 3/1/74.
		388-70-187	Payment standards for specialized foster family care—Child with special needs. [Order 825, § 388-70-187, filed 7/26/73.] Repealed by Order 913, filed 3/1/74.
		388-70-190	Payment standards for foster care in boarding school. [Order 825, § 388-70-190, filed 7/26/73 and repealed by Order 913, filed 3/1/74; Order 418, § 388-70-190, filed 12/31/69; Regulation 70.190, filed 7/27/67; Regulation 70.190, filed 3/31/66, 6/24/64, 9/26/63, 6/30/60, 3/22/60.] Repealed by Order 623, filed 10/27/71.
		388-70-200	Payment standards for foster care in boarding school—Payment to foster family receiving public assistance. [Order 623, § 388-70-200, filed 10/27/71; Order 554, § 388-70-200, filed 4/1/71; Order 418, § 388-70-200, filed 12/31/69; Regulation 70.200, filed 9/26/63; Regulation 70.200, filed 3/22/60.] Repealed by Order 913, filed 3/1/74.

388-70-201	DSHS—Private child caring agency relationships—Legal basis. [Order 1123, § 388-70-201, filed 6/7/76.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	filed 12/21/64, effective 2/1/65.] Repealed by Order 623, filed 10/27/71.
388-70-210	Payment standards for foster care in boarding school—Payment to relative. [Order 623, § 388-70-210, filed 10/27/71; Regulation 70.210, filed 9/26/63; Regulation 70.210, filed 3/22/60.] Repealed by Order 913, filed 3/1/74.	388-70-320 Use of resources other than state department of public assistance medical program. [Regulation 70.240, filed 9/26/63.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.
388-70-211	DSHS—Private child caring agency relationships—General terms. [Order 1123, § 388-70-211, filed 6/7/76.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-410 Adoption services for children—Legal basis—Purpose. [Order 1167, § 388-70-410, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-216	Contractual relationships. [Order 1123, § 388-70-216, filed 6/7/76.] Repealed by Order 1186, filed 2/3/77.	388-70-420 Definitions. [Order 1167, § 388-70-420, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-220	Payment standards for foster care in boarding school—Earnings of foster child. [Order 623, § 388-70-220, filed 10/27/71; Regulation 70.220, filed 6/24/64; Regulation 70.220, filed 9/26/63; Regulation 70.220, filed 3/22/60.] Repealed by Order 913, filed 3/1/74.	388-70-430 Eligibility for adoption service. [Order 1167, § 388-70-430, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-221	Responsibilities of private child caring agencies and DSHS for placement and care. [Order 1123, § 388-70-221, filed 6/7/76.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-440 Adoption services for children. [Order 1167, § 388-70-440, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-222	Payment standards for foster care in boarding school—Out-of-state authorization—Payment. [Order 623, § 388-70-222, filed 10/27/71.] Repealed by Order 913, filed 3/1/74.	388-70-460 Adoption services for families. [Order 1167, § 388-70-460, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-225	Retroactive increase in old-age, survivors, and disability insurance and railroad retirement benefits—1965 amendments—Foster care. [Regulation 70.221, filed 10/1/65.] Repealed by Order 623, filed 10/27/71.	388-70-470 Interstate procedures. [Order 1167, § 388-70-470, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-230	Child care agency, institution, or maternity home—Setting rates of payment. [Order 1186, § 388-70-230, filed 2/3/77; Order 1116, § 388-70-230, filed 4/28/76; Order 965, § 388-70-230, filed 8/29/74; Regulation 70.230, filed 12/21/64, effective 2/1/65; Regulation 70.230, filed 6/24/64, 9/26/63, 8/28/62, 6/30/60, 3/22/60.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-480 Record confidentiality. [Order 1167, § 388-70-480, filed 10/27/76.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-235	Required reports—Content—Penalty for late reporting. [Order 1186, § 388-70-235, filed 2/3/77; Order 965, § 388-70-235, filed 8/29/74; Regulation 70.231, filed 12/24/64, effective 2/1/65.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-510 Adoption support for children—Legal basis—Purpose. [Statutory Authority: RCW 43.20A.550. 82-02-023 (Order 1744), § 388-70-510, filed 12/30/81; Order 1037, § 388-70-510, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-240	Computation of per capita expenditures. [Regulation 70.232, filed 12/24/64, effective 2/1/65.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-520 Adoption support for children—Definitions. [Statutory Authority: RCW 43.20A.550. 93-07-030 (Order 3524), § 388-70-520, filed 3/10/93, effective 4/10/93. Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-520, filed 11/20/90, effective 12/21/90; Order 1037, § 388-70-520, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-245	Nonprofit institution and maternity home—Rate setting—Exclusions. [Order 855, § 388-70-245, filed 9/13/73; Regulation 70.233, filed 12/21/64, effective 2/1/65.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-530 Adoption support for children—Eligible child. [Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-530, filed 11/20/90, effective 12/21/90. Statutory Authority: RCW 43.20A.550. 82-02-023 (Order 1744), § 388-70-530, filed 12/30/81; Order 1037, § 388-70-530, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-250	Nonprofit agency—Commercial operations. [Regulation 70.234, filed 12/21/64, effective 2/1/65.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-540 Adoption support for children—Application. [Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-540, filed 11/20/90, effective 12/21/90; Order 1037, § 388-70-540, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-255	Voluntary agency licensed foster family care—Rate setting. [Order 1186, § 388-70-255, filed 2/3/77; Order 1123, § 388-70-255, filed 6/7/76; Order 855, § 388-70-255, filed 9/13/73; Regulation 70.235, filed 12/21/64, effective 2/1/65.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-550 Adoption support for children—Types and amounts of payments. [Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-550, filed 11/20/90, effective 12/21/90. Statutory Authority: RCW 43.20A.550. 82-02-023 (Order 1744), § 388-70-550, filed 12/30/81. Statutory Authority: RCW 74.13.109. 80-08-028 (Order 1516), § 388-70-550, filed 6/25/80; Order 1037, § 388-70-550, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-260	New agency—Rate negotiated. [Regulation 70.236, filed 12/21/64, effective 2/1/65.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-560 Adoption support for children—Criteria governing amount of payment. [Order 1037, § 388-70-560, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-270	Proprietary agency—Rate setting. [Regulation 70.237, filed 12/21/64, effective 2/1/65.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-570 Adoption support for children—Agreement for adoption support. [Statutory Authority: RCW 43.20A.550. 82-02-023 (Order 1744), § 388-70-570, filed 12/30/81; Order 1037, § 388-70-570, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-275	Nonsubmission of reports—Late reporting—Penalties. [Regulation 70.238, filed 12/21/64, effective 2/1/65.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	388-70-580 Adoption support for children—Review of support payment. [Order 1037, § 388-70-580, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
388-70-280	Vouchering payment. [Order 1132, § 388-70-280, filed 7/8/76; Regulation 70.239, filed 12/21/64, effective 2/1/65.] Repealed by 78-09-098 (Order 1335), filed 9/1/78. Statutory Authority: RCW 74.08.090.	
388-70-300	(Appendix A) Informational list of voluntary child care agencies and institutions and agreed rates. [Appendix A,	

- 388-70-590 Adoption support for children—Appeal from secretary's decision—Hearing. [Statutory Authority: RCW 34.05.220 (1)(a) and 74.13.109. 90-04-072 (Order 2995), § 388-70-590, filed 2/5/90, effective 3/1/90; Order 1037, § 388-70-590, filed 7/29/75.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
- 388-70-595 Reimbursement for nonrecurring adoption finalization costs. [Statutory Authority: RCW 43.20A.550 and HB 2602. 90-23-076 (Order 3101), § 388-70-595, filed 11/20/90, effective 12/21/90.] Repealed by 01-08-045, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.
- 388-70-700 Juvenile records. [Statutory Authority: RCW 74.08.090 and 1979 c 155. 79-10-026 (Order 1431), § 388-70-700, filed 9/10/79. Statutory Authority: RCW 74.08.090. 78-09-098 (Order 1335), § 388-70-700, filed 9/1/78.] Repealed by 01-08-047, filed 3/30/01, effective 4/30/01. Statutory Authority: RCW 74.13.031.

WAC 388-70-091 Foster care planning for Indian children—Definitions. For the purposes of these rules, the term "Indian" includes the following groups:

- (1) An enrolled Indian:
 - (a) Any person who is enrolled or eligible for enrollment in a recognized tribe.
 - (b) Any person determined, or eligible to be found, to be an Indian by the Secretary of the Interior.
 - (c) An Eskimo, Aleut or other Alaskan native.
- (2) A Canadian Indian: Any person who is a member of a treaty tribe, Metis community or nonstatus Indian community from Canada.
- (3) An unenrolled Indian: A person considered to be an Indian by a federally or nonfederally recognized Indian tribe or urban Indian/Alaskan native community organization.

[Order 1167, § 388-70-091, filed 10/27/76.]

WAC 388-70-092 Foster care for Indian children—Tribal sovereignty. Neither the licensing of Indian foster homes nor the placement and supervision of Indian children within the exterior boundaries of an Indian reservation, shall in any way abridge the sovereignty of an Indian nation or tribe nor shall compliance with these rules and regulations be deemed a relinquishment of sovereign authority by an Indian nation or tribe or by the state of Washington.

[Order 1167, § 388-70-092, filed 10/27/76.]

WAC 388-70-093 Foster care for Indian children—Services. Documented efforts shall be made to avoid separating the Indian child from his parents, relatives, tribe or cultural heritage. Consequently:

- (1) In the case of Indian children being placed in foster care by the department or for whom the department has supervisory responsibility, the local Indian child welfare advisory committee, predesignated by a tribal council, or appropriate urban Indian organization shall be contacted. Members of that committee will serve as resource persons for the purposes of cooperative planning and aid in placement.
- (2) The resources of the tribal government, department and the Indian community shall be used to locate the child's parents and relatives to assist in locating possible placement resources, and to assist in the development of a plan to overcome the problem that brought the child to the attention of the authorities and/or the department.

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(3) In planning foster care placements for Indian children, demonstrable consideration shall be given to tribal membership, tribal culture and Indian religions. The case record shall document the reasons and circumstances of case-work decisions and consideration in those regards.

(4) The following resources for foster home placement of Indian children will be explored and followed in the following order: Relatives' homes, homes of other Indian families of same tribe, other Indian foster parents and non-Indian foster homes specifically recruited and trained in cooperation with the local Indian child welfare advisory committee to meet the special needs of Indian foster children and in the geographic proximity that will insure continuation of the parent-child relationship. The training of non-Indian foster parents shall be designed and delivered in cooperation with the above committee and/or persons designated by the committee.

(5) For each Indian child who will be in care for more than 30 days, including those for whom adoption is planned, the ESSO shall make documented effort to complete two copies of the "family ancestry chart" (except in those cases where parents specifically indicate in writing they do not want the child enrolled). One copy will be retained in the child's file; the other will be forwarded to the bureau of Indian affairs office or the department of Indian affairs agency in Canada serving that child's tribe or band. The BIA of the department of Indian affairs agency will review the chart for possible enrollment eligibility in conjunction with the enrollment committee of the appropriate tribe or urban Indian community.

(6) The ESSO shall develop its social resources and staff training programs designed to meet the special needs of Indian children through coordination with tribal, Indian health service, bureau of Indian affairs social service staff, appropriate urban Indian and Alaskan native consultants, national, state and local Indian welfare organizations and ESSO child welfare advisory committees.

(7) The ESSO shall make diligent and demonstrable efforts to recruit facilities and/or homes particularly capable of meeting the special needs of Indian children with the assistance of the local Indian child welfare advisory committees.

[Order 1167, § 388-70-093, filed 10/27/76.]

WAC 388-70-095 Foster care for Indian children—Serious injury, death, abandonment, child abuse, neglect, incarceration. When an Indian child in foster care dies, is seriously injured, abandoned or incarcerated, in addition to other appropriate notifications, the department shall promptly advise the ESSO Indian child welfare advisory committee and appropriate tribal council. WAC 388-15-131(4) provides for notification about child abuse/neglect incidents.

[Order 1255, § 388-70-095, filed 12/1/77; Order 1167, § 388-70-095, filed 10/27/76.]

WAC 388-70-450 Adoptive planning for Indian children by department staff. (1) Definitions: For the purposes of these rules the term "Indian" includes the following groups:

- (a) Enrolled Indian

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(i) Any person who is enrolled or eligible for enrollment in a recognized tribe.

(ii) Any person determined, or eligible to be found, to be an Indian by the secretary of the interior.

(iii) An Eskimo, Aleut or other Alaskan native.

(b) Canadian Indian: A person who is a member of a treaty tribe, Metis community or nonstatus Indian community from Canada.

(c) Unenrolled Indian: A person considered to be an Indian by a federally or nonfederally recognized tribe or urban Indian/Alaskan native community organization.

(2) An adoptive family shall be considered Indian if one or both parents are Indian by the above definitions.

(3) In adoptive planning for Indian children, the unique tribal, cultural and religious sovereignty of Indian nations, tribes and communities shall be recognized. When consistent with the wishes of the biological parents and/or the child, the adoption of Indian children by Indian families is the primary goal.

(4) Standards implementing the policy are:

(a) Adoption exchange. In the referrals for an Indian child, adoptive homes having the following characteristics shall be given preference in the following order, each category being allowed 30 days before proceeding to the next.

(i) An Indian family of the same tribe as the child.

(ii) A Washington Indian family considering tribal cultural differences.

(iii) An Indian family from elsewhere in the United States or Canada through the adoption resource exchange of North America. Attention shall be given to matching the child's tribal culture to that of the adoptive family.

(iv) Any other family which can provide a suitable home to an Indian child, as well as instill pride and understanding in the child's tribal and cultural heritage.

(b) Foster parent adoptions: As a part of the total evaluation for approving a foster parent adoption of an Indian child, ESSO service staff shall document the foster family's past performance and future commitment in exposing the child to its Indian tribal and cultural heritage. The child's wish to be involved in his Indian culture shall be considered.

(c) When an Indian child, in the custody of an out-of-state agency, is referred for potential adoptive parents residing in Washington, documentation shall be obtained that assures the department's standards for planning for Indian children have been complied with.

(5) Local staff shall consult with an Indian child welfare committee in planning for placement of Indian children.

[Order 1167, § 388-70-450, filed 10/27/76.]

WAC 388-70-600 Local Indian child welfare advisory committee—Purpose. The intent of WAC 388-70-096, 388-70-450, and 388-70-600 through 388-70-640 is to ensure protection of the Indian identity of Indian children, their rights as Indian children, and the maximum utilization of available Indian resources for Indian children. To ensure the realization of this intent, information about each current and future case involving Indian children for whom the department of social and health services has a responsibility shall be referred to a local Indian child welfare advisory committee on

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an ongoing basis according to procedures which recognize the privacy rights of the families.

The purposes of local Indian child welfare advisory committees are:

(1) To promote relevant social service planning for Indian children.

(2) To encourage the preservation of the Indian family, tribe, heritage, and identity of each Indian child served by the department of social and health services.

(3) To assist in obtaining participation by representatives of tribal governments and Indian organizations in departmental planning for Indian children for whom the department has a responsibility.

[Order 1167, § 388-70-600, filed 10/27/76.]

WAC 388-70-610 Local Indian child welfare advisory committee—Membership. Local Indian child welfare committees shall be established within each region. The number and locations of the local committees shall be mutually determined by the Indian tribal governments and urban Indian organizations served by that region and the DSHS regional administrator.

(1) The committee shall consist of representatives designated by tribal government and urban Indian organizations. The regional administrator shall appoint committee members from among those individuals designated by Indian authorities. These members should be familiar with and knowledgeable about the needs of children in general as well as the particular needs of Indian children residing in the service area.

(2) The committee may also include bureau of Indian affairs and/or Indian health service staff if approved by participating tribal councils and urban Indian organizations.

(3) The DSHS regional administrator and/or the ESSO administrator shall appoint a member of his child welfare supervisory staff as a liaison member of the committee.

(4) The local Indian child welfare advisory committee is an ad hoc advisory committee not specifically authorized by statute. As such its members are not entitled to per diem and travel expenses for the performance of advisory committee functions. This rule shall not be construed, however, to prohibit expense payments to members who are otherwise qualified for and perform services compensable under other programs such as the volunteer programs.

[Order 1167, § 388-70-610, filed 10/27/76.]

WAC 388-70-615 Local Indian child welfare advisory committee—Subcommittees. Each committee may appoint a subcommittee of permanent members to participate in reviewing the situation of an individual child or children for the purpose of recommending future planning actions.

[Order 1167, § 388-70-615, filed 10/27/76.]

WAC 388-70-620 Local Indian child welfare advisory committee—Functions. (1) The functions of the local Indian child welfare advisory committee are:

(a) Assistance to DSHS staff in cooperative planning for Indian children.

(b) Consultation to DSHS staff regarding the provision of adoption, foster care and child protective services on behalf of Indian children.

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(c) Reviewing the situations of Indian children.

(d) Assisting in the implementation of recommended plans.

(e) Assisting in the recruitment of and making recommendations regarding the licensing of foster and adoptive homes for Indian children and providing culturally relevant services to Indian children.

(f) Requests the ESSO administrator to initiate reviews of casework decisions that the committee believes to be detrimental to the best interests of Indian children.

(g) Acts in an advisory capacity to the regional administrator and ESSO administrator regarding the department's implementation and monitoring of the rules related to foster care, child protection, and adoption services to Indian children and their families.

[Order 1167, § 388-70-620, filed 10/27/76.]

WAC 388-70-630 Local Indian child welfare advisory committee—Meetings. Each committee and the regional administrator and/or ESSO administrator will mutually agree as to time, place and frequency and conduct of official committee meetings.

[Order 1167, § 388-70-630, filed 10/27/76.]

WAC 388-70-640 Local Indian child welfare advisory committee—Confidentiality. The members of the local child welfare advisory committee shall agree to abide by RCW 74.04.060 and the rules of confidentiality binding the DSHS staff.

[Statutory Authority: RCW 74.15.030, 89-05-063 (Order 2743), § 388-70-640, filed 2/15/89; Order 1167, § 388-70-640, filed 10/27/76.]

Chapter 388-71 WAC

HOME AND COMMUNITY SERVICES AND PROGRAMS

WAC

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 388-71-0774 Adult day centers—Quality assurance and improvement.
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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 388-71-0120 What adjunct services are provided? [Statutory Authority: RCW 74.08.090, 74.34.165, and 74.39A.050(9). 00-03-029, § 388-71-0120, filed 1/11/00, effective 2/11/00.] Repealed by 04-19-136, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW.
 388-71-0150 When is the name of a personal aide placed on a registry? [Statutory Authority: RCW 74.08.090, 74.34.165, and 74.39A.050(9). 00-03-029, § 388-71-0150, filed 1/11/00, effective 2/11/00.] Repealed by 04-19-136, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW.
 388-71-0155 Prior to placing his or her name on the registry is the personal aide notified? [Statutory Authority: RCW 74.08.090, 74.34.165, and 74.39A.050(9). 00-03-029, § 388-71-0155, filed 1/11/00, effective 2/11/00.] Repealed by 04-19-136, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW.
 388-71-0194 Home and community services—Nursing services. [Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0194, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.04.200, 74.09.520, 74.39.020, 74.39A.090, 2003 1st sp.s. c 25, 2003 c 140. 03-24-001, § 388-71-0194, filed 11/19/03, effective 12/20/03. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0194, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. 02-21-098, § 388-71-0194, filed 10/21/02, effective 11/21/02.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC

	388-106-0200, 388-106-0300, 388-106-0305, 388-106-0400, 388-106-0500.	388-71-0250	Am I eligible for MPC services? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0250, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.-020.
388-71-0202	Long-term care services—Definitions. [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0202, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.08.090, 74.09.520, 04-04-042, § 388-71-0202, filed 1/29/04, effective 2/29/04. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0202, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.-090. 02-21-098, § 388-71-0202, filed 10/21/02, effective 11/21/02.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.-090, 74.09.520. Later promulgation, see WAC 388-71-0215.	388-71-0255	How do children remain eligible for MPC services? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0255, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.-520, 74.39A.010 and 74.39A.020.
388-71-0203	Long-term care services—Assessment of task self-performance and determination of required assistance. [Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0203, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. 02-21-098, § 388-71-0203, filed 10/21/02, effective 11/21/02.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.-090, 74.09.520. Later promulgation, see WAC 388-71-0230.	388-71-0260	Are there limitations to MPC services for children? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0260, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.-520, 74.39A.010 and 74.39A.020.
388-71-0205	Long-term care services—Service plan. [Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.-090. 02-21-098, § 388-71-0205, filed 10/21/02, effective 11/21/02.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.-090, 74.09.520. Later promulgation, see WAC 388-71-0235.	388-71-0400	What is the intent of the department's home and community programs? [Statutory Authority: RCW 74.39A.-130, 74.09.520, 74.08.090. 00-04-056, § 388-71-0400, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520.
388-71-0210	What is the purpose of WAC 388-71-0210 through 388-71-0260? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0210, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020.	388-71-0405	What are the home and community programs? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0405, filed 7/26/04, effective 8/26/04. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0405, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.09.520, 74.08.090, 74.39A.130. 00-04-056, § 388-71-0405, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0015.
388-71-0215	What definitions apply to WAC 388-71-0210 through 388-71-0260? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0215, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020.	388-71-0410	What services may I receive under HCP? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0410, filed 7/26/04, effective 8/26/04. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0410, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.-090. 02-21-098, § 388-71-0410, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.39.010, 74.09.520. 00-04-056, § 388-71-0410, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0300, 388-106-0305, 388-106-0400, 388-106-0500 and 388-106-0600.
388-71-0220	What is an assessment? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0220, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.-020.	388-71-0415	What other services may I receive under the waiver-funded programs? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0415, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.04.200, 74.09.520, 74.39.020, 74.39A.-090, 2003 1st sp.s. c 25, 2003 c 140. 03-24-001, § 388-71-0415, filed 11/19/03, effective 12/20/03. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0415, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.39.020. 00-04-056, § 388-71-0415, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0300, 388-106-0305.
388-71-0225	What is the purpose of a comprehensive assessment? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0225, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.-520, 74.39A.010 and 74.39A.020.	388-71-0420	What services are not covered under HCP? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0420, filed 7/26/04, effective 8/26/04. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0420, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.09.520, 74.08.090, 74.39A.130. 00-04-056, § 388-71-0420, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05.
388-71-0230	How are my needs for MPC services assessed? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0230, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020.		
388-71-0235	What is a service plan? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0235, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.-020.		
388-71-0240	What services may I receive under MPC as a child? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0240, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.-520, 74.39A.010 and 74.39A.020.		
388-71-0245	What services are not covered under MPC for children? [Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0245, filed 5/17/05, effective 6/17/05.] Repealed by 06-05-022, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020.		

		tive 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0020.	
388-71-0425		Who can provide HCP services? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0425, filed 7/26/04, effective 8/26/04. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0425, filed 6/12/03, effective 7/13/03. Statutory Authority: 1999 c 175, chapters 70.126, 70.127 RCW, RCW 74.08.044, 00-04-056, § 388-71-0425, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0040.	
388-71-0430		Am I eligible for one of the HCP programs? [Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0430, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. 02-21-098, § 388-71-0430, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.39A.-030. 00-13-077, § 388-71-0430, filed 6/19/00, effective 7/20/00. Statutory Authority: RCW 74.39.010, 74.08.090, 74.39A.110, 74.09.520. 00-04-056, § 388-71-0430, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0210, 388-106-0310, 388-106-0410, 388-106-0510, 388-106-0610.	
388-71-0435		Am I eligible for COPES-funded services? [Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0435, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. 02-21-098, § 388-71-0435, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.39A.-030. 00-13-077, § 388-71-0435, filed 6/19/00, effective 7/20/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0310.	
388-71-0440		Am I eligible for MPC-funded services? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0440, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.04.200, 74.09.520, 74.39.020, 74.39A.090, 2003 1st sp.s. c 25, 2003 c 140. 03-24-001, § 388-71-0440, filed 11/19/03, effective 12/20/03. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.39A.090. 02-23-063, § 388-71-0440, filed 11/18/02, effective 12/19/02. Statutory Authority: RCW 74.09.520. 00-04-056, § 388-71-0440, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0210.	
388-71-0442		Am I eligible for medically needy residential waiver services? [Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0442, filed 6/12/03, effective 7/13/03.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0410.	
388-71-0445		Am I eligible for chore-funded services? [Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0445, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. 02-21-098, § 388-71-0445, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.39A.-110, 74.39A.150. 01-02-051, § 388-71-0445, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 74.09.520, 74.09.530, 74.39A.110, [74.39A.]120, [74.39A.]130, 1998 c 346 § 205 (1)(c), and RCW 74.39A.030. 00-18-099, § 388-71-0445, filed 9/5/00, effective 10/6/00. Statutory Authority: RCW 74.39A.110, 74.39A.150. 00-04-056, § 388-71-0445, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Author-	
	388-71-0450	ity: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0610.	
		How do I remain eligible for services? [Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.-090. 02-21-098, § 388-71-0450, filed 10/21/02, effective 11/21/02. Statutory Authority: 42 C.F.R. 441.302, RCW 74.09.520. 00-04-056, § 388-71-0450, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0220, 388-106-0320, 388-106-0420, 388-106-0520, and 388-106-0620.	
	388-71-0455	Can my services be terminated if eligibility requirements for HCP change? [Statutory Authority: RCW 74.09.510, 74.09.520. 00-04-056, § 388-71-0455, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0220, 388-106-0320, 388-106-0420, 388-106-0520 and 388-106-0620.	
	388-71-0460	Are there limitations to HCP services I can receive? [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39.005. 03-15-010, § 388-71-0460, filed 7/3/03, effective 8/3/03. Statutory Authority: RCW 74.09.520. 00-04-056, § 388-71-0460, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0130.	
	388-71-0465	Are there waiting lists for HCP services? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0465, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.39.041 and 2003 1st sp.s. c 25 § 206(9). 04-01-090, § 388-71-0465, filed 12/16/03, effective 1/16/04. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0465, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.39.010, 74.39A.120. 00-04-056, § 388-71-0465, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0235, 388-106-0335, 388-106-0435, and 388-106-0535.	
	388-71-0470	Who pays for HCP services? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0470, filed 7/26/04, effective 8/26/04. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0470, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.09.-520, 74.09.530, 74.39A.110, [74.39A.]120, [74.39A.]130, 1998 c 346 § 205 (1)(c), and RCW 74.39A.030. 00-18-099, § 388-71-0470, filed 9/5/00, effective 10/6/00. Statutory Authority: RCW 74.39A.120, 74.39.010, 74.39.020. 00-04-056, § 388-71-0470, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0225, 388-106-0325, 388-106-0425, 388-106-0525 and 388-106-0625.	
	388-71-0475	What is the maximum amount that the department pays per month for your COPES care? [Statutory Authority: RCW 74.08.090. 00-04-056, § 388-71-0475, filed 1/28/00, effective 2/28/00.] Repealed by 03-09-092, filed 4/18/03, effective 5/19/03. Statutory Authority: Chapter 74.39 RCW.	
	388-71-0480	If I am employed, can I still receive HCP services? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0480, filed 7/26/04, effective 8/26/04. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0480, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.09.520, 74.09.530, 74.39A.110, [74.39A.]120, [74.39A.]130, 1998 c 346 § 205 (1)(c), and RCW 74.39A.030. 00-18-099, § 388-71-0480, filed 9/5/00, effective 10/6/00. Statutory Authority: RCW 74.39A.140, 74.39A.150. 00-04-056, § 388-71-0480, filed 1/28/00, effective 2/28/00.] Repealed by	

	05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0230, 388-106-0330, 388-106-0430, 388-106-0530, 388-106-0630.		
388-71-0525	Are there any exemptions from the training requirements? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0525, filed 1/13/00, effective 2/13/00.] Repealed by 02-10-117, filed 4/30/02, effective 5/31/02. Statutory Authority: Chapter 74.39A RCW and 2000 c 121.	388-71-05911	Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05665.
388-71-0530	Are there special rules about training for parents who are the individual providers of division of developmental disabilities (DDD) adult children? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0530, filed 1/13/00, effective 2/13/00.] Repealed by 02-10-117, filed 4/30/02, effective 5/31/02. Statutory Authority: Chapter 74.39A RCW and 2000 c 121.	388-71-05912	What is orientation? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05912, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05670.
388-71-0531	How many hours can my individual provider, agency provider, or personal aide work if I am receiving COPES, Medicaid Personal Care, or Chore services? [Statutory Authority: RCW 74.08.090, 74.09.520, 04-04-042, § 388-71-0531, filed 1/29/04, effective 2/29/04.] Repealed by 04-15-001, filed 7/7/04, effective 8/7/04. Statutory Authority: 2004 c 3, RCW 74.08.090, 74.09.520.	388-71-05913	What content must be included in an orientation? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05912, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05675.
388-71-0535	Are there special rules about training for parents who are the individual providers of non-DDD adult children? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0535, filed 1/13/00, effective 2/13/00.] Repealed by 02-10-117, filed 4/30/02, effective 5/31/02. Statutory Authority: Chapter 74.39A RCW and 2000 c 121.	388-71-05914	Is competency testing required for orientation? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05913, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05680.
388-71-0545	Under what conditions will the department/AAA deny payment to or terminate the contract of an individual provider, or deny payment to a home care agency provider? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0545, filed 1/13/00, effective 2/13/00.] Repealed by 01-11-019, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095.	388-71-05915	Is there a challenge test for orientation? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05914, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05685.
388-71-0550	Are there other conditions under which the department/AAA may deny payment, or deny or terminate a contract to an individual provider? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0550, filed 1/13/00, effective 2/13/00.] Repealed by 01-11-019, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095.	388-71-05916	What documentation is required for orientation? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05915, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05690.
388-71-0555	When can the department/AAA summarily suspend an individual provider's contract? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0555, filed 1/13/00, effective 2/13/00.] Repealed by 01-11-019, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095.	388-71-05917	Who is required to complete orientation, and when must it be completed? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05916, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05695.
388-71-0580	Self-directed care—Who must direct self-directed care? [Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0580, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0580, filed 1/13/00, effective 2/13/00.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05705.	388-71-05918	What is basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05917, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05700.
388-71-05910	What definitions apply to WAC 388-71-05911 through 388-71-05952? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05910, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory	388-71-05919	Is there an alternative to the basic training for some health care workers? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05918, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05705.
		388-71-05920	What core knowledge and skills must be taught in basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05919, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05710.
		388-71-05921	Is competency testing required for basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05920, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05715.
		388-71-05922	Is there a challenge test for basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05921, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05720.
			What documentation is required for successful completion of basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05922, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory

388-71-05923	Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05725. Who is required to complete basic training, and when? [Statutory Authority: RCW 74.39A.050, 03-19-076, § 388-71-05923, filed 9/12/03, effective 10/13/03. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05923, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05730.		
388-71-05924	What is modified basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05924, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05735.	388-71-05934	What kinds of training topics are required for continuing education? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05934, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05785.
388-71-05925	What knowledge and skills must be included in modified basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05925, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05740.	388-71-05935	Is competency testing required for continuing education? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05935, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05790.
388-71-05926	Is competency testing required for modified basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05926, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05745.	388-71-05936	May basic or modified basic training be completed a second time and used to meet the continuing education requirement? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05936, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05795.
388-71-05927	Is there a challenge test for modified basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05927, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05750.	388-71-05937	What are the documentation requirements for continuing education? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05937, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05799.
388-71-05928	What documentation is required for successful completion of modified basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05928, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05755.	388-71-05938	What is competency testing? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05938, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05835.
388-71-05929	Who may take modified basic training instead of the full basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05929, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05760.	388-71-05939	What components must competency testing include? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05939, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05840.
388-71-05930	What are the training requirements and exemptions for parents who are individual providers for their adult children receiving services through DDD? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05930, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05765.	388-71-05940	What experience or training must individuals have to be able to perform competency testing? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05940, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05845.
388-71-05931	What are the training requirements and exemptions for parents who are individual providers for their adult children who do not receive services through DDD? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05931, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05770.	388-71-05941	What training must include the DSHS-developed competency test? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05941, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05850.
388-71-05932	What is continuing education? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05932, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05775.	388-71-05942	How must competency test administration be standardized? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05942, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05855.
388-71-05933	How many hours of continuing education are required each year? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05933, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001,	388-71-05943	What form of identification must providers show a tester before taking a competency or challenge test? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05943, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05860.
		388-71-05944	How many times may a competency test be taken? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05944, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05865.

388-71-05945	What are an instructor's or training entity's responsibilities? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05945, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05870.		
388-71-05946	Must instructors be approved by DSHS or an AAA? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05946, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05875.	388-71-0610	Who pays for residential care? [Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0610, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.44 [74.08.044]. 00-04-056, § 388-71-0610, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0225, 388-106-0325, 388-106-0425, and 388-106-0525.
388-71-05947	Can DSHS or the AAA deny or terminate a contact with an instructor or training entity? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05947, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05880.	388-71-0613	For what days will the department pay the residential care facility? [Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, and 74.08.090. 01-14-055, § 388-71-0613, filed 6/29/01, effective 7/30/01.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0225, 388-106-0325, 388-106-0425, and 388-106-0525.
388-71-05948	What is a guest speaker, and what are the minimum qualifications to be a guest speaker for basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05948, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05885.	388-71-0615	If I leave a hospital, residential facility, or nursing facility, are there resources available to help me find a place to live? [Statutory Authority: RCW 74.42.450, 74.08.090. 00-04-056, § 388-71-0615, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0950.
388-71-05949	What are the minimum qualifications for an instructor for basic or modified basic training? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-15-064, § 388-71-05949, filed 7/11/02, effective 8/11/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05890.	388-71-0620	Am I eligible for a residential discharge allowance? [Statutory Authority: RCW 74.42.450, 74.08.090. 00-04-056, § 388-71-0620, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0955.
388-71-05950	What must be included in a class on adult education? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05950, filed 4/30/02, effective 5/31/02.] Decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05899.	388-71-0700	What are the requirements for nursing facility eligibility, assessment, and payment? [Statutory Authority: 2004 c 276 § 206 (6)(b) and <i>Townsend vs. DSHS</i> , U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0700, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.39A.040, 74.42.056. 00-22-018, § 388-71-0700, filed 10/20/00, effective 10/31/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0350, 388-106-0355, and 388-106-0360.
388-71-05951	What physical resources are required for basic or modified basic classroom training and testing? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05951, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05905.	388-71-0800	What is PACE? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520. 03-13-091, § 388-71-0800, filed 6/16/03, effective 7/17/03. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0800, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0015.
388-71-05952	What standard training practices must be maintained for basic or modified basic classroom training and testing? [Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05952, filed 4/30/02, effective 5/31/02.] Amended and decodified by 04-02-001, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. Recodified as § 388-71-05909.	388-71-0805	What services does PACE cover? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520. 03-13-091, § 388-71-0805, filed 6/16/03, effective 7/17/03. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0805, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0700.
388-71-0600	What are residential services? [Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0600, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090. 02-21-098, § 388-71-0600, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.44 [74.08.044]. 00-04-056, § 388-71-0600, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0010.	388-71-0810	Who provides these services? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520. 03-13-091, § 388-71-0810, filed 6/16/03, effective 7/17/03. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0810, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520.
388-71-0605	Am I eligible for residential services? [Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-71-0605, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, and 74.08.090. 01-14-055, § 388-71-0605, filed 6/29/01, effective 7/30/01. Statutory Authority: RCW 74.08.44 [74.08.044]. 00-04-056, § 388-71-0605, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Author-	388-71-0815	Where are these services provided? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520. 03-13-091, § 388-71-0815, filed 6/16/03, effective 7/17/03. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0815, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520.
		388-71-0820	How do I qualify for Medicaid-funded PACE services? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520. 03-13-091, § 388-71-0820, filed 6/16/03, effective 7/17/03; 02-15-138, § 388-71-0820, filed

- 7/22/02, effective 8/22/02. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0820, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0705.
- 388-71-0825 What are my appeal rights? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520. 03-13-091, § 388-71-0825, filed 6/16/03, effective 7/17/03. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0825, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1305.
- 388-71-0830 Who pays the PACE provider? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0830, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0710.
- 388-71-0835 How do I enroll into the PACE program? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520. 03-13-091, § 388-71-0835, filed 6/16/03, effective 7/17/03. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0835, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0705.
- 388-71-0840 How do I disenroll from the PACE program? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520. 03-13-091, § 388-71-0840, filed 6/16/03, effective 7/17/03. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0840, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0715.
- 388-71-0845 What are my rights as a PACE client? [Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520. 03-13-091, § 388-71-0845, filed 6/16/03, effective 7/17/03. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.520 and 74.39A.030. 99-19-048, § 388-71-0845, filed 9/13/99, effective 10/14/99.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1300.
- 388-71-0900 What is the intent of WAC 388-71-0900 through 388-71-0960? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0900, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0905 What is private duty nursing (PDN) for adults? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0905, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0910 Am I financially eligible for Medicaid-funded private duty nursing services? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0910, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0915 Am I medically eligible to receive private duty nursing services? [Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0915, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0915, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0920 How is my eligibility determined? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0920, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0925 Am I required to pay participation toward PDN services? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0925, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0930 Are PDN costs subject to estate recovery? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0930, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0935 Who can provide my PDN services? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0935, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0940 Are there limitations or other requirements for PDN? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0940, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0945 What requirements must a home health agency meet in order to provide and get paid for my PDN? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0945, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0950 What requirements must a private RN or LPN meet in order to provide and get paid for my PDN services? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0950, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0955 Can I receive PDN in a licensed adult family home (AFH)? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0955, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0960 Can I receive services in addition to PDN? [Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0960, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0960, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-0965 Can I choose to self-direct my care if I receive PDN? [Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 440.80. 01-11-018, § 388-71-0965, filed 5/4/01, effective 6/4/01.] Repealed by 05-24-091, filed 12/6/05, effective 1/6/06. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. Later promulgation, see chapter 388-106 WAC.
- 388-71-1000 What is the Senior Citizens Services Act? [Statutory Authority: RCW 74.38.030. 00-04-056, § 388-71-1000, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0015.
- 388-71-1005 Who administers the Senior Citizens Services Act funds? [Statutory Authority: RCW 74.38.030. 00-04-056, § 388-71-1005, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520.

- 388-71-1010 What services does the SCSA fund? [Statutory Authority: RCW 74.38.030. 00-04-056, § 388-71-1010, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1100.
- 388-71-1015 How do I apply for SCSA-funded services? [Statutory Authority: RCW 74.38.030. 00-04-056, § 388-71-1015, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1105.
- 388-71-1020 Am I eligible for SCSA-funded services at no cost? [Statutory Authority: RCW 74.38.030. 00-04-056, § 388-71-1020, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1110.
- 388-71-1025 What income and resources are exempt when determining eligibility? [Statutory Authority: RCW 74.38.030. 00-04-056, § 388-71-1025, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1115.
- 388-71-1030 What if I am not eligible to receive SCSA-funded services at no cost? [Statutory Authority: RCW 74.38.030. 00-04-056, § 388-71-1030, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1120.
- 388-71-1035 What are my rights under SCSA? [Statutory Authority: RCW 74.38.030. 00-04-056, § 388-71-1035, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1300.
- 388-71-1065 What is the purpose of the respite care program? [Statutory Authority: RCW 74.41.040. 00-04-056, § 388-71-1065, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0015, 388-106-1205.
- 388-71-1070 What definitions apply to respite care services? [Statutory Authority: RCW 74.41.040. 00-04-056, § 388-71-1070, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1200.
- 388-71-1075 Who is eligible to receive respite care services? [Statutory Authority: RCW 74.41.040. 00-04-056, § 388-71-1075, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1210.
- 388-71-1080 Who may provide respite care services? [Statutory Authority: RCW 74.41.040. 00-04-056, § 388-71-1080, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1215.
- 388-71-1085 How are respite care providers reimbursed for their services? [Statutory Authority: RCW 74.41.040. 00-04-056, § 388-71-1085, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1220.
- 388-71-1090 Are participants required to pay for the cost of their services? [Statutory Authority: RCW 74.41.040. 00-04-056, § 388-71-1090, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1225.
- 388-71-1095 Are respite care services always available? [Statutory Authority: RCW 74.41.040. 00-04-056, § 388-71-1095, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-1230.
- 388-71-1100 What is volunteer chore services (VCS)? [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, 74.39A.100. 00-04-056, § 388-71-1100, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed

- 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0015, 388-106-0650.
- 388-71-1105 Am I eligible to receive volunteer chore services? [Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-1105, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, 74.39A.100. 00-04-056, § 388-71-1105, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520. Later promulgation, see WAC 388-106-0655.
- 388-71-1110 How do I receive information on applying for volunteer chore services? [Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, 74.39A.100. 00-04-056, § 388-71-1110, filed 1/28/00, effective 2/28/00.] Repealed by 05-11-082, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520.

ADULT PROTECTIVE SERVICES

WAC 388-71-0100 What are the statutory references for WAC 388-71-0100 through 388-71-01280? The statutory references for WAC 388-71-0100 through WAC 388-71-01280 are:

- (1) Chapter 74.34 RCW;
- (2) Chapter 74.39A RCW; and
- (3) Chapter 74.39 RCW.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-0100, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.34.165, and 74.39A.050(9). 00-03-029, § 388-71-0100, filed 1/11/00, effective 2/11/00.]

WAC 388-71-0105 What definitions apply to adult protective services? In addition to the definitions found in chapter 74.34 RCW, the following definitions apply:

"**ADSA**" means DSHS aging and disability services administration.

"**ALJ**" means an administrative law judge, an impartial decision-maker who is an attorney and presides at an administrative hearing. The office of administrative hearings (OAH), which is a state agency, employs the ALJs. ALJs are not DSHS employees or DSHS representatives.

"**APS**" means adult protective services.

"**Basic necessities of life**" means food, water, shelter, clothing, and medically necessary health care, including but not limited to health-related treatment or activities, hygiene, oxygen, and medication.

"**BOA**" means the DSHS board of appeals. The board of appeals consists of lawyers who are members of the Washington State Bar Association. An ALJ's decision can be appealed to the board of appeals, allowing a level of review before an appeal to the court system may be considered.

"**DSHS**" means the department of social and health services.

"**Entity**" means any agency, corporation, partnership, association, limited liability company, sole proprietorship, for-profit or not-for-profit business that provides care and/or services to vulnerable adults under a license, certification or contract issued by DSHS or DSHS' contractor. An entity does not include a boarding home licensed under chapter 18.20 RCW, an adult family home licensed under chapter 70.128 RCW, or a nursing home licensed under chapter 18.51 RCW, but does include such facilities if they are required to be licensed but are not currently licensed.

"Facility" means a residence licensed as a boarding home under chapter 18.20 RCW, an adult family home under chapter 70.128 RCW, a nursing home under chapter 18.51 RCW, a soldier's home under chapter 72.36 RCW, a residential habilitation center under chapter 71A.20 RCW, or any other facility licensed by DSHS.

"Final finding" means the department's substantiated finding of abandonment, abuse, financial exploitation or neglect is upheld through the administrative appeal process specified in WAC 388-71-01205 through 388-71-01280, or is not timely appealed to the office of administrative hearings. The alleged perpetrator can appeal a final finding to Superior Court and the Court of Appeals under the Administrative Procedure Act, chapter 34.05 RCW.

"Initial finding" means a determination made by the department upon investigation of an allegation of abandonment, abuse, financial exploitation, neglect or self-neglect.

(1) If the department determines it is more likely than not the incident occurred, the department shall document the finding as "substantiated."

(2) If the department determines it is more likely than not the incident did not occur, the department shall document the finding as "unsubstantiated."

(3) If the department cannot make a determination about whether the incident occurred or did not occur on a more probable than not basis, the department shall document the finding as "inconclusive."

"Legal representative" means a guardian appointed under chapter 11.88 RCW.

"Person or entity with a duty of care" includes, but is not limited to, the following:

(1) A guardian appointed under chapter 11.88 RCW; or

(2) A person named in a durable power of attorney as the attorney-in-fact as defined under chapter 11.94 RCW.

(3) A person or entity providing the basic necessities of life to a vulnerable adult [adults] where:

(a) The person or entity is employed by or on behalf of the vulnerable adult; or

(b) The person or entity voluntarily agrees to provide, or has been providing, the basic necessities of life to the vulnerable adult on a continuing basis.

"Personal aide" as found in RCW 74.39.007.

"Self-directed care" as found in RCW 74.39.007.

"Willful" means the nonaccidental action or inaction by an alleged perpetrator that he/she knew or reasonably should have known could cause harm, injury or a negative outcome.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-0105, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.34.165, and 74.39A.050(9). 00-03-029, § 388-71-0105, filed 1/11/00, effective 2/11/00.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

PART A—PROGRAM DESCRIPTION

WAC 388-71-0110 What is the purpose of an adult protective services investigation? The purpose of an adult protective services investigation is to:

(1) Investigate allegations of abandonment, abuse, financial exploitation, neglect, or self-neglect.

(2007 Ed.)

(2) Provide protective services with the consent of the vulnerable adult or his or her legal representative when the allegation is substantiated, or prior to substantiation when it appears abandonment, abuse, financial exploitation, neglect or self-neglect may be occurring and protective services could assist in ending or preventing harm to the vulnerable adult.

(3) When an allegation is substantiated, APS may investigate whether other vulnerable adults may be at current risk of abuse, neglect, abandonment or financial exploitation by the person or entity.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-0110, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.34.165, and 74.39A.050(9). 00-03-029, § 388-71-0110, filed 1/11/00, effective 2/11/00.]

WAC 388-71-0115 When is an investigation conducted? The department determines when an investigation is conducted [required]. The following criteria must be met:

(1) The reported circumstances fit the definition of abandonment, abuse, financial exploitation, neglect, or self-neglect as defined in chapter 74.34 RCW; and

(2) The alleged victim is a vulnerable adult as defined in chapter 74.34 RCW.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-0115, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.34.165, and 74.39A.050(9). 00-03-029, § 388-71-0115, filed 1/11/00, effective 2/11/00.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-71-01201 What state-only funded services may be offered to a vulnerable adult victim of abandonment, abuse, financial exploitation, neglect or self-neglect? (1) Subject to available funding, state-only funded in-home personal care/household services and state-only funded placement in a department licensed and contracted adult family home, boarding home or nursing facility may be offered without regard to the vulnerable adult's functional status or income/resources, if:

(a) The vulnerable adult is the subject of an open APS case involving an allegation of abandonment, abuse, financial exploitation, neglect, and/or self-neglect;

(b) The services would help protect the vulnerable adult from harm;

(c) APS cannot verify alternative resources or options for payment for services available to the vulnerable adult at the time;

(d) Services are provided in the least restrictive and most cost effective setting available to appropriately meet the needs of the vulnerable adult;

(e) APS is actively pursuing other service alternatives and/or resolution of the issues that resulted in the need for protective services; and

(f) The state-only funded services are temporary and provided with the consent of the vulnerable adult or legal representative only until the situation has stabilized. State-only funded protective services are provided by DSHS on a discretionary basis and are not a benefit and not an entitlement. Ter-

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mination of state-only funded temporary protective services is exempt from notification and appeal requirements.

(2) State-only funded services to an individual vulnerable adult shall be based on assessed need and limited to:

(a) Up to one hundred forty-three hours of in-home personal care/household services per month; and

(b) A cumulative maximum total of ninety days service in any twelve-month period of time, with nursing facility services not exceeding thirty days of the ninety-day total. An exception to rule cannot be used to grant an extension.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-0121 (codified as WAC 388-71-01201), filed 9/21/04, effective 10/22/04.]

PART B—NOTIFICATION AND ADMINISTRATIVE APPEAL OF A SUBSTANTIATED FINDING

WAC 388-71-01205 When does APS notify the alleged perpetrator of the results of an APS investigation?

(1) APS will notify the alleged perpetrator in writing within ten working days of making a substantiated initial finding of abandonment, abuse, financial exploitation or neglect of a vulnerable adult.

(2) The time frame for notification can be extended beyond ten working days to include the time needed to translate the notification letter or make provisions for the safety of the alleged victim.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01205, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01210 How may APS give the alleged perpetrator notice of the substantiated initial finding?

(1) APS shall notify the alleged perpetrator of a substantiated initial finding by sending a letter certified mail/return receipt requested and regular mail to the alleged perpetrator's last known place of residence. The duty of notification created by this section is subject to the ability of the department to ascertain the location of the alleged perpetrator. APS shall make a reasonable, good faith effort to determine the address of the last known place of residence of the alleged perpetrator; or

(2) APS shall have the written notice delivered or personally served upon the alleged perpetrator.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01210, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01215 When is notice to the alleged perpetrator complete? Notice is complete when:

(1) Personal service is made;

(2) Mail is properly stamped, addressed and deposited in the United States mail;

(3) A parcel is delivered to a commercial delivery service with charges prepaid; or

(4) A parcel is delivered to a legal messenger service with charges prepaid.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01215, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01220 What proves that APS provided notice of the substantiated initial finding to the alleged perpetrator? APS may prove notice was provided to the alleged perpetrator by any of the following:

- (1) A sworn statement or declaration of personal service;
- (2) The certified mail receipt signed by the recipient;
- (3) An affidavit or certificate of mailing; or
- (4) A signed receipt from the person who accepted the commercial delivery service or legal messenger service package.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01220, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01225 What information must not be in the APS finding notice to the alleged perpetrator? The identities of the alleged victim, reporter, and witnesses must not be included in the APS finding notice to the alleged perpetrator.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01225, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01230 Will APS notify anyone other than the alleged perpetrator of the finding of abandonment, abuse, financial exploitation or neglect?

(1) In a manner consistent with confidentiality requirements concerning the vulnerable adult, witnesses, and reporter, APS may provide notification of a substantiated initial finding to:

(a) Other divisions within the department;

(b) The agency or program identified under RCW 74.34.068 with which the alleged perpetrator is associated as an employee, volunteer or contractor;

(c) Law enforcement;

(d) Other investigative authority consistent with chapter 74.34 RCW; and

(e) The facility in which the incident occurred.

(2) In the notification APS will identify the finding as an initial finding.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01230, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01235 Can an alleged perpetrator challenge an APS finding of abandonment, abuse, financial exploitation or neglect?

An alleged perpetrator of abandonment, abuse, financial exploitation or neglect may request an administrative hearing to challenge a substantiated initial finding made by APS on or after the effective date of this rule.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01235, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01240 How does an alleged perpetrator request an administrative hearing to challenge an APS finding of abandonment, abuse, financial exploitation or neglect?

(1) To request an administrative hearing the alleged perpetrator must send, deliver, or fax a written request to the office of administrative hearings. OAH must receive the written request within thirty calendar days of the date the department's letter of notice is mailed or personally served upon the alleged perpetrator, whichever occurs first. If the alleged perpetrator requests a hearing by fax, the alleged perpetrator must also mail a copy of the request to OAH on the same day.

(2) The alleged perpetrator must complete and submit the form to request an administrative hearing provided by APS or submit a written request for a hearing that includes:

(a) The full legal name, current address and phone number of the alleged perpetrator;

(b) A brief explanation of why the alleged perpetrator disagrees with the substantiated initial finding;

(c) A description of any assistance needed in the administrative appeal process by the alleged perpetrator, including a foreign or sign language interpreter or any accommodation for a disability;

(d) The alleged perpetrator should keep a copy of the request.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01240, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01245 What laws and rules will control the administrative hearings held regarding substantiated APS findings? Chapters 34.05 and 74.34 RCW, chapter 388-02 WAC, and the provisions of this chapter govern any administrative hearing regarding a substantiated APS finding. In the event of a conflict between the provisions of this chapter and chapter 388-02 WAC, the provisions of this chapter shall prevail.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01245, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01250 How is confidential information protected in the appeal process? (1) All information and documents provided by the department to the alleged perpetrator shall be used by the alleged perpetrator only to challenge the findings in the administrative hearing.

(2) Confidential information such as the name and other personal identifying information of the reporter and the vulnerable adult shall be redacted from documents and the parties shall use means in testimony to protect the identity of such persons, unless otherwise ordered by the ALJ consistent with chapter 74.34 RCW and other applicable state and federal laws.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01250, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01255 How does the administrative law judge make a decision regarding the substantiated APS finding? (1) The ALJ shall decide if a preponderance of the evidence in the hearing record supports a determination that the alleged perpetrator committed an act of abandonment, abuse, financial exploitation or neglect of a vulnerable adult.

(2) If the ALJ determines that a preponderance of the evidence in the hearing record supports the substantiated APS finding, the ALJ shall uphold the finding.

(3) If the ALJ determines that the substantiated APS finding is not supported by a preponderance of the evidence in the hearing record, the ALJ shall remand the matter to the department to modify the finding consistent with the initial decision of the ALJ.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01255, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01260 How is the alleged perpetrator notified of the administrative law judge's decision? After the administrative hearing, the ALJ will send a written deci-

sion to the alleged perpetrator and the department within ninety calendar days after the record is closed.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01260, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01265 What if the alleged perpetrator or the department disagrees with the decision? If the alleged perpetrator or the department disagrees with the ALJ's decision, either party may challenge this decision by filing a petition for review with the department's board of appeals consistent with the procedures contained in chapter 34.05 RCW and chapter 388-02 WAC.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01265, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01270 What happens if the administrative law judge rules against the department? If the department appeals the ALJ's decision, the department will not modify the finding in the department's records until a final hearing decision is issued. If the department does not appeal the ALJ's initial decision, the department will modify the finding in the department's records consistent with the ALJ's initial decision and document the ALJ's decision in the record.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01270, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01275 When does the APS substantiated initial finding become a final finding? A substantiated initial finding becomes a final finding when:

(1) The department gives the alleged perpetrator notice of the substantiated initial finding pursuant to WAC 388-71-01210 and the alleged perpetrator does not request an administrative hearing as set forth in WAC 388-71-01240; or

(2) The ALJ dismisses the hearing following default or withdrawal by the alleged perpetrator, or issues an initial order upholding the substantiated finding and the alleged perpetrator fails to file a request for review of the ALJ's initial decision with the department's board of appeals consistent with the procedures contained in chapter 34.05 RCW and chapter 388-02 WAC; or

(3) The board of appeals issues a final order upholding the substantiated finding when a request for review to the department's board of appeals is made consistent with the procedures contained in chapter 34.05 RCW and chapter 388-02 WAC.

(4) The final finding will remain as substantiated in the department's records unless the final finding is reversed after judicial review.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW. 04-19-136, § 388-71-01275, filed 9/21/04, effective 10/22/04.]

WAC 388-71-01280 Does the department disclose information about final findings of abuse, abandonment, neglect and financial exploitation? The department will maintain a registry of final findings and, upon request of any person, the department may disclose the identity of a person or entity with a final finding of abandonment, abuse, financial exploitation or neglect.

[Statutory Authority: RCW 34.05.020, 74.08.090, 74.39A.050, chapter 74.34 RCW, 04-19-136, § 388-71-01280, filed 9/21/04, effective 10/22/04.]

INDIVIDUAL PROVIDER AND HOME CARE AGENCY PROVIDER QUALIFICATIONS

WAC 388-71-0500 What is the purpose of WAC 388-71-0500 through [388-71-05952] [388-71-05909]? A client/legal representative may choose an individual provider or a home care agency provider. The intent of WAC 388-71-0500 through [388-71-05952] [388-71-05909] is to describe the:

- (1) Qualifications of an individual provider, as defined in WAC 388-106-0010;
- (2) Qualifications of a home care agency provider, as defined in WAC 388-106-0010 and chapter 246-336 WAC;
- (3) Conditions under which the department or the area agency on aging (AAA) will pay for the services of an individual provider or a home care agency provider;
- (4) Training requirements for an individual provider and home care agency provider.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0500, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090, 02-21-098, § 388-71-0500, filed 10/21/02, effective 11/21/02. Statutory Authority: Chapter 74.39A RCW and 2000 c 121, 02-10-117, § 388-71-0500, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0500, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0500, filed 1/13/00, effective 2/13/00.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-71-0505 How does a client hire an individual provider? The client, or legal representative:

- (1) Has the primary responsibility for locating, screening, hiring, supervising, and terminating an individual provider;
- (2) Establishes an employer/employee relationship with the provider; and
- (3) May receive assistance from the social worker/case manager or other resources in this process.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0505, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0505, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0510 How does a person become an individual provider? In order to become an individual provider, a person must:

- (1) Be eighteen years of age or older;
- (2) Provide the social worker/case manager/designee with:
 - (a) Picture identification; and
 - (b) A Social Security card; or
 - (c) Authorization to work in the United States.
- (3) Complete and submit to the social worker/case manager/designee the department's criminal conviction background inquiry application, unless the provider is also the

parent of the adult DDD client and exempted, per chapter 74.15 RCW;

(a) Preliminary results may require a thumb print for identification purposes;

(b) An FBI fingerprint-based background check is required if the person has lived in the state of Washington less than three years.

(4) Sign a home and community-based service provider contract/agreement to provide services to a COPES, MNIW, or Medicaid personal care client.

[Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z, 04-16-029, § 388-71-0510, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0510, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0510, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0513 Is a background check required of a home care agency provider? In order to be a home care agency provider, a person must complete the department's criminal conviction background inquiry application, which is submitted by the agency to the department. This includes an FBI fingerprint-based background check if the home care agency provider has lived in the state of Washington less than three years.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0513, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0515 What are the responsibilities of an individual provider or home care agency provider when employed to provide care to a client? An individual provider or home care agency provider must:

- (1) Understand the client's plan of care that is signed by the client or legal representative and social worker/case manager, and translated or interpreted, as necessary, for the client and the provider;
- (2) Provide the services as outlined on the client's plan of care, as defined in WAC 388-106-0010;
- (3) Accommodate client's individual preferences and differences in providing care;
- (4) Contact the client's representative and case manager when there are changes which affect the personal care and other tasks listed on the plan of care;
- (5) Observe the client for change(s) in health, take appropriate action, and respond to emergencies;
- (6) Notify the case manager immediately when the client enters a hospital, or moves to another setting;
- (7) Notify the case manager immediately if the client dies;
- (8) Notify the department or AAA immediately when unable to staff/serve the client; and
- (9) Notify the department/AAA when the individual provider or home care agency will no longer provide services. Notification to the client/legal guardian must:
 - (a) Give at least two weeks' notice, and
 - (b) Be in writing.
- (10) Complete and keep accurate time sheets that are accessible to the social worker/case manager; and
- (11) Comply with all applicable laws and regulations.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0515, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090, 02-21-098, § 388-71-0515, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0515, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0515, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0520 Are there training requirements for an individual provider or a home care agency provider of an adult client? An individual provider or a home care agency provider for an adult client must meet the training requirements in WAC 388-71-05665 through 388-71-05865.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0520, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW, 04-02-001, § 388-71-0520, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121, 02-10-117, § 388-71-0520, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0520, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0540 When will the department, AAA, or managed care entity deny payment for services of an individual provider or home care agency provider? The department, AAA, or managed care entity will deny payment for the services of an individual provider or home care agency provider who:

(1) Is the client's spouse, per 42 C.F.R. 441.360(g), except in the case of an individual provider for a chore services client. Note: For chore spousal providers, the department pays a rate not to exceed the amount of a one-person standard for a continuing general assistance grant, per WAC 388-478-0030;

(2) Is the natural/step/adoptive parent of a minor client aged seventeen or younger receiving services under Medicaid personal care;

(3) Has been convicted of a disqualifying crime, under RCW 43.43.830 and 43.43.842 or of a crime relating to drugs as defined in RCW 43.43.830;

(4) Has abused, neglected, abandoned, or exploited a minor or vulnerable adult, as defined in chapter 74.34 RCW;

(5) Has had a license, certification, or a contract for the care of children or vulnerable adults denied, suspended, revoked, or terminated for noncompliance with state and/or federal regulations;

(6) Does not successfully complete the training requirements within the time limits required in WAC 388-71-05665 through 388-71-05865;

(7) Is already meeting the client's needs on an informal basis, and the client's assessment or reassessment does not identify any unmet need; and/or

(8) Is terminated by the client (in the case of an individual provider) or by the home care agency (in the case of an agency provider).

(9) In addition, the department, AAA, or managed care entity may deny payment to or terminate the contract of an individual provider as provided under WAC 388-71-0546, 388-71-0551, and 388-71-0556.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-71-0540, filed 2/6/06, effective 3/9/06. Statu-

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tory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0540, filed 5/17/05, effective 6/17/05. Statutory Authority: Chapter 74.39A RCW and 2000 c 121, 02-10-117, § 388-71-0540, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0540, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0540, filed 1/13/00, effective 2/13/00.]

WAC 388-71-0546 When can the department, AAA, or managed care entity reject the client's choice of an individual provider? The department, AAA, or managed care entity may reject a client's request to have a family member or other person serve as his or her individual provider if the case manager has a reasonable, good faith belief that the person will be unable to appropriately meet the client's needs. Examples of circumstances indicating an inability to meet the client's needs could include, without limitation:

(1) Evidence of alcohol or drug abuse;

(2) A reported history of domestic violence, no-contact orders, or criminal conduct (whether or not the conduct is disqualifying under RCW 43.43.830 and 43.43.842;

(3) A report from the client's health care provider or other knowledgeable person that the requested provider lacks the ability or willingness to provide adequate care;

(4) Other employment or responsibilities that prevent or interfere with the provision of required services;

(5) Excessive commuting distance that would make it impractical to provide services as they are needed and outlined in the client's service plan.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-71-0546, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0546, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0551 When can the department, AAA, or managed care entity terminate or summarily suspend an individual provider's contract? The department, AAA, or managed care entity may take action to terminate an individual provider's contract if the provider's inadequate performance or inability to deliver quality care is jeopardizing the client's health, safety, or well-being. The department, AAA, or managed care entity may summarily suspend the contract pending a hearing based on a reasonable, good faith belief that the client's health, safety, or well-being is in imminent jeopardy. Examples of circumstances indicating jeopardy to the client could include, without limitation:

(1) Domestic violence or abuse, neglect, abandonment, or exploitation of a minor or vulnerable adult;

(2) Using or being under the influence of alcohol or illegal drugs during working hours;

(3) Other behavior directed toward the client or other persons involved in the client's life that places the client at risk of harm;

(4) A report from the client's health care provider that the client's health is negatively affected by inadequate care;

(5) A complaint from the client or client's representative that the client is not receiving adequate care;

(6) The absence of essential interventions identified in the service plan, such as medications or medical supplies; and/or

(7) Failure to respond appropriately to emergencies.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-71-0551, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0551, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0556 When can the department, AAA, or managed care entity otherwise terminate an individual provider's contract? The department, AAA, or managed care entity may otherwise terminate the individual provider's contract for default or convenience in accordance with the terms of the contract and to the extent that those terms are not inconsistent with these rules.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-71-0556, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0556, filed 5/4/01, effective 6/4/01.]

WAC 388-71-0560 What are the client's rights if the department denies, terminates, or summarily suspends an individual provider's contract? If the department denies, terminates, or summarily suspends the individual provider's contract, the client has the right to:

(1) A fair hearing to appeal the decision, per chapter 388-02 WAC, and

(2) Receive services from another currently contracted individual provider or home care agency provider, or other options the client is eligible for, if a contract is summarily suspended.

(3) The hearing rights afforded under this section are those of the client, not the individual provider.

[Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0560, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0560, filed 1/13/00, effective 2/13/00.]

WAC 388-71-05640 Self-directed care—Who must direct self-directed care? Self-directed care under chapter 74.39 RCW must be directed by an adult client for whom the health-related tasks are provided. The adult client is responsible to train the individual provider in the health-related tasks which the client self-directs.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW, 04-02-001, recodified as § 388-71-05640, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 74.39.095, 01-11-019, § 388-71-0580, filed 5/4/01, effective 6/4/01. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0580, filed 1/13/00, effective 2/13/00.]

WAC 388-71-05665 What definitions apply to WAC 388-71-05670 through 388-71-05909? "Client" means an individual age eighteen or older, receiving in-home services through Medicaid personal care, COPES, MNIW, or Chore programs.

"Competency" means the minimum level of information and skill trainees are required to know and be able to demonstrate.

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"DSHS" refers to the department of social and health services.

"Learning outcomes" means the specific information, skills and behaviors desired of the learner as a result of a specific unit of instruction, such as what they would learn by the end of a single class or an entire course. Learning outcomes are generally identified with a specific lesson plan or curriculum.

"Routine interaction" means contact with clients that happens regularly.

[Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z, 04-16-029, § 388-71-05665, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW, 04-02-001, amended and recodified as § 388-71-05665, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121, 02-10-117, § 388-71-05910, filed 4/30/02, effective 5/31/02.]

ORIENTATION

WAC 388-71-05670 What is orientation? Orientation provides basic introductory information appropriate to the in-home setting and population served. The department does not approve specific orientation programs, materials, or trainers for home care agencies. Department-developed orientation materials must be used for orientation of individual providers. No test is required for orientation.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW, 04-02-001, recodified as § 388-71-05670, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121, 02-10-117, § 388-71-05911, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05675 What content must be included in an orientation? Orientation may include the use of videotapes, audiotapes, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Orientation must include introductory information in the following areas:

- (1) The care setting;
- (2) The characteristics and special needs of the population served;
- (3) Fire and life safety, including:
 - (a) Emergency communication (including phone system if one exists);
 - (b) Evacuation planning (including fire alarms and fire extinguishers where they exist);
 - (c) Ways to handle client injuries and falls or other accidents;
 - (d) Potential risks to clients or providers (for instance, aggressive client behaviors and how to handle them); and
 - (e) The location of agency policies and procedures, when orientation takes place in a home care agency.
- (4) Communication skills and information, including:
 - (a) Methods for supporting effective communication among the client/guardian, the provider, and family members;
 - (b) Use of verbal and nonverbal communication;
 - (c) Review of written communications and/or documentation required for the job, including the client's service plan; and
 - (d) Whom to contact about problems and concerns.

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(5) Universal precautions and infection control, including:

- (a) Proper hand washing techniques;
 - (b) Protection from exposure to blood and other body fluids;
 - (c) Appropriate disposal of contaminated/hazardous articles;
 - (d) Reporting exposure to contaminated articles, blood, or other body fluids; and
 - (e) What a provider should do if they are ill.
- (6) Client rights, including:
- (a) The client's right to confidentiality of information about the client;
 - (b) The client's right to participate in decisions about the client's care, and to refuse care;
 - (c) The provider's duty to protect and promote the rights of each client, and assist the client to exercise his or her rights;
 - (d) How and to whom providers should report any concerns they may have about a client's decision concerning the client's care, including the client's case manager;
 - (e) Providers' duty to report any suspected abuse, abandonment, neglect, or exploitation of a client;
 - (f) Advocates that are available to help clients (LTC ombudsmen, organizations); and
 - (g) Complaint lines, hot lines, and client grievance procedures.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05675, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05912, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05680 Is competency testing required for orientation? There is no competency testing required for orientation.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05680, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05913, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05685 Is there a challenge test for orientation? There is no challenge test for orientation.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05685, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05914, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05690 What documentation is required for orientation? The home care agency or individual provider must maintain documentation of completion of orientation, issued by the home care agency, area agency on aging, or DSHS office that provides the orientation, that includes:

- (1) The trainee's name;
- (2) A list of the specific information taught;
- (3) Signature of the person overseeing the orientation indicating completion of the required information;
- (4) The trainee's date of employment;
- (5) The location of the orientation; and
- (6) The date(s) of orientation.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05690, filed 12/24/03, effective (2007 Ed.)

1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05915, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05695 Who is required to complete orientation, and when must it be completed? (1) Home care agency providers must complete orientation before working with the agency's clients. Orientation must be provided by appropriate agency staff.

(2) Individual providers must complete orientation provided by DSHS, the area agency on aging (AAA), or managed care entity no later than fourteen calendar days after beginning to work with their first DSHS client. Individual providers who live and are providing care at a great distance from the DSHS or AAA office may be oriented by distance learning, with phone contact by the person overseeing the orientation to answer questions.

(3) Parents who are individual providers for their adult children are exempt from the orientation requirement.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-71-05695, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05695, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05916, filed 4/30/02, effective 5/31/02.]

BASIC TRAINING

WAC 388-71-05700 What is basic training? Basic training includes the core knowledge and skills that providers need to provide personal care services effectively and safely. Only the training curriculum developed by DSHS may be used for basic training.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05700, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05917, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05705 Is there an alternative to the basic training for some health care workers? Certain health care workers may complete the modified basic training instead of basic training if they meet the requirements in WAC 388-71-05760.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05705, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05918, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05710 What core knowledge and skills must be taught in basic training? The basic training knowledge and skills must include all of the learning outcomes and competencies published by the department for the following core knowledge and skills:

- (1) Understanding and using effective interpersonal and problem solving skills with clients, family members, and other care team members;
- (2) Taking appropriate action to promote and protect client rights, dignity, and independence;
- (3) Taking appropriate action to promote and protect the health and safety of the client and the caregiver;
- (4) Correctly performing required personal care tasks while incorporating client preferences, maintaining the cli-

ent's privacy and dignity, and creating opportunities that encourage client independence;

(5) Adhering to basic job standards and expectations. The basic training learning outcomes and competencies may be obtained from the DSHS aging and disability services administration.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05710, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05919, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05715 Is competency testing required for basic training? Competency testing is required for basic training as provided under WAC 388-71-05835 through 388-71-05865.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05715, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05920, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05720 Is there a challenge test for basic training? Individuals may take the DSHS challenge test instead of the required training. If a person does not pass a challenge test on the first attempt, they may not retake the challenge test and must attend a class.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05720, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05921, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05725 What documentation is required for successful completion of basic training? Basic training must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (1) The name of the trainee;
- (2) The name of the training;
- (3) The location of the training;
- (4) The instructor's name and signature; and
- (5) The date(s) of training.

The trainee must retain the original certificate. A home care agency must keep a copy of the certificate on file. An individual provider must give a copy of the certificate to DSHS or area agency on aging.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05725, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05922, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05730 Who is required to complete basic training, and when? Individual providers and home care agency providers must complete basic training developed by the department and demonstrate competency within one hundred twenty days after being authorized to provide department-paid in-home services for a client. A certificate of successful completion of basic training, using a curriculum developed or approved by the department, meets this requirement.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05730, filed 12/24/03, effective 1/24/04. Statutory Authority: RCW 74.39A.050. 03-19-076, § 388-71-05923, filed 9/12/03, effective 10/13/03. Statutory Authority: Chapter

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74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05923, filed 4/30/02, effective 5/31/02.]

MODIFIED BASIC TRAINING

WAC 388-71-05735 What is modified basic training?

Modified basic training is a subset of the basic training curriculum designed for certain health care workers defined in WAC 388-71-05760, whose previous training includes many of the competencies taught in the full basic training. Only the training curriculum developed by DSHS may be used for modified basic training.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05735, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05924, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05740 What knowledge and skills must be included in modified basic training? Modified basic training must include all of the learning outcomes and competencies published by DSHS for the following core knowledge and skills:

- (1) Client rights, including mandatory reporting requirements;
- (2) Medication assistance regulations;
- (3) Nurse delegation regulations;
- (4) Assessment and observations in home and community settings;
- (5) Documentation in home and community settings;
- (6) Service planning in home and community care settings;
- (7) Resource information, including information on continuing education; and
- (8) Self-directed care regulations.

The modified basic learning outcomes and competencies may be obtained from the DSHS aging and disability services administration.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05740, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05925, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05745 Is competency testing required for modified basic training? Competency testing is required for modified basic training as provided under WAC 388-71-05835 through 388-71-05865.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05745, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05926, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05750 Is there a challenge test for modified basic training? Individuals may take the department's challenge test instead of the required training. If a person does not pass a challenge test on the first attempt, they may not retake the challenge test and must attend the class.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05750, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05927, filed 4/30/02, effective 5/31/02.]

(2007 Ed.)

WAC 388-71-05755 What documentation is required for successful completion of modified basic training? Modified basic training must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (1) The name of the trainee;
- (2) The name of the training;
- (3) The location of the training;
- (4) The instructor's name and signature; and
- (5) The date(s) of training.

The trainee must retain the original certificate. A home care agency must keep a copy of their employees' certificates on file. An individual provider must give a copy to DSHS or area agency on aging.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05755, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05928, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05760 Who may take modified basic training instead of the full basic training? Modified basic training may be taken, instead of the full basic training, by a person who can document they have successfully completed training as a registered or licensed practical nurse, certified nursing assistant, physical therapist, occupational therapist, or Medicare-certified home health aide. In addition, modified basic training may be taken by a natural, step, or adoptive parent who is the individual provider for his or her adult child who is not receiving services through DSHS' division of developmental disabilities.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05760, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05929, filed 4/30/02, effective 5/31/02.]

EXEMPTION FOR IP PARENTS FOR ADULT CHILDREN

WAC 388-71-05765 What are the training requirements and exemptions for parents who are individual providers for their adult children receiving services through DDD? A natural, step, or adoptive parent who is the individual provider for his or her adult child who is receiving services through DSHS' division of developmental disabilities (DDD):

- (1) Must possess a certificate of successfully completing a six-hour DDD-approved training or a specially designed DSHS-approved training within one hundred eighty days of beginning employment; and
- (2) Is exempt from the orientation, basic training, and continuing education requirements if the parent provides care only for his or her own adult child.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05765, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05930, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05770 What are the training requirements and exemptions for parents who are individual providers for their adult children who do not receive services through DDD? A natural, step, or adoptive parent who is the individual provider for his or her adult child who is not

receiving services through DSHS' division of developmental disabilities:

(1) Must:

(a) Possess a certificate of successfully completing modified basic training or the modified basic challenge test within one hundred eighty days of beginning employment, and have documentation that the parent has received individualized or other specific instruction on the care of the adult child; or

(b) Possess a certificate of successfully completing basic training or the basic training challenge test.

(2) Is exempt from the orientation and continuing education requirements if the parent provides care only for his or her own adult child.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05770, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05931, filed 4/30/02, effective 5/31/02.]

CONTINUING EDUCATION

WAC 388-71-05775 What is continuing education?

Continuing education is additional caregiving-related training designed to increase and keep current a person's knowledge and skills. DSHS does not preapprove continuing education programs or instructors.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05775, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05932, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05780 How many hours of continuing education are required each year? (1) Individual providers and home care agency providers must complete at least ten hours of continuing education each calendar year (January 1 through December 31) after the year in which they successfully complete basic or modified basic training.

(2) One hour of completed classroom instruction or other form of training (such as a video or on-line course) equals one hour of continuing education.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05780, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05933, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05785 What kinds of training topics are required for continuing education? Continuing education must be on a topic relevant to the care setting and care needs of clients, including but not limited to:

- (1) Client rights;
- (2) Personal care (such as transfers or skin care);
- (3) Mental illness;
- (4) Dementia;
- (5) Developmental disabilities;
- (6) Depression;
- (7) Medication assistance;
- (8) Communication skills;
- (9) Positive client behavior support;
- (10) Developing or improving client centered activities;
- (11) Dealing with wandering or aggressive client behaviors; and
- (12) Medical conditions.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05785, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05934, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05790 Is competency testing required for continuing education? Competency testing is not required for continuing education.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05790, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05935, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05795 May basic or modified basic training be completed a second time and used to meet the continuing education requirement? Retaking basic or modified basic training may not be used to meet the continuing education requirement.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05795, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05936, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05799 What are the documentation requirements for continuing education? (1) The home care agency or individual provider must maintain documentation of continuing education including:

- (a) The trainee's name;
 - (b) The title or content of the training;
 - (c) The instructor's name or the name of the video, on-line class, professional journal, or equivalent instruction materials completed;
 - (d) The number of hours of training; and
 - (e) The date(s) of training.
- (2) Home care individual providers must provide DSHS or the area agency on aging with documentation of completion of continuing education credits.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05799, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05937, filed 4/30/02, effective 5/31/02.]

NURSE DELEGATION CORE TRAINING

WAC 388-71-05805 What is nurse delegation core training? Nurse delegation core training is required before a nursing assistant may be delegated a nursing task. DSHS approves instructors for nurse delegation core training.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, § 388-71-05805, filed 12/24/03, effective 1/24/04.]

WAC 388-71-05810 What knowledge and skills must nurse delegation core training include? Only the curricula developed by DSHS may be used for nurse delegation core training.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, § 388-71-05810, filed 12/24/03, effective 1/24/04.]

WAC 388-71-05815 Is competency testing required for nurse delegation core training? Passing the DSHS competency test is required for successful completion of nurse

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delegation core training, as provided under WAC 388-71-05835 through 388-71-05865.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, § 388-71-05815, filed 12/24/03, effective 1/24/04.]

WAC 388-71-05820 Is there a challenge test for nurse delegation core training? There is no challenge test for nurse delegation core training.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, § 388-71-05820, filed 12/24/03, effective 1/24/04.]

WAC 388-71-05825 What documentation is required for successful completion of nurse delegation core training? (1) Nurse delegation core training must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (a) The name of the trainee;
 - (b) The name of the training;
 - (c) The name of the training entity giving the training;
 - (d) The instructor's name and signature; and
 - (e) The date(s) of training.
- (2) The trainee must be given an original certificate.

Home care agencies must keep a copy of the certificate on file.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, § 388-71-05825, filed 12/24/03, effective 1/24/04.]

WAC 388-71-05830 Who is required to complete nurse delegation core training, and when? Before performing any delegated nursing task, individual providers and home care agency providers must:

- (1) Successfully complete DSHS-designated nurse delegation core training;
- (2) Be a nursing assistant registered or certified under chapter 18.88A RCW; and
- (3) If a nursing assistant registered, successfully complete basic training.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, § 388-71-05830, filed 12/24/03, effective 1/24/04.]

SAFETY TRAINING

WAC 388-71-05832 What is safety training? Safety training and applicable requirements are defined in WAC 257-05-020 through 257-05-240.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-71-05832, filed 5/17/05, effective 6/17/05.]

COMPETENCY TESTING

WAC 388-71-05835 What is competency testing? Competency testing, including challenge testing, is evaluating a trainee to determine if they can demonstrate the required level of skill, knowledge, and/or behavior with respect to the identified learning outcomes of a particular course.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05835, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05938, filed 4/30/02, effective 5/31/02.]

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WAC 388-71-05840 What components must competency testing include? Competency testing must include the following components:

- (1) Skills demonstration of ability to perform and/or implement specific caregiving approaches, and/or activities as appropriate for the training;
- (2) Written evaluation to show knowledge of the learning outcomes included in the training; and
- (3) A scoring guide for the tester with clearly stated scoring criteria and minimum proficiency standards.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05840, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05939, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05845 What experience or training must individuals have to be able to perform competency testing? Individuals who perform competency testing must have documented experience or training in assessing competencies.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05845, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05940, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05850 What training must include the DSHS-developed competency test? Basic training, modified basic training, and nurse delegation core training must include the DSHS-developed competency test.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05850, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05941, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05855 How must competency test administration be standardized? To standardize competency test administration, testing must include the following components:

- (1) An instructor for the course who meets all minimum qualifications for the course he or she teaches must oversee all testing; and
- (2) The tester must follow DSHS guidelines for:
 - (a) The maximum length of time allowed for testing;
 - (b) The amount and nature of instruction given to students before beginning a test;
 - (c) The amount of assistance to students allowed during testing;
 - (d) The accommodation guidelines for students with disabilities; and
 - (e) Accessibility guidelines for students with limited English proficiency.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05855, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05942, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05860 What form of identification must providers show a tester before taking a competency or challenge test? Providers must show a tester photo identification before taking a competency test (or challenge test, when applicable) for basic training, modified basic training, or nurse delegation core training.

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[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05860, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05943, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05865 How many times may a competency test be taken? (1) A competency test that is part of a course may be taken twice. If the test is failed a second time, the person must retake the course before any additional tests are administered.

(2) If a challenge test is available for a course, it may be taken only once. If the test is failed, the person must take the classroom course.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05865, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05944, filed 4/30/02, effective 5/31/02.]

INSTRUCTOR QUALIFICATIONS

WAC 388-71-05870 What are an instructor's or training entity's responsibilities? The instructor or training entity is responsible for:

- (1) Coordinating and teaching classes;
- (2) Assuring that the curriculum used is taught as designed;
- (3) Selecting qualified guest speakers where applicable;
- (4) Administering or overseeing the administration of DSHS competency and challenge tests;
- (5) Maintaining training records including student tests and attendance records for a minimum of six years;
- (6) Reporting training data to DSHS in DSHS-identified time frames; and
- (7) Issuing or reissuing training certificates to students.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05870, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05945, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05875 Must instructors be approved by DSHS or an AAA? (1) DSHS must approve any instructor under contract with DSHS to conduct basic training, modified basic training, or nurse delegation core training classes using the training curricula developed by DSHS. DSHS may select contracted instructors using any applicable contracting procedures. Contractors must meet the minimum qualifications for instructors under this chapter and any additional qualifications established through the contracting procedure.

(2) DSHS contracts with area agencies on aging (AAA) or other entities to conduct orientation, basic, modified basic, nurse delegation core training, and continuing education training programs for individual providers and home care agency providers. The training entity must approve any instructor under contract with the entity to conduct training programs. The entity's contractors must meet the minimum qualifications for instructors under this chapter and any additional qualifications established through the entity's contracting procedures.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05875, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05946, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05880 Can DSHS or the AAA deny or terminate a contract with an instructor or training entity? (1) DSHS or an area agency on aging (AAA), as applicable, may determine not to accept an offer by a person or organization seeking a contract with DSHS or the AAA to conduct training programs. No administrative remedies are available to dispute DSHS' or the AAA's decision not to accept an offer, except as may be provided through the contracting process.

(2) DSHS or the AAA may terminate any training contract in accordance with the terms of the contract. The contractor's administrative remedies shall be limited to those specified in the contract.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05880, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05947, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05885 What is a guest speaker, and what are the minimum qualifications to be a guest speaker for basic training? Guest speakers for basic training programs teach a specific subject in which they have expertise, under the supervision of the instructor. The guest speaker must have, as minimum qualifications, an appropriate background and experience that demonstrates that the guest speaker has expertise on the topic he or she will teach. The instructor must select guest speakers that meet the minimum qualifications, and maintain documentation of this background. DSHS does not approve guest speakers.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05885, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05948, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05890 What are the minimum qualifications for an instructor for basic, modified basic or nurse delegation core training? An instructor for basic, modified basic, or nurse delegation core training must meet the following minimum qualifications:

- (1) General qualifications:
 - (a) Twenty-one years of age;
 - (b) Has not had a professional health care or social services license or certification revoked in Washington state (however, no license or certification is required).
- (2) Education and work experience:
 - (a) Upon initial approval or hire, must have:
 - (i) A high school diploma and one year of professional or caregiving experience within the last five years in an adult family home, boarding home, supported living through DDD per chapter 388-820 WAC, or home care setting; or
 - (ii) An associate degree in a health field and six months of professional or caregiving experience within the last five years in an adult family home, boarding home, supported living through DDD per chapter 388-820 WAC, or home care setting.
 - (b) Teaching experience:
 - (a) Must have one hundred hours of experience teaching adults on topics directly related to the basic training; or
 - (b) Must have forty hours of teaching while being mentored by an instructor who meets these qualifications, and must attend a class on adult education that meets the requirements of WAC 388-71-05899.

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(4) The instructor must be experienced in caregiving practices and capable of demonstrating competency with respect to the course content or units being taught;

(5) Instructors who will administer tests must have experience or training in assessment and competency testing; and

(6) If required under WAC 388-71-05730 or 388-71-05760, instructors must successfully complete basic or modified basic training prior to beginning to train others.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05890, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-15-064, § 388-71-05949, filed 7/11/02, effective 8/11/02.]

WAC 388-71-05895 What additional qualifications are required for instructors of nurse delegation core training? An instructor for nurse delegation core training must have a current RN license in good standing.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, § 388-71-05895, filed 12/24/03, effective 1/24/04.]

PHYSICAL RESOURCES AND STANDARD PRACTICES FOR TRAINING

WAC 388-71-05899 What must be included in a class on adult education? A class on adult education must include content, student practice, and evaluation of student skills by the instructor in:

- (1) Adult education theory and practice principles;
- (2) Instructor facilitation techniques;
- (3) Facilitating learning activities for adults;
- (4) Administering competency testing; and
- (5) Working with adults with special training needs (for example, English as a second language or learning and literacy issues).

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05899, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05950, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05905 What physical resources are required for basic, modified basic, or nurse delegation core classroom training and testing? (1) Classroom facilities used for basic, modified basic, or nurse delegation core classroom training must be accessible to trainees and provide adequate space for learning activities, comfort, lighting, lack of disturbance, and tools for effective teaching and learning such as white boards and flip charts. Appropriate supplies and equipment must be provided for teaching and practice of caregiving skills in the class being taught.

(2) Testing sites must provide adequate space for testing, comfort, lighting, and lack of disturbance appropriate for the written or skills test being conducted. Appropriate supplies and equipment necessary for the particular test must be provided.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05905, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05951, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05909 What standard training practices must be maintained for basic, modified basic, or nurse delegation core classroom training and testing? The

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following training standards must be maintained for basic, modified basic, or nurse delegation core classroom training and testing:

- (1) Training, including all breaks, must not exceed eight hours within one day;
- (2) Training provided in short time segments must include an entire unit, skill or concept;
- (3) Training must include regular breaks; and
- (4) Students attending a classroom training must not be expected to leave the class to attend to job duties, except in an emergency.

[Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05909, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05952, filed 4/30/02, effective 5/31/02.]

ADULT DAY SERVICES

WAC 388-71-0702 Purposes and definitions. (1) WAC 388-71-0702 through 388-71-0776 contain the eligibility requirements for Medicaid-funded adult day care and adult day health services. These rules also contain the requirements that apply to adult day care or day health centers that contract with the department, an area agency on aging, or other department designee to provide Medicaid services to department clients. Nothing in these rules may be construed as requiring the department, area agency on aging, or other designee to contract with an adult day care or day health center.

(2) An adult day services program is a community-based program designed to meet the needs of adults with impairments through individual plans of care. This type of structured, comprehensive, nonresidential program provides a variety of health, social, and related support services in a protective setting. By supporting families and caregivers, an adult day services program enables the person to live in the community. An adult day services program assesses the needs of the persons served and offers services to meet those needs. The persons served attend on a planned basis. Nothing in this generic description of adult day services may be construed to modify the specific services or eligibility requirements referenced in the definition of adult day care and adult day health.

(3) The following definitions apply under WAC 388-71-0702 through 388-71-0774:

(a) **"Adult day care"** means the services under WAC 388-71-0704 that are provided to clients who meet the eligibility requirement under WAC 388-71-0708.

(b) **"Adult day center"** means an adult day care or adult day health center. A day care or day health center for purposes of these rules is a center operating in a specific location, whether or not the center's owner also operates adult day centers in other locations.

(c) **"Adult day health"** means the services under WAC 388-71-0706 that are provided to clients who meet the eligibility requirements under WAC 388-71-0710.

(d) **"Adult day services"** is a generic term referring to adult day care and adult day health services.

(e) **"Client"** means an applicant for or recipient of Medicaid-reimbursed adult day services.

(f) **"Participant"** means clients and other persons receiving adult day services at an adult day center.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0702, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0704 Adult day care—Services. Adult day care is a supervised daytime program providing core services as defined in WAC 388-106-0800. Core services are appropriate for adults with medical or disabling conditions that do not require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician. The adult day care center must offer and provide on site the following core services. These core services must meet the level of care needed by the client as assessed by the department case manager for waiver funded clients and do not exceed the scope of services that the adult day care center is able to provide.

- (1) Assistance with activities of daily living:
 - (a) Locomotion outside of room, locomotion in room, walk in room;
 - (b) Body care;
 - (c) Eating;
 - (d) Repositioning;
 - (e) Medication management that does not require a licensed nurse;
 - (f) Transfer;
 - (g) Toileting;
 - (h) Personal hygiene at a level that ensures client safety while in attendance at the program; and
 - (i) Bathing at a level that ensures client safety and comfort while in attendance at the program.
- (2) Social services on a consultation basis, which may include:
 - (a) Referrals to other providers for services not within the scope of Medicaid reimbursed adult day care services;
 - (b) Caregiver support and education; or
 - (c) Assistance with coping skills.
- (3) Routine health monitoring with consultation from a registered nurse that a consulting nurse acting within the scope of practice can provide with or without a physician's order. Examples include:
 - (a) Obtaining baseline and routine monitoring information on client health status, such as vital signs, weight, and dietary needs;
 - (b) General health education such as providing information about nutrition, illnesses, and preventative care;
 - (c) Communicating changes in client health status to the client's caregiver;
 - (d) Annual and as needed updating of the client's medical record; or
 - (e) Assistance as needed with coordination of health services provided outside of the adult day care program.
- (4) General therapeutic activities that an unlicensed person can provide or that a licensed person can provide with or without a physician's order. These services are planned for and provided based on the client's abilities, interests, and goals. Examples include:
 - (a) Recreational activities;
 - (b) Diversionary activities;
 - (c) Relaxation therapy;

- (d) Cognitive stimulation; or
- (e) Group range of motion or conditioning exercises.
- (5) General health education that an unlicensed person can provide or that a licensed person can provide with or without a physician's order, including but not limited to topics such as:
 - (a) Nutrition;
 - (b) Stress management;
 - (c) Disease management skills; or
 - (d) Preventative care.
- (6) A nutritional meal and snacks every four hours, including a modified diet if needed and within the scope of the program, as provided under WAC 388-71-0768;
- (7) Supervision and/or protection if needed for client safety;
- (8) Assistance with arranging transportation to and from the program; and
- (9) First aid and provisions for obtaining or providing care in an emergency. NOTE: If the client requires the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of a physician, consider adult day health services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-71-0704, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-71-0704, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0704, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0706 Adult day health—Services. Adult day health is a supervised daytime program providing skilled nursing and rehabilitative therapy services in addition to core services. Adult day health services are only appropriate for adults with medical or disabling conditions that require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of the client's physician.

The adult day health center must offer and provide on site the following services:

- (1) All core services under WAC 388-71-0704;
- (2) Skilled nursing services other than routine health monitoring with nurse consultation;
- (3) At least one of the following skilled therapy services: physical therapy, occupational therapy, or speech-language pathology or audiology, as defined under chapters 18.74, 18.59 and 18.35 RCW; and
- (4) Psychological or counseling services, including assessing for psycho-social therapy need, dementia, abuse or neglect, and alcohol or drug abuse; making appropriate referrals; and providing brief, intermittent supportive counseling.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-71-0706, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-71-0706, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0706, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0708 Adult day care—Eligibility. Clients are eligible for adult day care services if they meet criteria outlined in WAC 388-106-0805.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-71-0708, filed 5/17/05, effective 6/17/05. Statutory Authority: 2004 c 276 § 206

(6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-71-0708, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0708, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0710 Adult day health—Eligibility. Clients are eligible for adult day health services if they meet the criteria outlined in WAC 388-106-0815.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-71-0710, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0710, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0712 Adult day health—Skilled nursing. (1) Skilled nursing services are medically necessary services provided directly or indirectly by a registered nurse under physician supervision, or by a licensed practical nurse under physician or registered nurse supervision, that a licensed nurse acting within the scope of practice can provide or supervise. Physician orders must be obtained when required by applicable state practice laws for licensed nurses.

(2) Skilled nursing services must exceed the level of routine health monitoring, general health education, and general therapeutic activities as defined in WAC 388-71-0704, and must be provided with the reasonable expectation that the services will improve, restore, or maintain function as defined in WAC 388-71-0710 (1)(c). Skilled nursing services are:

- (a) Specific to a client diagnosis;
 - (b) Individualized to the client with planned measurable outcomes; and
 - (c) Evaluated every ninety days for effect on improvement of health status or prevention of decline.
- (3) Skilled nursing services, including the initial client nursing assessment and development of the nursing plan of care, must be provided or supervised by a registered nurse in accordance with nursing practice standards under chapter 246-840 WAC.
- (4) A skilled nursing service is not a qualifying adult day health service merely because the service is ordered by a physician or is provided by a nurse. If, by way of example, the service can be performed by the client or at the client's direction by a person other than a licensed nurse, or the client does not meet eligibility criteria, it is not a qualifying adult day health service.

(5) Skilled nursing services must be medically necessary as defined under WAC 388-500-0005. Medically necessary skilled nursing services may, but do not necessarily, include:

(a) Care and assessment of an unstable or unpredictable medical condition, with time limited measurable treatment goals, requiring frequent intervention by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse according to WAC 246-840-705;

(b) Evaluation and management of the care plan when unstable medical conditions or complications require complex nonskilled care and skilled nurse oversight to ensure that the nonskilled care is achieving its purpose;

(c) Time-limited training by licensed nursing staff to teach the client and/or the client's caregiver self-care for newly diagnosed, acute, or episodic medical conditions that require the skills of a licensed nurse to teach, and that will

optimize client function, as illustrated by the following examples:

- (i) Self administration of an injection;
- (ii) Prefilling insulin syringes;
- (iii) Irrigating a catheter;
- (iv) Caring for a colostomy or urostomy;
- (v) Wound dressing changes or aseptic technique; or
- (vi) Disease self-management.

(d) Skilled interventions provided directly by a licensed nurse such as:

- (i) Inserting or irrigating a catheter;
- (ii) Administering medications or oxygen;
- (iii) Administering and managing infusion therapy; or
- (iv) Treating decubitus ulcers, or other types of wound care.

(6) Medically necessary skilled nursing services, by way of example, do **not** include:

- (a) Reminding or coaching the client;

(b) Monitoring of a medical condition that does not require frequent skilled nursing intervention or a change in physician treatment orders, or where there is no reasonable expectation that skilled services will maintain, improve, or slow the effect of a progressive disabling condition on the pain, health or functioning of a client;

(c) Medication assistance when the client is capable of self-administration or is having this need met through paid or unpaid caregivers;

(d) Evaluation and management of the care plan when the complexity of care to be provided by nonskilled persons does not require skilled nurse oversight beyond routine health monitoring;

(e) Continued training by nursing staff to teach self-care for newly diagnosed, acute, or episodic medical conditions when it is apparent that the training should have achieved its purpose or that the client is unwilling or unable to be trained;

(f) Core services that can be provided by an adult day care center, such as routine health monitoring, general health education, or general therapeutic activities; or

(g) Group therapy or training where three or more clients are being simultaneously treated or trained by the nurse.

(7) Skilled nursing services must be documented as provided under WAC 388-71-0746 and chapter 388-502 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0712, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0714 Adult day health—Rehabilitative therapy. (1) Skilled rehabilitative therapy services are medically necessary services provided by or under the supervision of a licensed physical, occupational, or speech-language pathology or audiology therapist that the therapist acting within the scope of practice can provide or supervise directly or indirectly. Physician orders must be obtained when required by applicable state practice laws for licensed therapists.

(a) Persons that can provide rehabilitative care under the direction and supervision of a licensed therapist include occupational therapy aides, occupational therapy assistants, physical therapy aides, physical therapy assistants, and nurses within their respective scopes of practice. Adult day health program aides, specifically trained in rehabilitative

techniques, may also provide care under the direction and supervision of a licensed therapist.

(b) Services, group or individual, must be related to an active written plan of care with time limited measurable treatment goals approved by the physician;

(c) Services, group or individual, must require the assessment, knowledge and skills of a licensed therapist; and

(d) Services, group or individual, must be provided with the reasonable expectation that the services will improve, restore, or maintain function, or slow decline. Rehabilitative services are:

- (i) Specific to a client diagnosis;

(ii) Individualized to the client with planned, measurable outcomes; and

(iii) Evaluated every ninety days for effect on improvement of health status or prevention of decline.

(2) Skilled rehabilitative therapy is not a qualifying adult day health service merely because the therapy is ordered by a physician or is provided by a therapist or under the supervision of a therapist. If, by way of example, the therapy can be performed independently by the client or at the client's direction by a person other than a licensed therapist, or the client does not meet eligibility criteria, it is not a qualifying adult day health service.

Skilled rehabilitative therapy services must be medically necessary as defined under WAC 388-500-0005.

(3) Medically necessary physical therapy services may, but do not necessarily include:

(a) Assessing baseline mobility level, strength, range of motion, endurance, balance, and ability to transfer;

(b) One to one and group treatment to relieve pain or develop, restore, or maintain functioning, with individualized and measurable client treatment goals;

(c) Establishing a maintenance or restorative program with measurable treatment goals, and providing written and oral instruction to the client, caregivers, or program staff as needed to assist the client in implementing the program;

(d) Training the client or the client's caregivers in the use of supportive, adaptive equipment or assistive devices;

(e) Evaluation and management of the care plan when medical conditions or complications require complex non-skilled care and skilled therapist oversight to ensure that the nonskilled care is achieving its purpose; or

(f) Providing other medically necessary services that can only be provided by or under the direct or indirect supervision of a physical therapist acting within the therapist's scope of practice.

(4) Medically necessary occupational therapy services may, but do not necessarily include:

(a) Administering a basic evaluation to determine baseline level of functioning, ability to transfer, range of motion, balance, strength, coordination, activities of daily living and cognitive-perceptual functioning;

(b) Teaching and training the client, caregivers, or program staff in the use of therapeutic, creative, and self care activities to improve or maintain the client's capacity for self-care and independence, and to increase the range of motion, strength and coordination;

(c) One to one and group treatment to develop, restore, or maintain functioning with individualized and measurable client treatment goals;

(d) Training the client or the client's caregivers in the use of supportive, adaptive equipment or assistive devices;

(e) Evaluation and management of the care plan when medical conditions or complications require complex non-skilled care and skilled therapist oversight to ensure that the non-skilled care is achieving its purpose; or

(f) Providing other medically necessary services that can only be provided by or under the direct or indirect supervision of an occupational therapist acting within the therapist's scope of practice.

(5) Medically necessary speech-language pathology or audiology services may, but do not necessarily include;

(a) Assessing baseline level of speech, swallowing, auditory, or communication disorders;

(b) Establishing a treatment program to improve speech, swallowing, auditory, or communication disorders;

(c) Providing speech therapy procedures that include auditory comprehension tasks, visual and/or reading comprehensive tasks, language intelligibility tasks, training involving the use of alternative communication devices, or swallowing treatment;

(d) Training the client or the client's caregivers in methods to assist the client in improving speech, communication, or swallowing disorders;

(e) Evaluation and management of the care plan when medical conditions or complications require complex non-skilled care and skilled therapist oversight to ensure that non-skilled care is achieving its purpose; or

(f) Providing other medically necessary services that can only be provided by or under the direct or indirect supervision of a speech-language pathology or audiology therapist acting with the therapist's scope of practice.

(6) Medically necessary skilled rehabilitative therapy services, by way of example, do **not** include:

(a) Reminding or coaching the client in tasks that are not essential to the skilled therapy or intervention in the client's service plan;

(b) Monitoring of a medical condition that does not require frequent skilled therapist intervention or a change in physician treatment orders, or where there is no reasonable expectation that skilled services will maintain, improve, or slow the effect of a progressive disabling condition on the pain, health or functioning of a client;

(c) Massage therapy;

(d) Evaluation and management of the care plan when the complexity of the care to be provided by nonskilled persons does not require the skills of a licensed therapist for oversight;

(e) Continued training by therapy staff to teach self-care for newly diagnosed, acute, or episodic medical conditions when it is apparent that the training should have achieved its purpose or that the client is unwilling or unable to be trained;

(f) Core services that can be provided by an adult day care center, such as routine health monitoring, general health education, or general therapeutic activities; or

(g) Group therapy or training where the ratio of licensed therapists and assisting program staff to clients is inadequate to ensure that:

(i) The group activity contributes to the individual client's planned therapy goals; and

(ii) The complexity of the individual client's need can be met.

(7) Skilled therapy services must be documented as provided under WAC 388-71-0746 and chapter 388-502 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0714, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0716 Adult day care—Assessment and service plan.

(1) The department or an authorized case manager must perform a CARE assessment to determine a client's need for adult day care, per WAC 388-106-0065. Based on the assessment, the case manager determines whether the client should be referred for day care services or whether the client's needs can be met in other ways.

(2) If the case manager determines an unmet need for a core service that may be provided at a day care center, the case manager works with the client and/or the client's representative to develop a service plan that documents the needed services and the number of days per week that the services are to be provided. The case manager refers the client to a waiver-contracted day care center that the client and the case manager agree can potentially meet the client's needs.

(3) Clients receiving adult day care services must be reassessed at least annually.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0716, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0716, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0718 Adult day care—Negotiated care plan.

(1) Upon referral of a COPES eligible client by the case manager, the day care center must conduct an intake evaluation based on an interview with the client and/or the client's representative to assess the center's ability to meet the client's needs as identified in the department service plan. The case manager will provide the client's service plan to the adult day care provider within five working days after the client or client's representative has signed it.

(2) Within two working days of the referral, the day care center must respond to the referral and notify the case manager of its ability to process and evaluate the referral.

(3) Within ten working days of the initial date of client attendance at the day care center, the center must determine whether it can meet the client's needs, how those needs will be met, and whether to accept the client to the program. The center must not accept a client whose needs the center cannot meet.

(4) Within thirty days of acceptance into the program, the day care center must develop a negotiated care plan signed by the client or the client's representative and the day care center. The care plan must:

(a) Be consistent with the department-authorized service plan and include all day care services authorized in the service plan;

(b) Document the client's needs as identified in the service plan, the adult day care services that will be provided to meet those needs, and when, how, and by whom the services will be provided;

(c) Document the client's choices and preferences concerning the provision of care and services, and how those preferences will be accommodated;

(d) Document potential behavioral issues identified in the assessment, service plan, or through the intake evaluation, and how those issues will be managed;

(e) Document contingency plans for responding to a client's emergent care needs or other crises; and

(f) Be approved by the client's case manager.

(5) The adult day care center must keep the negotiated care plan in the client's file, must offer a copy of the plan to the client or client representative, and must provide a copy to the client's case manager. The case manager must review the negotiated care plan for inclusion of services that are appropriate and authorized for the client's care needs.

(6) The negotiated care plan must limit the frequency of services to the number of days authorized in the department-authorized service plan.

(7) The day care center must review each service in the negotiated care plan if the client's condition changes, and determine if the care plan continues to meet the client's needs. Changes in the client's condition or unanticipated absences of more than three consecutive days of scheduled service must be reported to the client's case manager within one week. Unanticipated absences by way of example may include absences due to client illness or injury, or a change in transportation access. The case manager may follow-up with the client and determine if any updates to the assessment, service plan, and service authorization are needed.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0718, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0720 Adult day health—Assessment and service plan. (1) The department or an authorized case manager must perform a CARE assessment to determine a client's need for adult day health, per WAC 388-106-0065. Based on the assessment, the case manager determines whether the client should be referred for day health services or whether the client's needs can be met in other ways.

(2) If the client has a department or area agency on aging case manager, the adult day health center or other referral source must notify the case manager of the client's potential adult day health service need. The case manager must assess the client's need for skilled nursing or skilled rehabilitative therapy within the department's normal time frames for client reassessments.

(3) If the client does not have a department or area agency on aging case manager, the adult day health center or other referral source must notify the department of the referral and the client's potential adult day health service need, or refer the client to the department for intake. The department's assigned case manager must assess the client's need for adult day health services within the department's normal time frames for initial client eligibility assessments.

(4) The case manager may consult with the client's practitioner, department or area agency on aging nursing services staff, or other pertinent collateral contacts, concerning the client's need for skilled nursing or rehabilitative therapy.

(5) If the department or area agency on aging case manager determines and documents a potential unmet need for

day health services, the case manager works with the client and/or the client's representative to develop a service plan that documents the potential unmet needs and the anticipated number of days per week that the services are needed. The case manager refers the client to a department contracted day health center for evaluation and the development of a preliminary negotiated plan of care.

(6) The department or area agency on aging case manager must reassess adult day health clients at least annually. Clients must also be reassessed if they have a break in service of more than thirty days. The adult day center must inform the case manager of the break in service so payment authorization can be discontinued.

(7) Recipients of adult day health services must be assessed by the department or an authorized case manager for continued or initial eligibility as follows:

(a) Annual reassessment for department clients;

(b) Adult day health quarterly review for current nondepartmental clients as resources allow; and

(c) New referrals for adult day health services are to be forwarded to local department offices for intake and assessment for eligibility.

(8) The department or area agency on aging case manager must review a client's continued eligibility for adult day health services every ninety days, coinciding with the quarterly review completed by the adult day health program. At the case manager's discretion, additional information will be gathered through face to face, collateral or other contact methods to determine continued eligibility. Services will be continued, adjusted, or terminated based upon the case manager's determination during the eligibility review.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-71-0720, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0720, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0722 Adult day health—Negotiated care plan. (1) Upon referral of a client by the department or an authorized case manager, the day health center must conduct an intake evaluation and multidisciplinary assessment based on an interview with the client or the client's representative to determine the center's ability to meet the client's core service needs and potential adult day health needs as identified in the preliminary department service plan. The case manager will provide the client's service plan to the day health center within five working days after the client or client's representative has signed it. The day health center must evaluate the client's skilled and core service needs, and may provide up to ten days of paid service to complete the evaluation and develop a preliminary or negotiated plan of care to be provided to the client and the case manager.

(2) Within two working days of the referral, the day health center must respond to the referral and notify the case manager of its ability to process and evaluate the referral.

(3) Within ten paid days of service, the day health center must determine whether it can meet the client's needs, how those needs will be met, and whether to accept the client to the program. The center must not accept a client whose needs the center cannot meet. The center will be reimbursed under WAC 388-71-0724 for any service days provided from the start of the evaluation if the case manager has authorized ser-

vices. The evaluation includes acceptance of the client to the center, the development of the initial assessment, and the preliminary negotiated plan of care.

(4) Upon approval by the case manager of the adult day health preliminary or negotiated care plan, the day health center multidisciplinary team must obtain and provide to the case manager any required practitioner's orders for skilled nursing and rehabilitative therapy along with a copy of the negotiated plan of care, according to department documentation requirements. Orders must indicate how often the client is to be seen by the authorized practitioner. The case manager or nursing services staff may follow up with the practitioner or other pertinent collateral contacts concerning the client's need for skilled services. Services may not be authorized for payment without current practitioner orders and the client's consent to follow up with the practitioner.

(5) Within thirty days of the client's acceptance into the program, the day health multidisciplinary team must work with the client to develop a negotiated care plan signed by the client or the client's representative and the day health center. The care plan must:

(a) Be consistent with the department-authorized service plan and include all day health services authorized in the service plan;

(b) Include an authorized practitioner's order(s) for skilled nursing and/or skilled rehabilitative therapy according to applicable state practice laws for licensed nurses or therapists;

(c) Document that the client or the client's representative has consented to follow up with the primary authorizing practitioner;

(d) Document the client's needs as identified in the service plan, the authorized services that will be provided to meet those needs, and when, how, and by whom the services will be provided;

(e) Establish time-limited, client specific, measurable goals, not to exceed ninety days from the date of signature of the negotiated care plan, for accomplishing the objectives of adult day health skilled services and/or discharging or transitioning the client to other appropriate settings or services;

(f) Document the client's choices and preferences concerning the provision of care and services, and how those preferences will be accommodated;

(g) Document potential behavioral issues identified in the assessment, service plan, or through the intake evaluation, and how those issues will be managed;

(h) Document contingency plans for responding to a client's emergent care needs or other crises; and

(i) Be approved by the case manager.

(6) The adult day health center must keep the negotiated care plan in the client's file, the plan to the client or client representative, and must provide a copy to the client's case manager, including any required authorizing practitioner orders. The department case manager must review the negotiated care plan for inclusion of services that are appropriate and authorized for the client's care needs.

(7) The negotiated care plan must limit the frequency of department-funded services to the number of days in the department-authorized service plan.

(8) The day health center must review each service in the negotiated care plan every ninety days or more often if the

client's condition changes, or if the client is reassessed for eligibility after a break in service of more than thirty days. Changes in the client's condition or unanticipated absences of more than three consecutive days of scheduled service must be reported to the client's case manager within one week. Unanticipated absences by way of example may include absences due to client illness or injury. The case manager may follow-up with the client and determine if any updates to the assessment, service plan, and service authorization are needed.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0722, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0724 Adult day services—Contracting and rates. (1) The department, or an area agency on aging (or other department designee) as authorized by the department, must determine that the adult day care or day health center meets the applicable adult day care or day health requirements and any additional requirements for contracting with the area agency on aging through a COPES contract or with the department through a Medicaid provider contract. If a center is contracting for both day care and day health, requirements of both adult day services must be met.

(a) A prospective provider desiring to provide adult day services shall be provided an application form from the department or the area agency on aging.

(b) The prospective provider will provide the area agency on aging with evidence of compliance with, or administrative procedures to comply with, the adult day service rules under this chapter.

(c) The area agency on aging will conduct a site inspection of the adult day center and review of the requirements for contracting.

(d) Within thirty days of completing the site visit, the area agency on aging will advise the prospective provider in writing of any deficiencies in meeting contracting requirements.

(e) The area agency on aging will verify correction of any deficiencies within thirty days of receiving notice from the prospective provider that deficiencies have been corrected, before contracting can take place.

(f) The area agency on aging will provide the department with a written recommendation as to whether or not the center meets contracting requirements.

(2) Minimum application information required to apply for contract with the department, or an area agency on aging includes:

(a) Mission statement, articles of incorporation, and bylaws, as applicable;

(b) Names and addresses of the center's owners, officers, and directors as applicable;

(c) Organizational chart;

(d) Total program operating budget including all anticipated revenue sources and any fees generated;

(e) Program policies and operating procedure manual;

(f) Personnel policies and job descriptions of each paid staff position and volunteer position functioning as staff;

(g) Policies and procedures meeting the requirements of mandatory reporting procedures as described in chapter

74.34 RCW to adult protective services for vulnerable adults and local law enforcement for other participants;

(h) Audited financial statement;

(i) Floor plan of the facility;

(j) Local building inspection, fire department, and health department reports;

(k) Updated TB test for each staff member according to local public health requirements;

(l) Sample client case file including all forms that will be used; and

(m) Activities calendar for the month prior to application, or a sample calendar if the day service provider is new.

(3) The area agency on aging or other department designee monitors the adult day center at least annually to determine continued compliance with adult day care and/or adult day health requirements and the requirements for contracting with the department or the area agency on aging.

(a) The area agency on aging will send a written notice to the provider indicating either compliance with contracting requirements or any deficiencies based on the annual monitoring visit and request a corrective action plan. The area agency on aging will determine the date by which the corrective action must be completed

(b) The area agency on aging will notify the department of the adult day center's compliance with contracting requirements or corrected deficiencies and approval of the corrective action plan for continued contracting.

(4) Adult day care services are reimbursed on an hourly basis up to four hours per day. Service provided four or more hours per day will be reimbursed at the daily rate.

(5) Payment rates are established on an hourly and daily basis for adult day care centers as may be adopted in rule. Rate adjustments are determined by the state legislature. Providers seeking current reimbursement rates can refer to SSPS billing instructions.

(6) Rates as of July 1, 2002, are as follows:

Counties	COPES Adult Day Care	
	Daily Rate	Hourly Rate
King	\$36.48	\$9.10
Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, & Yakima	\$32.45	\$8.11
All other counties	\$30.75	\$7.69

(7) Payment rates are established on a daily basis for adult day health centers as may be adopted in rule. Rate adjustments are determined by the state legislature. Providers seeking current reimbursement rates can refer to MAA billing instructions or <http://maa.dshs.wa.gov>.

(8) Rates as of July 1, 2002, are as follows:

Counties	Day Health Daily
King	\$47.48
Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, & Yakima	\$43.06
All other counties	\$40.68

A one-time only initial intake evaluation provided by an adult day health center, including development of a negoti-

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ated care plan, is reimbursed at an established rate as may be adopted in rule. The rate as of July 1, 2002 is eighty-nine dollars and thirty-eight cents. Rate adjustments are determined by the state legislature. Separate reimbursement is not available for subsequent evaluations.

(9) Transportation to and from the program site is not reimbursed under the adult day care rate. Transportation arrangements are made with locally available transportation providers or informal resources.

(10) Transportation to and from the program site is not reimbursed under the adult day health rate. Transportation arrangements for eligible Medicaid clients are made with local Medicaid transportation brokers, informal providers, or other available resources per chapter 388-546 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0724, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0726 Adult day health transportation.

The following rules apply if Medicaid transportation services are requested:

(1) The day health center must refer the client to a local Medicaid transportation broker. The broker may consult with the client, the client's physician, family, case manager, or day health center as needed in making any transportation arrangements.

(2) In referring the client to a day health center, the case manager may consider: The frailty and endurance of the client, the client's skilled nursing or rehabilitative therapy needs, and a reasonable round-trip travel time that may not exceed two hours, unless there is no closer center that can meet the client's skilled care needs. Documentation of language barriers may be considered on an exception to rule basis by the case manager.

(3) All brokered transportation under this subsection is subject to the requirements of chapter 388-546 WAC or its successors. In the case of any conflicts, the provisions of chapter 388-546 WAC take precedence.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0726, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0728 Coordination of services. (1) A COPES-eligible client may receive adult day care services on some days and adult day health services on different days if the service plan documents which level of service is to be provided on which days. However, core services must be provided on all days that adult day health skilled services are provided, and reimbursement is limited to the day health rate on days that day health services are provided.

(2) Clients receiving services from the department in an adult family home, boarding home, or other licensed community residential facility may not receive COPES-funded adult day care, but may receive Medicaid adult day health services when the skilled nursing or rehabilitative services are approved by the client's case manager as part of the client's service plan.

(3) A licensed boarding home providing department-approved day care under chapter 388-78A WAC is subject to any applicable provisions of that chapter and is also subject to the rules under this chapter if the facility contracts with an

area agency on aging or the department to provide COPES or other Medicaid-funded adult day services.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0728, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0730 Senior Citizens Services Act/Respite care. (1) Except as provided under this section, the adult day services rules under this chapter do not apply to adult day care or day health services funded under chapters 74.38 and 74.41 RCW.

(2) An area agency on aging that elects to provide adult day services using Senior Citizens Services Act funding under chapter 74.38 RCW or respite care funding under chapter 74.41 RCW must contract with an adult day center that meets all administrative and facility requirements under WAC 388-71-0736 through 388-71-0774.

(3) The adult day care or day health services funded under chapters 74.38 or 74.41 RCW must be the same as the day care services required under WAC 388-71-0704 or the day health services required under WAC 388-71-0706. The area agency on aging may require additional services by contract.

(4) The area agency on aging may, by contract, establish eligibility and assessment requirements for day care or day health services in accordance with locally identified needs. However, funding provided under chapters 74.38 or 74.41 RCW may only be used to meet the needs of individuals who are not eligible for adult day care under WAC 388-71-0708 or for adult day health under WAC 388-71-0710, or who are eligible for those services and are not receiving them because of funding limitations.

(5) Nothing in this section or chapter may be construed as requiring an area agency on aging to contract with an adult day center, whether or not the center has a COPES or other Medicaid contract. Nor may anything in this section or chapter be construed as creating an entitlement to state-funded adult day services authorized under chapters 74.38 and 74.41 RCW.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0730, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0732 Hearing rights. (1) If the department or area agency on aging denies, terminates, or reduces an individual client's adult day care or day health services, the client has the right to a fair hearing as provided under chapter 388-02 WAC.

(2) An adult day care or day health center has those hearing or dispute resolution rights that are afforded under RCW 43.20B.675 and the center's contract with the area agency on aging or the department. An adult day health center has any other applicable hearing or dispute resolution rights under chapter 388-502 WAC.

(3) Adult day health centers are subject to all applicable provisions of chapter 388-502 WAC, and the department's aging and adult services administration may exercise the department's authority under that chapter to the same extent as the medical assistance administration.

[Title 388 WAC—p. 376]

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0732, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0734 Limiting expenditures. (1) In order to provide adult day services within the limits of available funding, the department may limit services when program expenditures exceed the budget appropriation or when limiting services is required to prevent expenditures from exceeding the appropriation.

(2) When adult day health program expenditures exceed available funding, the department may limit adult day health services based on the four care level system as determined through the established department assessment and described in chapter 388-105 WAC.

(a) Using the care level determined by the department assessment tool, the department will limit adult day services on a statewide basis to clients whose total scores exceed the assessed need level identified by the department as necessary to provide adult day health services to the extent of available funding.

(b) At least thirty days before implementing the limitation on services under this subsection, the department will notify the area agencies on aging, adult day health centers, and the affected adult day health clients that services are being limited and for what period of time the limitation is estimated to remain in effect.

(c) For purposes of RCW 74.08.080, the reduction in services shall be deemed an assistance adjustment for an entire class of recipients that is required by state laws prohibiting the department from expending funds in excess of appropriations.

(3) The department may adopt additional or alternative rules to control costs, such as, but not limited to, imposing a moratorium on contracting with new adult day centers, limiting services to clients based on level of care need, or reducing the numbers of days per week that clients may receive services.

[Statutory Authority: RCW 74.04.050, 74.04.200, 74.09.520, 74.39A.030. 05-02-064, § 388-71-0734, filed 1/4/05, effective 2/4/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0734, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0736 Adult day centers—Administrative policies and procedures. (1) Adult day centers must have written policies, procedures, and documentation of the organizational structure and administration of the program.

(2) Administrative policies and procedures must include:

(a) Mission statement;

(b) Articles of incorporation and bylaws, as applicable;

(c) Current business license;

(d) Names and addresses of the center's owners, officers, and directors, as applicable;

(e) Certificates of insurance, including but not limited to property and general liability insurance; business auto if the center uses vehicles to transport clients; professional liability; workers' compensation; employers' liability if applicable; coverage for acts and omissions of employees and volunteers; and certificates of insurance for any subcontractors;

(f) Minutes of last three meetings of the board of directors, if applicable, and the advisory committee;

(2007 Ed.)

(g) Role and functions of an advisory committee, which must meet at least twice a year and which must be representative of the community and include family members of current or past clients and nonvoting staff representatives (When an adult day center is a subdivision of a multifunction organization, a committee or subcommittee of the governing body of the multifunction organization may serve as the advisory committee. A single purpose agency may utilize its governing board as an advisory committee.);

(h) An organizational chart illustrating the lines of authority and communication channels of the center, which must be available to all staff and clients;

(i) A calendar of programming (or sample calendar if the center is new);

(j) A monthly menu (or sample menu if the center is new);

(k) Current building, health, food service and fire safety inspection reports, and food handler permits, as applicable; and

(l) Quality improvement plans and results.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0736, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0738 Adult day centers—Operating policies and procedures. (1) All policies and procedures must be reviewed on a regular basis, at least annually by the advisory committee, and conform to the requirements outlined in WAC 388-71-0702 through 388-71-0774, as applicable.

(2) Policies and procedures must include:

(a) Core values and mission of the organization;

(b) Ethical standards of the center and professional standards of conduct;

(c) Short- and long-range program goals;

(d) Definition of the target population, including number, age, and needs of participants;

(e) Geographical definition of the service area;

(f) Hours and days of operation (Centers or a combination of centers under single ownership must operate at least three days a week for four consecutive hours, with each center providing at least four hours of programming a day.);

(g) Description of basic services and any optional services;

(h) Description of service delivery;

(i) Procedures for assessments, reassessments, and the development of a negotiated care plan with clients and/or representatives, including provisions for the utilization of a multidisciplinary team for this process;

(j) If applicable, research procedures that comply with chapter 388-04 WAC;

(k) Staffing pattern;

(l) A plan for utilizing community resources;

(m) Gift policy;

(n) Marketing plan;

(o) Contracting for services; and

(p) Grievance and complaint processes for staff and participants.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0738, filed 2/24/03, effective 7/1/03.]

(2007 Ed.)

WAC 388-71-0740 Adult day centers—Fiscal operations. (1) Adult day centers must demonstrate fiscal responsibility by using generally accepted accounting principles. Fiscal policies, procedures, and records must be developed to enable the administrator to meet the fiscal reporting needs of the governing body.

(2) Adult day centers must develop a plan to address the future financial needs of the center. The plan must include projected program growth, capital purchases, projected revenue, projected expenses, and plans for fund raising, if applicable.

(3) Adult day centers must create a total center operating budget, including all revenue sources and participant fees generated annually.

(4) A financial statement or the latest audit report of the organization by a certified public accountant must be available.

(5) A statement of charges for services, including private pay rates and/or ancillary charges for additional services outside the scope of these rules, must be available.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0740, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0742 Adult day centers—Client policies and procedures. (1) Center policies must define admission criteria, discharge criteria, Health Insurance Portability and Accountability Act (HIPAA) policies, medication policy, participant rights and responsibilities, fee schedule, confidentiality, and grievance procedures.

(2) The center must comply with all applicable nondiscrimination laws, including but not limited to age, race, color, gender, religion, national origin, creed, marital status, Vietnam era or disabled veteran's status, or sensory, physical, or mental handicap.

(3) A participant bill of rights describing the client's rights and responsibilities must be developed, posted, distributed to, and explained to participants, families, staff, and volunteers. Participants will be provided the bill of rights in the language understood by the individual upon request.

(4) The center must have an advance directive policy as required by the Patient Self Determination Act of 1990 (see 42 C.F.R. § 489.102 and chapter 70.122 RCW).

(5) Discharge policies must include specific criteria that establish when the participant is no longer eligible for services and under what circumstances the participant may be discharged for other factors, unless the discharge is initiated by the client's department or authorized case manager, the center must notify the client, client representative if applicable, and case manager in writing of the specific reasons for the discharge. The center must also provide the client with adequate information about appeal and hearing rights. Discharge may occur due to client choice, other criteria as defined in the center's policy such as standards of conduct or inappropriate behavior, or changes in circumstances making the client ineligible for services under WAC 388-71-0708 or 388-71-0710.

(6) Incident report policies must include investigation and reporting of any neglect, abuse, exploitation, accident, or incident jeopardizing or affecting a participant's health or safety. The policy must include how the center will determine

the circumstances of the event, restrictions on staff or clients during the investigation, how similar future situations will be prevented or decreased, and the location of incident reports. The center must keep a log of all reported incidents, participant grievances, complaints, and outcomes.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0742, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0744 Adult day center—Client records. (1) The adult day center must have policies and procedures to ensure that the client's record/chart is appropriately organized and that confidentiality of information is maintained.

(2) Client information forms must be standardized, with each page showing the client's name or identification number.

(3) Individual client files must include:

(a) Personal/biographical data, including addresses, phone numbers, emergency contacts, and client representatives, reviewed and updated as needed;

(b) Application, enrollment, and consent to services forms;

(c) Department-authorized service plan and service authorization;

(d) All client information, including but not limited to the intake evaluation, negotiated care plan, attendance and service records, progress notes, and correspondence;

(e) Signed authorizations concerning the release of client information, photographs, and receipt of emergency medical care, as appropriate;

(f) Client photograph, with client or client representative permission, updated as needed;

(g) Transportation plans;

(h) Fee determination forms;

(i) Appropriate medical information, with client consent, including but not limited to significant illnesses, accidents, treatments, medical conditions, immunizations, allergies, medications, tobacco use, and alcohol or substance use;

(j) Advance directives (if any) and a statement signed by the client that he or she has received the center's policies concerning advance directives; and, as applicable,

(k) Physician orders for skilled nursing and/or rehabilitative therapy containing department-required information and in accordance with applicable licensing and practice act regulations.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0744, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0746 Adult day center—Documentation. (1) Entries in the client's record must be typewritten or legibly written in ink, dated, and signed by the recording person with his/her title. Identification of the author may be a signature, initials, or other unique identifier within the requirements of applicable licensing standards and center policy.

(2) Progress notes must be chronological, timely, and recorded at least weekly by adult day health centers and at least monthly by adult day care center. Client dates of attendance are to be kept daily.

[Title 388 WAC—p. 378]

(3) Consultation and/or care plan reviews must be dated and initialed by the physician or other authorizing practitioner who reviewed them. If the reports are presented electronically, there must be representation of review by the ordering practitioner.

(4) Documentation of medication use must include the name of the medication, dosage, route of administration, site of injection if applicable, and signature or initials of the person administering the medication, title, and date.

(5) The record must be legible to someone other than the writer.

(6) Department-contracted adult day health centers must comply with all other applicable documentation requirements under WAC 388-502-0020.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0746, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0748 Adult day centers—Record retention.

(1) The adult day center must maintain a secure client record system to ensure confidentiality for all records, whether paper or electronic, in accordance with state and federal laws, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA).

(2) The adult day center must maintain a permanent registry of all clients with dates of admission and discharge.

(3) The adult day center must have written policies concerning:

(a) Confidentiality and the protection of records that define procedures governing the use and removal, and conditions for release of information contained in the records;

(b) The release of client information and circumstances under which a signed authorization from the client or client representative is required; and

(c) The retention and storage of records for at least six years from the last date of service to the client, including contingency plans in the event the center discontinues operation.

(4) Client records maintained on the center's premises must be in a secure storage area that includes locking cabinets or storage. Computerized records must be backed up weekly and stored off-site.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0748, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0750 Adult day centers—Personnel policies and procedures. (1) Personnel policies and procedures must be in place to ensure that staff are trained and knowledgeable to provide quality services in a safe environment. Policies must include at least the following:

(a) The center must have policies concerning the recruitment, orientation, training, evaluation, and professional development of staff and volunteers.

(b) The center must have job descriptions for each paid staff and volunteer position that are in accordance with ADA requirements and that specify qualifications for the job, delineation of tasks, and lines of supervision and authority.

(c) Each employee must receive, review, and sign a copy of the job description at the time of employment and whenever job descriptions are modified. Volunteers who function as staff must receive written descriptions of responsibilities.

(2007 Ed.)

(d) Probationary evaluations and annual performance evaluations, in accordance with job descriptions, must be conducted and must conform to the policy of the funding or parent organization. Both the employee and supervisor will sign the written evaluation. Copies will be kept in locked personnel files.

(e) Each staff person is to have a tuberculin test within thirty days of employment. If a test has been performed within twelve months of employment, the results of that test may be accepted. Tuberculin tests will be repeated according to local public health requirements.

(f) The center must have policies to restrict a staff person or participant's contact with clients when the staff person or participant has a known communicable disease in the infectious stage that is likely to spread in the center.

(g) Policies must also be established concerning hand washing, universal precautions, infection control, infectious waste disposal, bloodborne pathogens, and laundry and handling of soiled and clean items.

(2) The center must have policies and procedures concerning suspected abuse, neglect, or exploitation reporting that include provisions preventing access to any participant until the center investigates and takes action to assure the participant's safety.

(3) The center must not interfere with the lawful investigation of a complaint, coerce a participant, or conceal evidence of alleged improprieties occurring within the center.

(4) The center must have policies that meet the requirements of mandatory reporting procedures as described in chapter 74.34 RCW to adult protective services for vulnerable adults and to local law enforcement for other participants.

(5) Each employee must receive or have access to a copy of the program's personnel policies at the time of employment.

(6) Whenever volunteers function in the capacity of staff, all applicable personnel policies must pertain.

(7) The center must conform to federal and state labor laws and be in compliance with equal opportunity guidelines.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0750, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0752 Adult day center—Staffing requirements. (1) Staff selection is dependent on participant needs, program design, and contracting requirements. The center must have the proper balance of professionals and paraprofessionals or nonprofessionals to adequately meet the needs of participants. Services must be delivered by those with adequate professional training. A staff person can have multiple functions, such as an administrator who is also responsible for providing nursing services or social services.

(2) To ensure continuity of direction and supervision, there must be a clear division of responsibility between the governing body and the adult day center administrator.

(3) The administrator must be given full authority and responsibility to plan, staff, direct, and implement the program. The administrator must also have the responsibility for establishing collaborative relations with other community organizations to ensure necessary support services to participants and their families/caregivers.

(4) The administrator must be on site to manage the center's day-to-day operations during hours of operation. If the administrator is responsible for more than one site, or has duties not related to adult day center administration or provision of services, a program director must be designated for each additional site and must report to the administrator.

(5) The administrator must be responsible for the development of a written plan of operation with approval of the governing body and the development, coordination, supervision, fiscal control, and evaluation of services provided through the adult day center.

(6) A nurse or personnel trained in first aid and CPR must be on hand whenever participants are present.

(7) Background checks pursuant to RCW 43.43.830 and 43.43.832 must be performed for all applicants hired, existing employees, and volunteers. Unsupervised access to participants is prohibited until a background check has been completed and the employee's suitability for employment has been determined.

(8) Required credentials must be verified to ensure that they are current and in good standing for licensed and certified staff.

(9) Adult day centers may utilize a range of staff under contract or consulting from a larger parent organization or from a private entity to provide services.

(10) Staff commonly utilized by both adult day care and adult day health centers must meet the following requirements:

(a) An activity coordinator must have a bachelor's degree in recreational therapy or a related field and one year of experience (full-time equivalent) in social or health services; or an associate degree in recreational therapy or a related field plus two years of appropriate experience; or three years of paid experience in an activity program and expertise with the population served at the center.

(b) The nurse must be a registered nurse (RN) with valid state credentials and have at least one-year applicable experience (full-time equivalent). In addition to a registered nurse, an adult day center can utilize a licensed practical nurse (LPN), but the LPN must be supervised in compliance with all applicable nurse practice acts and standards. The LPN must have valid state credentials and at least one-year applicable experience (full-time equivalent).

(c) The social services professional must have a master's degree in social work, gerontology, or other human services field, or counseling and at least one year of professional work experience (full-time equivalent), or a bachelor's degree in social work, counseling, or a related field and two years of experience in a human services field.

(d) Program assistant/aides or personal care aides must have one or more years of experience (full-time equivalent) in working with adults in a health care or social service setting.

(e) Consultants from a larger parent organization without formal contracts may be utilized whenever the center is part of a larger organization that has the ability to provide professional services within the larger framework.

(f) Consultants, with appropriate, valid state credentials may be utilized as needed to meet the requirements outlined in this chapter.

(g) Secretary/bookkeepers must have at least a high school diploma or equivalent and skills and training to carry out the duties of the position.

(h) If the adult day center provides transportation drivers must have a valid and appropriate state driver's license, a safe driving record, and training in first aid and CPR. The driver must meet all state requirements for licensure or certification.

(i) Volunteers may be individuals or groups who desire to work with adult day center clients and must take part in program orientation and training. Volunteers and staff must mutually determine the duties of volunteers. Duties to be performed under the supervision of a staff member must either supplement staff in established activities or provide additional services for which the volunteer has special talents. Volunteers will be included in the staff ratio only when they conform to the same standards and requirements as paid staff, meet the job qualification standards of the organization, and have designated responsibilities.

(j) Dietitians must be certified with valid state credentials and have a minimum of one year applicable experience (full-time equivalent).

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0752, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0754 Staffing ratios. (1) Staffing levels in adult day centers will vary based upon the number of participants and the care provided.

(2) The staffing level must be sufficient to serve the number and functioning levels of adult day center participants, meet program objectives, and provide access to other community resources.

(3) There must be sufficient maintenance and house-keeping personnel to assure that the facility is clean, sanitary, and safe at all times.

(4) To ensure adequate care and safety of participants, there must be provision for qualified substitute staff.

(5) As the number of participants with functional impairments, skilled nursing or skilled rehabilitative therapy needs increases, the required staff-participant ratio must be adjusted accordingly.

(6) All centers must have written policies regarding staff-participant ratios. The ratio must be a minimum of one staff to six participants. The provider must ensure that appropriate professionals provide needed services to the participants based upon the participants' service and care plans. The center is also required to employ sufficient staff to meet the needs of the participants.

(7) Staff counted in the staff-participant ratio are those who provide direct service to participants. When there is more than one participant present, there must be at least two staff members on the premises, one of whom is directly supervising the participants.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0754, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0756 Adult day care—Staffing requirements. (1) Minimum staffing requirements for adult day care centers include an administrator/program director, activity

coordinator, a consulting registered nurse, and a consulting social worker.

(2) The administrator/program director must have a master's degree and one year of supervisory experience in health or social services (full-time equivalent); or a bachelor's degree in health, social services or a related field, with two years of supervisory experience (full-time equivalent) in a social or health service setting; or a high school diploma or equivalent and four years of experience in a health or social services field, of which two years must be in a supervisory position, and have expertise with the populations served at the center.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0756, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0758 Adult day health—Staffing requirements. (1) Minimum staffing requirements for adult day health centers include an administrator, program director, registered nurse, activity coordinator, a PT/OT or speech therapist, and a social worker. The administrator and program director may be the same person.

(2) The program administrator must have a master's degree and one year of supervisory experience in health or social services (full-time equivalent), or a bachelor's degree and two years of supervisory experience in a social or health service setting. The degree may be in nursing.

(3) The program director must have a bachelor's degree in health, social services or a related field with one year of supervisory experience (full-time equivalent) in a social or health service setting. Upon approval by the department, a day health center may request an exception for an individual with an associate's or vocational degree in health, social services, or a related field with four years of experience in a health or social service setting, of which two years must be in a supervisory position.

(4) Therapists, regardless of specific expertise, such as physical therapists, occupational therapists, speech therapists, recreation therapists, mental health therapists, or any other therapists used, must have valid state credentials and one year of experience in a social or health setting.

(5) Rehabilitative therapeutic assistants must be certified with valid state credentials, have at least one year of applicable experience (full-time equivalent), and meet the requirements of chapter 246-915, 246-847, or 246-828 WAC.

(6) A certified or registered nursing assistant must meet the requirements of RCW 18.88A.020.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0758, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0760 Adult day centers—Employee records. (1) Each employee must have an individual file containing the employee's application, verification of references, TB status, signed job description, and all performance evaluations. Copies of current license or certificate and verification of current good standing, and certification of CPR and first aid training, if applicable, must also be in the file.

(2) Centers must maintain employee records for the duration of staff employment and at least seven years after termination of employment.

(3) Employee records must contain all records of training, such as staff orientation and training pertinent to duties or regulatory compliance, including CPR, first aid, and universal precautions training.

(4) Employee records must contain criminal history disclosure and background checks.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0760, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0762 Adult day centers—Education and training. (1) Provision must be made for orientation of new employees, contractors, and volunteers.

(2) All staff, contractors, and volunteers must receive, at a minimum, quarterly in-service training and staff development that meets their individual training needs to support program services. This must be documented and readily accessible in the personnel file and in a general file.

(3) Staff, contractors, and volunteers must receive training about documentation, reporting requirements, and universal precautions.

(4) At a minimum, one staff person per shift must be trained and certified in CPR.

(5) Staff and volunteers must receive training on all applicable policies and procedures.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0762, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0764 Adult day centers—Medication. (1) The center must develop written medication policies that are explained and accessible to all staff, contractors, volunteers, and participants that have responsibility in this area. At a minimum, policies must meet the following requirements:

(a) Medications must be kept in locked storage. If medications need to be refrigerated, they should be in a locked box, if not in a separate refrigerator dedicated to medication refrigeration.

(b) Medication policies must describe:

(i) Under what conditions licensed program staff will administer medications;

(ii) How medications brought to the program by a client must be labeled;

(iii) How nonprescription medications such as aspirin or laxatives are to be used;

(iv) How the administration of medications will be entered in participant case records as described in WAC 388-71-0744(4); and

(v) Medication policies must be consistent with laws governing medication administration under RCW 69.41.010 and chapter 246-888 WAC.

(2) Participants who need to take medications while at the center, and who are able to self-medicate, must be encouraged and expected to bring and take their own medications as prescribed. Some participants may need assistance with their medications, and a few may need to have their medications administered by qualified program staff.

(3) In order for center staff to administer any prescribed medication, there must be a written authorization from the participant's authorizing practitioner stating that the medication is to be administered at the program site.

(2007 Ed.)

(4) Staff must be trained to observe medication usage and effects, and to document and report any concerns or difficulties with medications.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0764, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0766 Adult day centers—Facility. (1) Selection of a location for a center must be based on information about potential participants in the service area and be made in consultation with other agencies, organizations, and institutions serving older individuals and those with functional impairments, as well as considering the availability of a suitable location.

(2) Centers must have available a current floor plan of the facility indicating usage of space with interior measurements, building inspection report, fire department inspection report, and the local health department inspection report if operating a kitchen.

(3) The facility must comply with applicable state, county, and local building regulations, zoning, fire, and health codes or ordinances.

(4) When possible, the facility should be located at street level. If the facility is not located at street level, it is essential to have a ramp and/or elevators. An evacuation plan for relocation of participants must also be in place in the event of an emergency.

(5) Each adult day center co-located in a facility housing other services must have its own separate identifiable space for main activity areas during operational hours. Certain space can be shared, such as the kitchen and therapy rooms.

(6) Each center must provide appropriate hardware on doors of storage rooms, closets, bathrooms, and other rooms to prevent participants from being accidentally locked in.

(7) When possible, the location should be within a transit authority's core service area.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0766, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0768 Adult day centers—Physical environment requirements. (1) The facility must have sufficient space to accommodate the full range of program activities and services. The facility must be adaptable to accommodate variations of activities (group and/or individual) and services. The program must provide and maintain essential space necessary to provide services and to protect the privacy of the participants receiving services. There must be sufficient private space to permit staff to work effectively and without interruption. There must be sufficient space available for private discussions.

(2) The facility must provide at least sixty square feet of program space for multipurpose use for each day center participant. In determining adequate square footage, only those activity areas commonly used by participants are to be included. Dining and kitchen areas are to be included only if these areas are used by clients for activities other than meals. Reception areas, storage areas, offices, restrooms, passageways, treatment rooms, service areas, or specialized spaces used only for therapies are not to be included when calculating square footage.

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(3) Storage space.

(a) There must be adequate storage space for program and operating supplies.

(b) Toxic substances, whether for activities or cleaning, must be stored in an area not accessible to participants. Substances must be clearly marked, the contents identified, and stored in original containers.

(4) Restrooms.

(a) The facility's restrooms must be located as near the activity area as possible, preferably no more than forty feet away. The facility must include at least one toilet for every ten participants.

(b) Programs that have a large number of participants who require more scheduled toileting or assistance with toileting must have at least one toilet for every eight participants.

(c) The toilets shall be equipped for use by mobility-limited persons and easily accessible from all program areas. One toilet area should be designed to allow assistance from one or two staff. More accessible units may be required based upon the needs of the participants.

(d) Each restroom must contain an adequate supply of soap, toilet tissues, and paper towels.

(e) Showers are to be accessible to those who require bathing as a core service.

(5) Rest area.

(a) In addition to space for program activities, the facility must have a rest area and designated areas to permit privacy and to isolate participants who become ill or disruptive, or who may require rest.

(b) The rest area must be located away from activity areas and near a restroom and the nurse's office. There must be at least one bed, couch, or recliner for every ten participants that can be used for resting or the isolation of a participant who is ill or suspected of coming down with a communicable disease.

(c) If beds are used, the mattresses must be protected and linens changed after each use by different participants.

(6) Loading zones/parking/entrances/exits.

(a) A loading zone with sufficient space for getting in and out of a vehicle must be available for the safe arrival and departure of participants and the use of emergency personnel.

(b) There must be sufficient parking available to accommodate family caregivers, visitors, and staff.

(c) When necessary, arrangements must be made with local authorities to provide safety zones for those arriving by motor vehicle and adequate traffic signals for people entering and exiting the facility.

(d) Adequate lighting must be provided in all loading and parking zones, entrances, and exits.

(e) An adult day center must be visible and recognizable as a part of the community. The entrance to the facility must be clearly identified. The center must also be appealing and protective to participants and others.

(f) At least two well-identified exits must be accessible from the building.

(7) Atmosphere and design.

(a) The center's design must facilitate the participants movement throughout the facility and encourage involvement in activities and services.

(b) The environment must reinforce orientation and awareness of the surroundings by providing cues and information about specific rooms, locations, and functions that help the participant to get his/her orientation to time and space.

(c) A facility must be architecturally designed in conformance with the requirements of section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act to accommodate individuals with a disability and meet any state and local barrier-free requirements.

(d) Illumination levels in all areas must be adequate, and careful attention must be given to avoiding glare. Attention must be paid to lighting in transitional areas, such as outside to inside and between different areas of the facility.

(e) Sound transmission must be controlled. Excessive noise, such as fan noise, must be avoided.

(f) Comfortable conditions must be maintained within a comfortable temperature range. Excessive drafts must be avoided uniformly throughout the facility.

(g) Sufficient furniture must be available for the entire population present. Furnishings must accommodate the needs of participants and be attractive, comfortable, sturdy, and safe. Straight-backed chairs with arms must be used during activities and meals.

(h) A telephone must be available for participant use. Local calls are to be available at no cost to the participant.

(8) Safety and sanitation.

(a) The facility and grounds must be safe, clean, and accessible to all participants, and must be designed, constructed, and maintained in compliance with all applicable local, state, and federal health and safety regulations.

(b) Nonslip surfaces or bacteria-resistant carpets must be provided on stairs, ramps, and interior floors.

(c) Alarm/warning systems are necessary to ensure the safety of the participants in the facility in order to alert staff to potentially dangerous situations. It is recommended that call bells be installed or placed in the rest areas, restroom stalls, and showers.

(d) An evacuation plan/disaster plan must be strategically posted in each facility.

(e) The facility must be free of hazards, such as high steps, steep grades, and exposed electrical cords. Steps and curbs must be painted and the edges of stairs marked appropriately to highlight them. All stairs, ramps, and bathrooms accessible to those with disabilities must be equipped with securely anchored handrails.

(f) Emergency first-aid kits must be visible and accessible to staff. Contents of the kits must be replenished after use and reviewed as needed.

(g) Maintenance and housekeeping must be carried out on a regular schedule and in conformity with generally accepted sanitation standards, without interfering with the program.

(h) If smoking is permitted, an adequately ventilated area away from the main program area must be provided and supervised.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0768, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0770 Adult day center—Food and nutrition services. Centers must provide meal service to all participants as outlined in WAC 388-71-0704 and 388-71-0706

(1) All meals provided are to meet one-third of the minimum required daily allowance or dietary reference intake as determined by the Food and Nutrition Board of the Institute of Medicine.

(2) The center must ensure that food served meets nutritional needs, takes into consideration individual and ethnic preferences to the extent reasonably possible, caloric need, special dietary requirements, and any physical condition making food intake difficult.

(3) The center must provide a variety of foods and not repeat menus for a minimum of three weeks.

(4) Participant input must be gathered when planning meals.

(5) Menus must be posted at least one week in advance; indicate the date, day of the week, month and year; and include all food and snacks served that contribute to nutritional requirements.

(6) Nutrient concentrates, supplements, and dysphagia-modified diets related to a choking or aspiration risk, are to be served only with the written approval of the participant's physician.

(7) Safe and sanitary handling, storage, preparation, and serving of food must be assured. If meals are prepared on the premises, kitchen appliances, food preparation area, and equipment must meet state and local requirements.

(8) All staff and volunteers handling or serving meals must have the appropriate food handler's permits, if applicable.

(9) In the event meals are prepared at a separate kitchen facility, the adult day center must ensure that persons preparing food have a food handler's permit and that the food is transported in airtight containers to prevent contamination.

(10) The center must ensure that the food is transported and served at the appropriate and safe temperature.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0770, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0772 Adult day centers—Emergency procedures. (1) A written emergency/disaster/earthquake plan must be posted at each program site and in all program owned vehicles. Staff must be trained to ensure smooth implementation of the emergency plan.

(2) All staff and volunteers must be trained in evacuation/fire safety procedures.

(3) A written illness/injury/medical emergency/death procedure must be followed in the event a participant becomes ill, is injured, or dies. The procedures must be posted in at least one visible location at all program sites and must be explained to staff, volunteers, and participants. The procedures must describe arrangements for hospital inpatient and emergency room service and include directions on how to secure ambulance transportation and complete incident reports.

(4) Procedures for fire safety as approved by the local fire authority must be adopted and posted, including provisions for fire drills, inspection and maintenance of fire extin-

guishers, and periodic inspection and training by fire department personnel. The center must conduct and document quarterly fire drills and document the center's ability to meet procedures. Improvements must be based on the fire drill evaluation. Smoke detectors must also be used.

(5) Each center must provide adequate emergency lighting or flashlights in all areas.

(6) Each center must provide and maintain first aid kits in adequate numbers to meet the needs of the participant and staff.

(7) Each center must ensure, in accordance with local emergency procedures, that supplies, food, water and equipment are available in the event power, heat and/or electricity are not available during an emergency.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0772, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0774 Adult day centers—Quality assurance and improvement. (1) Every adult day center must develop a quality improvement plan, with specific measurable objectives, designed to meet requirements of any licensing, funding sources, professional standards, or regulatory compliance.

(2) Policies and procedures for monitoring program quality and determining further action must be developed by the administrator with the advice of the multidisciplinary staff team and the advisory committee, and with the approval of the governing body and center clients and/or representatives.

(3) Quality assurance and improvement plans may include but are not limited to annual evaluations, utilization reviews, participant satisfaction surveys, and participant improvement and/or care plan audits.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0774, filed 2/24/03, effective 7/1/03.]

WAC 388-71-0776 Effective date. WAC 388-71-0702 through 388-71-0776 are effective July 1, 2003.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.200, 74.08.090, 74.09.520, and 74.39A.030. 03-06-024, § 388-71-0776, filed 2/24/03, effective 7/1/03.]

Chapter 388-76 WAC

ADULT FAMILY HOMES MINIMUM LICENSING REQUIREMENTS

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 388-76-010 Authority. [Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-010, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-010, filed 12/18/85.]

	Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.		
388-76-020	Adult family homes. [Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-020, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-020, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-087	Inspections. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-087, filed 10/1/92, effective 11/1/92. Statutory Authority: RCW 70.128.040, 91-09-016 (Order 3131), § 388-76-087, filed 4/9/91, effective 5/10/91. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-087, filed 1/16/90, effective 2/16/90.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
388-76-030	Definitions. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-030, filed 10/1/92, effective 11/1/92. Statutory Authority: RCW 70.128.040, 91-09-016 (Order 3131), § 388-76-030, filed 4/9/91, effective 5/10/91. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-030, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-030, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-090	Licensure—Denial, suspension, or revocation. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-090, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-090, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-090, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
388-76-040	Application or renewal for license. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-040, filed 10/1/92, effective 11/1/92. Statutory Authority: RCW 70.128.040, 91-09-016 (Order 3131), § 388-76-040, filed 4/9/91, effective 5/10/91. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-040, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-040, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-095	License action notice—Adjudicative proceeding. [Statutory Authority: RCW 74.08.044, 90-24-029 (Order 3107), § 388-76-095, filed 11/30/90, effective 1/1/91. Statutory Authority: RCW 34.05.220 (1)(a) and 74.08.044, 90-04-071 (Order 3003), § 388-76-095, filed 2/5/90, effective 3/1/90.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
388-76-045	Unlicensed facilities. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-045, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-045, filed 1/16/90, effective 2/16/90.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-100	License fees. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-100, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-100, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-100, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
388-76-050	Licensing of state employees. [Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-050, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-050, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-110	Discrimination prohibited. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-110, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-110, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-110, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
388-76-060	Limitations on licenses. [Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-060, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-060, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-130	Persons subject to licensing. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-130, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-130, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-130, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
388-76-070	General qualifications of provider, staff persons, and other persons on the premises. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-070, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-070, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-070, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-140	Persons not subject to licensing. [Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-140, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044, 86-01-079 (Order 2319), § 388-76-140, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
388-76-080	Multiple facility ownership. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-080, filed 10/1/92, effective 11/1/92. Statutory Authority: RCW 74.08.044, 89-05-033 (Order 2761), § 388-76-080, filed 2/13/89.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-155	Exceptions. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-155, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-155, filed 1/16/90, effective 2/16/90.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
388-76-085	General standards. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-085, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427, 90-03-051 (Order 2934), § 388-76-085,	388-76-160	Capacity. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-160, filed 10/1/92,

	effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-160, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-160, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	
388-76-170	Providers' or resident managers' outside employment. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-170, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-170, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 89-05-033 (Order 2761), § 388-76-170, filed 2/13/89; 86-01-079 (Order 2319), § 388-76-170, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-260
388-76-180	Provider or resident manager absence from home. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-180, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-180, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-180, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-280
388-76-185	Placement of residents outside home. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-185, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-185, filed 1/16/90, effective 2/16/90.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-290
388-76-190	Effect of local ordinances. [Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-190, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-190, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-300
388-76-200	Fire safety. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-200, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-200, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-200, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-310
388-76-220	Corporal punishment and physical and chemical restraints. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-220, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-220, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-220, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-320
388-76-240	Resident's records and information. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-240, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-240, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-240, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-325
388-76-250	Reporting of illness, death, injury, epidemic, or adult abuse. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-250, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-250, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-250, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-330
	Reporting change in circumstances. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-260, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-260, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-260, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	388-76-340
	Provider or resident manager-provided transportation for residents. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-280, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-280, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-280, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	
	Clothing. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-290, filed 10/1/92, effective 11/1/92. Statutory Authority: RCW 74.08.044. 90-24-028 (Order 3106), § 388-76-290, filed 11/30/90, effective 1/1/91. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-290, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-290, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	
	Personal hygiene. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-300, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-300, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-300, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	
	Training. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-310, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-310, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-310, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	
	Site. [Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-320, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	
	Telephone. [Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-325, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	
	Safety and maintenance. [Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-330, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	
	Water safety. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-340, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-340, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-340, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.	

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- 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
- 388-76-490 Medication services. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-490, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-490, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-490, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
- 388-76-500 Self-administration of medications. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-500, filed 10/1/92, effective 11/1/92. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-500, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
- 388-76-520 Infection control, communicable disease. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-520, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-520, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-520, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
- 388-76-530 Food services. [Statutory Authority: Chapter 70.128 RCW. 92-20-050 (Order 3466), § 388-76-530, filed 10/1/92, effective 11/1/92. Statutory Authority: 1989 c 427. 90-03-051 (Order 2934), § 388-76-530, filed 1/16/90, effective 2/16/90. Statutory Authority: RCW 74.08.044. 86-01-079 (Order 2319), § 388-76-530, filed 12/18/85.] Repealed by 96-14-003 (Order 3984), filed 6/19/96, effective 7/20/96. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230.
- 388-76-59020 What definitions apply to specialty adult family home designations? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59020, filed 5/29/98, effective 7/1/98.] Repealed by 05-17-158, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040.
- 388-76-59100 Does completion of this training substitute for any other required trainings? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59100, filed 5/29/98, effective 7/1/98.] Repealed by 02-15-065, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233.
- 388-76-59110 For the dementia and mental health specialties can providers take a test instead of attending the training? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59110, filed 5/29/98, effective 7/1/98.] Repealed by 02-15-065, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233.
- 388-76-59120 Are there any different training requirements for adult family homes providing services to persons with developmental disabilities? [Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59120, filed 5/29/98, effective 7/1/98.] Repealed by 02-15-065, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233.
- 388-76-640 Resident medications. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-640, filed 6/19/96, effective 7/20/96.] Repealed by 02-20-005, filed 9/18/02, effective 10/19/02. Statutory Authority: RCW 70.128.040, 69.41.085.
- 388-76-64005 Definitions. [Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64005, filed 9/18/02, effective 10/19/02.] Repealed by 05-17-158, filed

- 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040.
- 388-76-765 Fire safety. [Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-765, filed 6/19/96, effective 7/20/96.] Repealed by 02-20-004, filed 9/18/02, effective 10/19/02. Statutory Authority: RCW 70.128.040, 70.128.130, and 70.128.140.
- 388-76-9970 Purpose. [Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9970, filed 9/3/97, effective 9/4/97.] Repealed by 05-17-158, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040.
- 388-76-9972 Definitions. [Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9972, filed 9/3/97, effective 9/4/97.] Repealed by 05-17-158, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040.
- 388-76-9974 Effective date of the moratorium. [Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9974, filed 9/3/97, effective 9/4/97.] Repealed by 05-17-158, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040.
- 388-76-9976 Process for requesting an individual accommodation. [Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9976, filed 9/3/97, effective 9/4/97.] Repealed by 05-17-158, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.-040.
- 388-76-9978 Applications that will be processed during the moratorium. [Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9978, filed 9/3/97, effective 9/4/97.] Repealed by 05-17-158, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040.
- 388-76-9980 Notification of the end of the moratorium. [Statutory Authority: 1997 c 392 §§ 402, 403 and 532 (E2SHB 1850). 97-18-089, § 388-76-9980, filed 9/3/97, effective 9/4/97.] Repealed by 05-17-158, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040.

PART I AUTHORITY AND DEFINITIONS

WAC 388-76-535 Authority. The following rules are adopted under RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210, 18.88A.230, and 69.41.-085.

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-15-081, § 388-76-535, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.-230. 96-14-003 (Order 3984), § 388-76-535, filed 6/19/96, effective 7/20/96.]

WAC 388-76-540 Definitions. "Abandonment" means action or inaction by a person or entity with a duty of care for a frail elder or vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means a nonaccidental act of physical or mental mistreatment or injury, or sexual mistreatment, which harms a person through action or inaction by another individual.

"Adult family home" means the same as the definition in RCW 70.128.010.

"Applicant" means an individual, partnership, corporation, or other entity seeking a license to operate an adult family home.

"Capacity" means the maximum number of persons in need of personal or special care permitted in an adult family home at a given time. This number shall include related children or adults in the home who receive special care.

"Caregiver" means any person eighteen years of age or older responsible for providing direct personal care to a resident and may include but is not limited to the provider, resident manager, employee, relief caregiver, volunteer, student, entity representative, or household member.

"Case manager" means the department staff person or designee assigned to negotiate, monitor, and facilitate a service plan for residents receiving services fully or partially paid for by the department.

"Chemical restraint" means a psychopharmacologic drug that is used for discipline or convenience and not required to treat the resident's medical symptoms.

"Dementia" is defined as a condition documented through the assessment process required by WAC 388-76-61020.

"Department" means the Washington state department of social and health services.

"Developmental disability" means:

(1) A person who meets the eligibility criteria defined in Washington Administrative Code by the division of developmental disabilities under WAC 388-823-0040; or

(2) A person with a severe, chronic disability which is attributable to cerebral palsy or epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation which results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, and requires treatment or services similar to those required for these persons (i.e., autism); and

(a) The condition was manifested before the person reached age twenty-two;

(b) The condition is likely to continue indefinitely; and

(c) The condition results in substantial functional limitations in three or more of the following areas of major life activities:

- (i) Self-care;
- (ii) Understanding and use of language;
- (iii) Learning;
- (iv) Mobility;
- (v) Self-direction; and
- (vi) Capacity for independent living.

"Enablers" means a physical device used to facilitate a resident's self-administration of a prescribed or over-the-counter medication. Physical devices include, but are not limited to a medicine cup, glass, cup, spoons, bowl, pre-filled syringes, syringes used to measure oral liquids, specially adapted table surfaces, drinking straw, piece of cloth, and the resident's hand.

"Entity provider" means any corporation, partnership, association, or limited liability company that is licensed under this chapter to operate an adult family home.

"Entity representative" means the individual designated by an entity provider who is responsible for the daily operation of the adult family home.

"Exploitation" means the illegal or improper use of a frail elder or vulnerable adult or that person's income or resources, including trust funds, for another person's profit or advantage.

"Frail elder or vulnerable adult" means the same as the definition in RCW 74.34.020 or 43.43.830.

"Individual provider" means an individual person or a legally married couple who is licensed to operate an adult family home.

"Inspection" means an on-site visit by department personnel to determine the adult family home's compliance with this chapter and chapter 70.128 RCW, Adult family homes.

"Medication organizer" is a container with separate compartments for storing oral medications organized in daily doses.

"Mental illness" is defined as an Axis I or II diagnosed mental illness as outlined in volume IV of the Diagnostic and Statistical Manual of Mental Disorders (a copy is available for review through the aging and disability services administration).

"Multiple facility provider" means an individual or entity provider who is licensed to operate more than one adult family home.

"Neglect" means a pattern of conduct or inaction resulting in deprivation of care necessary to maintain a resident's physical or mental health.

"Nursing assistant" means the same as the definition in chapter 18.88A RCW.

"Over-the-counter (OTC) medication" is any medication that can be purchased without a prescriptive order, including but not limited to vitamin, mineral, or herbal preparations.

"Personal care services" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks as determined by the resident's needs. Personal care services do not include assistance with tasks performed by a licensed health professional.

"Physical restraint" means a manual method, obstacle, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that restricts freedom of movement or access to his or her body, is used for discipline or convenience, and not required to treat the resident's medical symptoms.

"Practitioner" includes a physician, osteopathic physician, podiatric physician, pharmacist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, dentist, and physician assistant. Refer to chapter 69.41 RCW for a complete listing of practitioners.

"Prescribed medication" refers to any medication (legend drug, controlled substance, and over-the-counter) that is prescribed by an authorized practitioner.

"Provider" means any person or entity that is licensed under this chapter to operate an adult family home.

"Resident" means any adult unrelated to the provider who lives in the adult family home and who is in need of care. **"Resident"** includes former residents when examining complaints about admissions, readmissions, transfers or discharges. For decision-making purposes, the term "resident" includes the resident's surrogate decision maker in accordance with state law or at the resident's request.

"Resident manager" means a person employed or designated by the provider to manage the adult family home.

"Special care" means care beyond personal care services as defined by **"personal care services"** in this section.

"Unsupervised" means the same as the definition in RCW 43.43.830(9).

[Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-540, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090, 02-21-098, § 388-76-540, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW, 98-11-095, § 388-76-540, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-540, filed 6/19/96, effective 7/20/96.]

PART II ADULT FAMILY HOME LICENSE

WAC 388-76-545 License required. No person or entity shall operate an adult family home without a license under this chapter. An adult family home license is required to provide care to more than one but not more than six adults unrelated to the person(s) providing care in the home.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-545, filed 6/19/96, effective 7/20/96.]

WAC 388-76-550 License application. (1) All applications for adult family home licensure are subject to review under this chapter.

(2) Persons who have not held an adult family home license within the last twelve months must attend department orientation to receive an initial adult family home application.

(3)(a) To apply for an initial adult family home license, an applicant shall complete and submit the department application form.

(b) The applicant must provide all information requested, including information regarding any facilities and homes for the care or provision of services to children or vulnerable adults that the applicant is or has been affiliated with in the last ten years. This information is needed so the department can determine whether the applicant meets all applicable qualifications and requirements.

(c) An entity shall provide the information in (b) of this subsection with regard to any partner, officer, director, managerial employee, or owner of five percent or more of the entity.

(4)(a) An adult family home license is a nonexpiring license which means it does not need to be renewed every year.

(b) The adult family license remains valid unless:

(i) The department takes enforcement action to suspend or revoke the license in accordance with state law;

(ii) The provider voluntarily surrenders the license or closes the home; or

(iii) The provider fails to pay the annual licensing fee.

(5) All entity providers shall include their Unified Business Identifier (UBI) and Federal Employer Identification (FEI) numbers on the application.

(6) Married couples may not apply for separate adult family home licenses for each spouse.

(7)(a) Couples considered legally married under Washington state law are the only individuals who may apply jointly for an individual provider adult family home license.

(b) After the effective date of these rules two (or more) unmarried individuals applying for an initial adult family home license to be held jointly, must become an entity pro-

vider by forming a corporation, partnership, association, or limited liability company.

(8) The license applicant/provider shall be the person or entity ultimately responsible for the operation of the adult family home. The license applicant or the applicant's authorized representative shall sign the adult family home license application.

(9)(a) All entity providers shall designate an individual on their adult family home application who is responsible for the daily operation of the adult family home. This person is called the entity representative and is considered the department's primary contact person within the entity organization.

(b) For some entity providers one person may act as both the entity representative and the resident manager.

(c) Entity providers shall immediately notify their licensor when there is a change in the entity representative.

(10) An applicant who enters into a lease or contractual agreement with a landlord who takes an active interest in the operation of the adult family home, shall include the landlord's name and address on the license application. Active interest includes but is not limited to:

(a) The charging of rent as a percentage of the business;

(b) Assistance with start up and operational expenses;

(c) Collection of resident fees;

(d) Recruitment of residents;

(e) Management oversight;

(f) Assessment and negotiated care plan development for residents; or

(g) The provision of personal or special care to residents.

(11) The department shall not commence review of an incomplete license application, and incomplete applications shall become void sixty days following the department's written request for additional documentation or information to complete the application.

[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW, 98-11-095, § 388-76-550, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-550, filed 6/19/96, effective 7/20/96.]

WAC 388-76-555 License fees. (1) The adult family home license fee is fifty dollars per home per year.

(2) The provider shall submit the annual license fee to the department at the time of the application for license renewal. The annual license fee shall be refundable if the department denies the license renewal application.

(3) For the initial licensure of a new adult family home, the license applicant shall submit the annual license fee with the license application. The annual license fee shall be refundable if the department denies the license application.

(4) Applicants completing an initial license application shall submit a fifty dollar processing fee with the application in addition to the required annual license fee payment. The processing fee is nonrefundable.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-555, filed 6/19/96, effective 7/20/96.]

WAC 388-76-560 License eligibility. (1) The department shall consider separately and jointly as applicants each person and entity named or affiliated in an application for an

adult family home license. A person is considered affiliated with the applicant if the person is listed on the application as a partner, officer, director, resident manager, or majority owner of the applying entity, or is the spouse of the applicant. If the department finds any person or entity unqualified, the department shall deny the license.

(2) In making a determination whether to grant an adult family home license, the department shall review:

(a) The information in the application; and

(b) Other documents and information the department deems relevant, including inspection and complaint investigation findings in each facility or home for the care or provision of services to children or vulnerable adults with which the applicant or any partner, officer, director, managerial employee, or owner of five percent or more of the entity applicant is or has been affiliated.

(3) The applicant and the home for which the license is sought shall comply with all requirements established by chapter 70.128 RCW and this chapter. The department may deny a license for noncompliance with any such requirements.

(4) An individual provider shall be twenty-one years of age or older.

(5) A provider shall have the understanding, ability, emotional stability and physical health suited to meet the emotional and physical care needs of vulnerable adults.

(6) An adult family home shall not simultaneously be licensed as a boarding home.

(7) The department shall deny, suspend or revoke a license if any of the following people have a history of significant noncompliance with federal or state regulations in providing care or services to vulnerable adults or children:

- An applicant/provider,
- A person affiliated with the applicant,
- A resident manager,
- A partner of the entity,
- An officer of the entity,
- A director of the entity,
- A managerial employee of the entity,
- An entity representative,
- Spouse of the provider, or
- An owner of five percent or more of the entity.

The department shall consider, at a minimum, the following as a history of significant noncompliance requiring denial of a license:

(a) Revocation or suspension of a license for the care of children or vulnerable adults;

(b) Enjoined from operating a facility for the care of children or adults;

(c) Revocation, cancellation, suspension, or nonrenewal of a Medicaid or Medicare provider agreement by the contracting agency; or

(d) Revocation, cancellation, suspension, or nonrenewal of any agreement with a public agency for the care or treatment of children or vulnerable adults, when the action is taken by the public agency.

(8) The department may deny, suspend or revoke a license if any of the following people meet any of the criteria under subsection (9) of this section:

- Any person who is a caregiver;

• Any person who has unsupervised access to residents in the adult family home; or

• Any person who lives in the home but who is not a resident.

(9) The department shall deny, suspend or revoke a license if:

- An applicant/provider,
- A person affiliated with the applicant,
- Any person who is a caregiver,
- Any person who has unsupervised access to residents in the adult family home,
- Any person who lives in the home but who is not a resident,

- A resident manager,
 - A partner of the entity,
 - An officer of the entity,
 - A director of the entity,
 - A managerial employee of the entity,
 - An entity representative,
 - A spouse of the provider,
 - An owner of fifty percent or more of the entity, or
 - An owner who exercises control over daily operations,
- has been:

(a) Convicted of a crime against a person as defined under RCW 43.43.830 or 43.43.842;

(b) Convicted of a crime relating to financial exploitation as defined under RCW 43.43.830 or 43.43.842;

(c) Found by a court in a protection proceeding under chapter 74.34 RCW to have abused or financially exploited a vulnerable adult;

(d) Found in any final decision issued by a disciplinary board to have sexually or physically abused or exploited any minor or a person with a developmental disability or to have abused or financially exploited any vulnerable adult;

(e) Found in any dependency action under RCW 13.34.030 (5)(b) to have sexually abused or exploited any minor or to have physically abused any minor; or

(f) Found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor.

(10) The department may deny, suspend or revoke a license, if:

- An applicant/provider,
- A person affiliated with the applicant,
- Any person who is a caregiver,
- Any person who has unsupervised access to residents in the adult family home,
- Any person who lives in the home but who is not a resident,

- A resident manager,
- A partner of the entity,
- An officer of the entity,
- A director of the entity,
- A managerial employee of the entity,
- An entity representative,
- A spouse of the provider,
- An owner of fifty percent or more of the entity, or
- An owner who exercises control over daily operations

has:

(a) Obtained or attempted to obtain a license by fraudulent means or misrepresentation;

(b) Permitted, aided, or abetted the commission of any illegal act on the adult family home premises;

(c) Been convicted of a felony or a crime against a person if the conviction reasonably relates to the competency of the person to own or operate an adult family home;

(d) Had sanction, corrective, or remedial action taken by federal, state, county, or municipal health or safety officials related to the care or treatment of children or vulnerable adults;

(e) Engaged in or been convicted of the illegal use of drugs or the excessive use of alcohol within the past five years without evidence of rehabilitation;

(f) Been convicted of the illegal selling or distribution of drugs;

(g) Been convicted of any crime involving a firearm used in the commission of a felony or in an act of violence against a person;

(h) Operated a facility for the care of children or adults without a license;

(i) Misappropriated property of residents;

(j) Been denied a license or license renewal to operate a facility that was licensed for the care of children or vulnerable adults;

(k) Relinquished or returned a license in connection with the operation of any facility for the care of children or vulnerable adults, or did not seek the renewal of such license, following written notification of the licensing agency's initiation of denial, suspension, cancellation or revocation of the license;

(l) Had resident trust funds or assets of an entity providing care to children or vulnerable adults seized by the IRS or a state entity for failure to pay income or payroll taxes;

(m) Refused to permit authorized department representatives to interview residents or have access to resident records;

(n) Interfered with a long term care ombudsman in the performance of his or her official duties;

(o) Exceeded licensed capacity in the operation of an adult family home; or

(p) Been found by the court in a proceeding under Title 26 RCW to have committed an act of domestic violence toward a family or household member.

(11) The department may deny, suspend or revoke a license if:

- An applicant,
- A provider,
- A resident manager,
- A partner of the entity,
- An officer of the entity,
- A director of the entity,
- A managerial employee of the entity,
- An entity representative,
- An owner of fifty percent or more of the entity, or
- An owner who exercises control over daily operations,

Failed to meet financial obligations as the obligations fell due in the normal course of business, thereby impeding his/her ability to care for residents.

(12) The department shall deny an adult family home license to an applicant who is licensed to care for children in the same home unless:

(a) It is necessary in order to allow a resident's child(ren) to live in the same home as the resident or to allow a resident who turns eighteen to remain in the home;

(b) The applicant provides satisfactory evidence to the department of the home's capability to meet the needs of children and adults residing in the home; and

(c) The total number of persons receiving care in the home does not exceed the number permitted by the licensed capacity of the adult family home.

[Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-560, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW, 98-11-095, § 388-76-560, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-560, filed 6/19/96, effective 7/20/96.]

WAC 388-76-565 Resident manager and live-in requirements. (1) The adult family home provider shall either:

(a) Reside at the adult family home; or

(b) Employ or otherwise contract with a qualified resident manager who resides at the adult family home and who is responsible for the care of residents at all times.

(2) An entity provider must designate a qualified resident manager.

(3) The provider or resident manager shall be exempt from the requirement to live at the adult family home if:

(a) The adult family home has twenty-four hour staffing coverage; and

(b) A qualified staff person or caregiver who can make needed decisions is always present.

(4) Multiple facility providers shall have a qualified resident manager for each adult family home who is responsible for the care of residents at all times. Resident managers may not manage more than one adult family home.

(5) A resident manager shall be twenty-one years of age or older.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-565, filed 6/19/96, effective 7/20/96.]

WAC 388-76-570 Additional license requirements—Multiple facility providers. (1) The department shall not issue a license to a provider to operate more than one adult family home unless:

(a) The applicant has operated an adult family home for at least one year in this state without any significant violation of the rules of this chapter; or

(b) The applicant has submitted evidence demonstrating that it has the capability to operate multiple adult family homes.

(2) An applicant that is applying to be licensed for more than one adult family home shall submit to the department for each adult family home:

(a) A twenty-four hour per day, seven days per week, staffing plan; and

(b) A plan for covering administrative responsibilities.

(3) Multiple facility providers shall have on-site at each adult family home a plan that addresses visitor parking, deliveries, and staff parking.

(4) The department may consider the applicant's credit history in determining whether to license the applicant for

more than two adult family homes, when the department determines the credit history relates to an applicant's ability to provide care and services to vulnerable adults.

(5) Prior to operating two or more adult family homes, the individual provider or entity representative shall successfully complete forty-eight hours of residential care administrator's training, as specified in WAC 388-112-0265 through 388-112-0285.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233, 02-15-065, § 388-76-570, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW, 98-11-095, § 388-76-570, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-570, filed 6/19/96, effective 7/20/96.]

WAC 388-76-575 Licensing of state employees. (1) Aging and disability services administration employees and any member of an employee's household shall be prohibited from obtaining an adult family home license.

(2) Department employees and any member of the employee's household shall be prohibited from obtaining an adult family home license when the employee's duties include:

(a) Placement of persons in a licensed adult family home; or

(b) Authorizing payment for such persons.

[Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-575, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-575, filed 6/19/96, effective 7/20/96.]

WAC 388-76-580 License capacity. (1) The department shall license an adult family home for no more than six residents. The license capacity includes:

(a) All unrelated adults who need personal or special care; and

(b) Other household members, including relatives, who receive special care.

(2) The department shall license an adult family home for the care of two to six residents. In determining the appropriate capacity, the department shall consider:

(a) The structural design of the house;

(b) The number and qualifications of staff;

(c) The total household composition, including children and other household members who require personal or special care;

(d) The number of persons for whom the home provides adult day care;

(e) The needs of all persons residing in the home; and

(f) Safe evacuation of all people living in the adult family home.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-580, filed 6/19/96, effective 7/20/96.]

WAC 388-76-585 Change of provider or provider address. (1) A change of provider occurs when there is a substitution of:

(a) The provider ultimately responsible for the daily operational decisions of the adult family home; or

(b) Control of an entity provider.

(2007 Ed.)

(2) Events which constitute a change of provider include but are not limited to the following:

(a) The form of legal organization of the provider is changed (e.g., an individual provider forms a partnership, corporation, association, or dissolution or merger of a licensed entity with another legal organization);

(b) Operational responsibilities are transferred by the initial provider to another party regardless of whether ownership of some or all of the real property and/or personal property assets of the adult family home is also transferred;

(c) Two individuals are both licensed as a married couple to operate the adult family home and an event, such as divorce, occurs which results in only one of the individuals operating the home;

(d) If the provider is a partnership, any event occurs which dissolves the partnership;

(e) If the provider is a corporation, and the corporation:

(i) Is dissolved;

(ii) Merges with another corporation which is the survivor; or

(iii) Consolidates with one or more corporations to form a new corporation;

(f) If the provider is a corporation and, whether by a single transaction or multiple transactions within any continuous twenty-four month period, fifty percent or more of the stock is transferred to one or more:

(i) New or former stockholders; or

(ii) Present stockholders each having held less than five percent of the stock before the initial transaction; or

(g) Any other event or combination of events which results in a substitution or substitution of control of the provider.

(3) An adult family home license is not transferable and is only valid for the location and provider listed on the license. A change in either the provider or the location requires a new license.

(4) The operation or ownership of an adult family home shall not be transferred until the new provider has been issued a license to operate the home. The new provider shall comply with license application requirements.

(5) The provider shall not commence operation of an adult family home at a new location until the department has approved a license for that location.

(6) The provider shall notify the adult family home's residents, in writing, at least thirty days prior to the effective date of a change of provider or location.

(7) The new provider is subject to the provisions of this chapter, the rules adopted under this chapter, and other applicable law.

(8) In order to ensure that the safety of residents is not compromised by a change in provider, the new provider is responsible for correction of all violations that may exist at the time of the new license.

[Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-585, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-585, filed 6/19/96, effective 7/20/96.]

SPECIALTY ADULT FAMILY HOMES

WAC 388-76-590 Specialty adult family homes.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-590, filed 5/29/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-590, filed 6/19/96, effective 7/20/96.]

WAC 388-76-59000 What authority does the department have to adopt rules related to specialty homes? (1) The legislature under RCW 70.128.005 and 70.128.040 authorizes the department to adopt rules to cover the needs of different populations living in adult family homes. This includes, but is not limited to, the developmentally disabled and the elderly.

(2) The department is authorized to adopt rules to cover special care training necessary for adult family home providers or resident managers. The legislature established that, as a minimum qualification, each of the adult family home providers and resident managers must complete special care training before providing special care services. (See RCW 70.128.120.)

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59000, filed 5/29/98, effective 7/1/98.]

WAC 388-76-59010 What types of specialty adult family home designations are there? Adult family homes may be designated as a specialty home in one or more of the following three categories:

- (1) Developmental disability,
- (2) Mental illness, and/or
- (3) Dementia.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59010, filed 5/29/98, effective 7/1/98.]

WAC 388-76-59050 What is required in order to obtain the specialty designation? The department will grant an adult family home a specialty designation for one or more of the three areas of specialty when:

(1) The individual provider or entity representative, and the resident manager, if there is a resident manager, have successfully completed one or more of the specialty care trainings; and

(2) The provider supplies the department with certification of successful completion of the required specialty care training or the challenge test; and

(3) The provider ensures that the specialty needs of the resident are identified and met, and that all caregivers in the home receive training regarding the specialty needs of the individual residents in the home. This training must cover the routine and changing care needs of the resident. The provider or a person knowledgeable about the specialty area may give this training.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59050, filed 5/29/98, effective 7/1/98.]

WAC 388-76-59060 Are adult family home providers required to obtain more than one specialty designation if an individual resident has more than one specialty need? If an individual resident has needs that meet more than one of

the definitions for developmental disability, mental illness, and dementia, described in WAC 388-76-59020, the provider must determine which one of the specialty trainings will most appropriately address the overall needs of the resident. The provider must then obtain the specialty training and designation that corresponds with this determination. The provider must ensure additional training of caregivers is obtained if needed to meet all of the resident's needs. This additional training may be the specialty designation training or another training chosen by the provider.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59060, filed 5/29/98, effective 7/1/98.]

WAC 388-76-59070 Are adult family home providers required to obtain more than one specialty designation if they serve two or more residents with different specialty needs? When adult family home providers serve two or more residents with different specialty needs they must obtain a separate specialty designation for each of the specialty needs. For example, if one resident has needs meeting the definition for dementia, and a second resident has needs meeting the definition for mental illness, the provider must obtain a specialty designation for both dementia and mental illness. In a home where one resident has needs meeting the definition for a developmental disability, a second resident has needs meeting the definition for mental illness, and a third resident has needs meeting the definition for dementia, the provider must obtain a specialty designation for developmental disabilities, mental illness, and dementia.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59070, filed 5/29/98, effective 7/1/98.]

WAC 388-76-59080 When will providers be required to become specialty adult family homes in order to serve persons with mental illness or dementia? Beginning October 1, 1999:

(1) An adult family home is required to become a specialty adult family home in order to admit and serve residents who have been determined to meet the definitions in this section for a mental illness or dementia; and

(2) Individual providers, entity representatives, and resident managers will have one hundred twenty days to complete specialty care training after a resident already living in the home develops mental illness or dementia as defined in this section.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59080, filed 5/29/98, effective 7/1/98.]

WAC 388-76-59090 When will providers be required to become specialty adult family homes in order to serve persons with developmental disabilities? (1) For providers serving persons with developmental disabilities prior to July 1, 1998, the deadline for successfully completing specialty training is July 1, 1999.

(2) All other adult family home providers must obtain a specialty designation before admitting and serving a person with a developmental disability.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-59090, filed 5/29/98, effective 7/1/98.]

WAC 388-76-595 Inspections and ombudsman visits.

(1) The department shall conduct unannounced inspections and complaint investigations to determine the provider's compliance with this chapter and chapter 70.128 RCW.

(2) The provider shall ensure that department staff have access to the home, residents, and all resident records therein and shall not willfully interfere or fail to cooperate with department staff in the performance of official duties. Examples of willful interference or failure to cooperate include but are not limited to, not allowing department staff to talk to residents in private, not allowing department staff entrance into the home, or not allowing department staff access to resident records.

(3) Department staff shall have access to relevant staff records which must be kept in the adult family home. Relevant staff records include: Criminal history background inquiries; tuberculosis test documentation; CPR-first-aid cards; department of health registration; fundamentals of caregiving, modified fundamentals of caregiving, nurse delegation and continuing education certificates; and any other special certificates.

(4) Within ten working days of the inspection of the adult family home, the department's inspection report will be mailed or hand delivered to the provider.

(5) Within ten calendar days of the completion of complaint investigation data collection, any department inspection report related to a complaint investigation will be mailed or hand delivered to the provider.

(6) A provider shall submit to the department the planned corrective measures for violations and/or deficiencies within ten calendar days of receipt of a statement of deficiencies or an inspection report.

(7) Upon request, the department will supply to the public copies of inspection reports and complaint investigation reports, as soon as they are completed.

(8) The department will include a copy of the provider's planned corrective measures with the inspection and complaint investigation reports, if a copy is available at the time of the request.

(9) Any written decision by the department to take an enforcement action will be immediately available to the public.

(10) Subsections (7) through (9) above are subject to applicable public disclosure and confidentiality requirements.

(11) The adult family home shall not willfully interfere with a representative of the Washington protection and advocacy system as defined under RCW 71A.10.080 or the long term care ombudsman in the performance of official duties, as defined under chapter 43.190 RCW, Long-term care ombudsman program, the state regulations for the long-term care ombudsman program, and under federal law. The department shall impose a penalty of not more than one thousand dollars for any such willful interference with a representative from the long-term care ombudsman program.

[Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-595, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW, 98-11-095, § 388-76-595, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-595, filed 6/19/96, effective 7/20/96.]

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PART III RIGHTS AND SERVICES

GENERAL RESIDENT RIGHTS

WAC 388-76-600 General resident rights.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-600, filed 5/29/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.-130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-600, filed 6/19/96, effective 7/20/96.]

WAC 388-76-60000 What are resident rights? (1)

Under RCW 70.129.005 long-term care facility residents should have the opportunity to exercise reasonable control over life decisions.

(2) Long-term care residents should have privacy and choices to engage in religious, political, civic, recreational, and other social activities to foster a sense of self-worth and enhance the quality of life. (See chapter 70.129 RCW.)

(3) Long-term care residents should receive appropriate services, be treated with courtesy, and continue to enjoy their basic civil and legal rights. (See chapter 70.129 RCW.)

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-60000, filed 5/29/98, effective 7/1/98.]

WAC 388-76-60010 Why do providers need to know resident rights? The legislature determined that residents of long term care facilities are entitled to certain rights. The provider is required to comply with all requirements of chapter 70.129 RCW, Long-term care resident rights. The provider must promote and protect the resident's exercise of all rights granted under that law.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-60010, filed 5/29/98, effective 7/1/98.]

WAC 388-76-60020 Is the provider required to supply information to potential residents and current residents, or the resident's representative? RCW 70.128.007(3) states that it is the goal of the legislature to "Encourage consumers, families, providers, and the public to become active in assuring their full participation in development of adult family homes that provide high quality and cost-effective care." The information that the provider supplies to potential residents and their families assists them to make informed choices about whether the individual adult family home will be able to provide appropriate high quality services, and what the costs will be for services.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-60020, filed 5/29/98, effective 7/1/98.]

WAC 388-76-60030 When must this information be supplied? Before admitting any resident, the provider must supply information about the adult family home to the potential resident. This information must also be supplied to current residents at least every twenty four months. The information must be presented orally and in writing in a language understandable to the potential resident or resident, or the resident's representative, and acknowledged in writing.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-60030, filed 5/29/98, effective 7/1/98.]

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WAC 388-76-60040 Must the information be updated and supplied again in advance of changes? The provider must inform each resident or the resident's representative in writing thirty days in advance of changes in the availability or the charges for services, items, or activities, or of changes in the adult family home's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. When there are substantial and continuing changes in the resident's condition necessitating substantially greater or lesser services, items or activities, then the related charges may be changed with fourteen days' advance written notice.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60040, filed 5/29/98, effective 7/1/98.]

WAC 388-76-60050 What information is the provider required to supply to potential residents and current residents? At a minimum, information supplied to the resident prior to admission must include:

- (1) House rules and policies, including:
 - (a) A description of services, items, and activities regularly available in the home or arranged for by the home;
 - (b) House rules and policies governing resident conduct and responsibilities;
 - (c) A statement describing charges for all services, items and activities provided in the home. This must include a description of added charges for items, services or activities that are not covered by the home's per diem rate or applicable public benefit programs;
 - (d) The schedule for payment of fees expected of residents by the provider;
 - (e) The home's policy on refunds and deposits, which must be consistent with RCW 70.129.150;
 - (f) House policies governing resident conduct and responsibilities during the resident's stay in the adult family home;
 - (g) A statement indicating whether the provider will accept Medicaid or other public funds as a source of payment for services.
- (2) Information about caregivers, including:
 - (a) The following information describing the licensed provider and the resident manager if there is a resident manager:
 - (i) Availability in the home, including a general statement about how often he or she is in the home;
 - (ii) Education and training relevant to resident caregiving;
 - (iii) Caregiving experience;
 - (iv) His or her primary responsibilities, including whether he or she makes daily general care management decisions;
 - (v) How to contact the provider or resident manager when he or she is not in the home.
 - (b) The following information describing a licensed practical nurse or registered nurse, if there is one who is in any way involved in the care of residents:
 - (i) Whom the LPN or RN is employed by, including the adult family home or another agency;
 - (ii) The specific routine hours that the LPN or RN is on site, if they are on-site routinely;

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(iii) His or her primary responsibilities, including whether he or she makes daily general care management decisions;

(iv) The nonroutine times when the LPN or RN will be available, such as on-call; and

(vi) A description of what the provider will do to make available the services of an RN or LPN in the event of an emergency or a change in the resident's condition.

(3) A statement indicating whether the provider or staff are qualified or willing to become qualified to perform nurse delegation as allowed under state law;

(4) Types of care that can and cannot be offered:

(a) A description of what the adult family home will try to do to make adjustments to accommodate a resident's foreseeable or likely increasing care needs for the kinds of residents served by the home;

(b) A list of the types of predictable resident needs and conditions for which the adult family home cannot or will not provide care.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60050, filed 5/29/98, effective 7/1/98.]

WAC 388-76-60060 Do residents have rights that are not listed here? Residents have many rights that are listed in detail in chapter 70.129 RCW. The provider must promote and protect all of these rights, in addition to those listed in this section.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60060, filed 5/29/98, effective 7/1/98.]

WAC 388-76-60070 What are some of the other resident rights that must be considered? (1) House policies implemented by the provider are required to be reasonable and must not conflict with rights granted to the resident under chapter 70.129 RCW, Long-term care resident rights or this chapter.

(2) The resident has the right to be fully informed in a language that he or she can understand of his or her total health status, including, but not limited to, his or her medical condition. This right is described in detail in chapter 7.70 RCW. The provider must not interfere with the resident's access to information from health care providers.

(3) The resident has the right to be fully informed in advance about recommended care and treatment and of any recommended changes in that care or treatment.

(4) The provider must not require or ask the resident or the resident's representative to sign any contract or agreement that waives any rights of the resident or waives potential liability for losses of personal property or injury.

(5) The resident shall be free from abuse, neglect, abandonment, or financial exploitation.

(6) The provider must comply with all applicable federal and state statutory requirements regarding nondiscrimination.

(7) The provider must post in a place and manner clearly visible and readable to residents and visitors the department's toll-free complaint telephone number, and the names, addresses, and telephone numbers of the state licensure office, the state ombudsman program, and the protection and advocacy systems. This posting shall include at a minimum all of the information listed on the NOTICE supplied by the

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department containing the toll free complaint hot line and the toll free ombudsman number, and a brief description of ombudsman services.

(8) The provider must post in a place and manner clearly visible and readable to residents and visitors a statement that copies of the results of the most recent licensing inspection, and, if there has been a complaint investigation, the results of the investigation, are available to be read in the adult family home.

(9) The provider is required to maintain a safe, clean, comfortable, and home-like environment, that supports residents in their activities of daily living and promotes their quality of life.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-60070, filed 5/29/98, effective 7/1/98.]

WAC 388-76-605 Restraints. (1) The resident has the right to be free from physical and chemical restraint and involuntary seclusion.

(2) Adult family homes are prohibited from using any and all forms of physical restraint that are used for the purposes of discipline or convenience and are not required to treat the resident's medical symptoms. Treatment of such medical symptoms must be applied and immediately supervised on-site by a licensed registered nurse (RN), licensed practical nurse (LPN) or a licensed physician. Immediate supervision means the licensed registered nurse, the licensed practical nurse, or the licensed physician is in the home and quickly and easily available.

(3) The provider shall ensure that the resident is free from chemical restraints which are:

- (a) Used for discipline or convenience; and
- (b) Not required to treat the resident's medical symptoms.

(4) In any situation where a psychopharmacological drug is used for the resident, the provider shall ensure:

- (a) That it is not used for the purpose of discipline or convenience;
- (b) That it has been prescribed by a physician or health care professional with prescriptive authority;
- (c) The resident's negotiated care plan includes other environmental and behavioral strategies/modifications to address the symptoms for which the psychopharmacological medication has been prescribed, where possible. An actual change in medication will only occur when the prescriber determines it is medically warranted for the resident; and
- (d) The resident or surrogate decision maker has given informed consent for its use.

[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-605, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-605, filed 6/19/96, effective 7/20/96.]

RESIDENT ASSESSMENT

WAC 388-76-610 Resident assessment.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-610, filed 5/29/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-610, filed 6/19/96, effective 7/20/96.]

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WAC 388-76-61000 Is an assessment needed before a person can be admitted to an adult family home? Before a person can be admitted, the provider must obtain a written assessment that contains current information. The contents of this assessment must at a minimum include the list in WAC 388-76-61020.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61000, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61010 Under what circumstances can a provider admit or continue services for a person? A provider must be knowledgeable about the needs of a resident, based on the needs documented in the resident assessment. The provider may only admit or continue services for a person when:

(1) The adult family home can meet the person's assessed needs with current staff or through reasonable accommodations.

(2) The person's admission will not adversely affect the provider's ability to meet the needs of other residents in the home or endanger the safety of other residents; and

(3) All residents and household members can be safely evacuated in an emergency.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61010, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61020 What must be included in the resident assessment? The current written assessment must contain specific information regarding the resident applicant. If, despite the best efforts of the person conducting the assessment, an element of the required assessment information is not available, the effort to obtain the information must be documented with the assessment. At a minimum, the assessment must include:

- (1) Recent medical history;
- (2) Current prescribed medications, and contraindicated medications (including, but not limited to, medications that are known to cause adverse reactions or allergies);
- (3) Medical diagnosis by a licensed medical professional;
- (4) Significant known behaviors or symptoms that may cause concern or require special care;
- (5) Evaluation of cognitive status in order to determine the individual's current level of functioning. This must include an evaluation of disorientation, memory impairment, and impaired judgment;
- (6) History of depression and anxiety;
- (7) History of mental illness, if applicable;
- (8) Social, physical, and emotional strengths and needs;
- (9) Functional abilities in relationship to activities of daily living including: Eating, toileting, ambulating, transferring, positioning, specialized body care, personal hygiene, dressing, bathing, and management of own medication;
- (10) Preferences and choices regarding daily life that are important to the person (including, but not limited to, such preferences as the type of food that the person enjoys, what time he or she likes to eat, and when he or she likes to sleep);
- (11) Preferences for activities; and
- (12) A preliminary service plan.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272. 98-12-054, § 388-76-61020, filed 5/29/98, effective 7/1/98.]

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WAC 388-76-61030 How does the preliminary service plan fit within the resident assessment? The preliminary service plan is part of the resident assessment, and is completed by the person conducting the assessment. The assessment and preliminary service plan create the foundation for the negotiated care plan, which is described in WAC 388-76-61500. The preliminary service plan describes needs for services and an initial plan for how to meet the needs that are identified at the time of the assessment. This plan should be developed by the provider and made more specific when the negotiated care plan is developed and reviewed. At a minimum, the preliminary service plan must contain:

- (1) A complete description of the client's specific problems and needs;
- (2) A description of needs for which the client chooses not to accept services;
- (3) Identification of client goals and preferences; and
- (4) A description of how the client's needs can be met.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61030, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61040 Is the use of an approved form required for the assessment? Beginning July 1, 1999 the assessment must be completed on a form that is approved by the department.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61040, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61050 Who can do the assessment? (1) Effective July 1, 1999, a qualified assessor is a person who:

- (a) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or
- (b) A bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or
- (c) Has a valid Washington state license to practice as a registered nurse and three years of clinical nursing experience; or
- (d) Is a physician with a valid Washington state license to practice medicine. This includes licensed osteopathic physicians.

(2) For individuals who will receive services paid for fully or partially by the department, the assessment must be completed by the authorized department case manager.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61050, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61060 In emergency situations, can a provider admit a resident without an assessment? In circumstances of genuine emergency, the provider may admit an individual without the required assessment and service plan. It is expected these situations will occur very infrequently. These circumstances are:

- (1) For individuals who use private funds to pay for care, the provider must determine that the individual's life, health or safety are at serious risk due to circumstances in the individual's current place of residence, or, if due to such circumstances, harm to an individual has occurred. Under these cir-

cumstances the required assessment must be completed within five working days of the resident's admission.

(2) For individuals whose care is paid for fully or partially by the department, the provider must obtain the approval of the authorized department case manager prior to admission. If this approval is obtained verbally, the provider must document the time, the date, and the name of the case manager.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61060, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61070 Does the assessment have to be updated? The provider must ensure that the assessment is reviewed and updated to document the resident's ongoing needs and preferences according to the following criteria:

- (1) At least every twelve months;
- (2) When there is a significant change in the resident's physical or mental condition; and
- (3) At the resident's request or at the request of the resident's legal representative.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61070, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61080 Who is qualified to update the assessment? Effective July 1, 1999, persons meeting the qualifications of an assessor are also qualified to update the assessment for an individual who will use private funds to pay for the adult family home.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61080, filed 5/29/98, effective 7/1/98.]

NEGOTIATED CARE PLAN

WAC 388-76-615 Negotiated care plan.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-615, filed 5/29/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.-130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-615, filed 6/19/96, effective 7/20/96.]

WAC 388-76-61500 What is a negotiated care plan? A negotiated care plan is a written plan developed between the provider and the resident, or the resident's representative, if the resident has a representative. The provider is responsible to make sure that it is written and signed. This plan identifies:

- (1) The care and services to be provided;
- (2) Who will provide the care and services;
- (3) When and how the care and services will be provided;
- (4) The resident's activities preferences and how those preferences will be accommodated; and
- (5) Other preferences and choices regarding issues important to the resident (including, but not limited to, food, daily routine, grooming), and what efforts will be made to accommodate those preferences and choices;
- (6) If needed, a plan to follow in case of a foreseeable crisis due to a resident's assessed need, such as, but not limited to, how to access emergency mental health services;
- (7) If needed, a plan to reduce tension, agitation and problem behaviors;

(8) If needed, a plan to respond to residents' special needs, including, but not limited to, the availability of staff when resident needs change;

(9) If needed, the identification of any communication barriers of the resident, including, but not limited to, how behaviors and nonverbal gestures may be used as a means for communication.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61500, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61510 When must the negotiated care plan be developed? The plan must be developed within thirty days of the resident's admission.

[Statutory Authority: RCW 70.128.040, 69.41.085, 02-15-081, § 388-76-61510, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61510, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61520 How does the negotiated care plan fit in with the assessment and preliminary service plan? The assessment and preliminary service plan, which are done by the person conducting the assessment, create the foundation for the negotiated care plan. The preliminary service plan describes needs for services and an initial plan for how to meet the needs. This plan is limited to needs that are identified at the time of the assessment. It is expected that, over time, the provider will learn more about the resident's needs and how to make sure they are met. The provider is responsible to work with the preliminary service plan and update it and make it more specific. As it is updated and made more specific, and as the resident or the resident's representative becomes involved in its development, it becomes the negotiated care plan. The negotiated care plan provides specific details about how the resident's needs and preferences will be addressed within the individual adult family home.

The provider must implement the negotiated care plan after it has been agreed to and signed by the resident or the resident's representative, if the resident has a representative.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61520, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61530 Who must be involved in the development of the negotiated care plan? The provider must involve the following people in developing the plan:

- (1) The resident, to the greatest extent he or she is able to participate;
- (2) The resident's family, if approved by the resident;
- (3) The resident's representative, if the resident has a representative;
- (4) Professionals involved in the care of the resident;
- (5) Other individuals the resident wants included; and
- (6) The authorized department case manager, if the resident is receiving services paid for fully or partially by the department.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61530, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61540 Who must sign the negotiated care plan? The provider must ensure that the negotiated care plan is agreed to and signed by the resident, or the resident's representative, if the resident has a representative.

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[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61540, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61550 How often must the negotiated care plan be reviewed and revised? The provider must ensure that the plan is reviewed and revised according to the following schedule:

- (1) At least every twelve months;
- (2) When there is a significant change in the resident's physical or mental condition;
- (3) At the resident's request; and
- (4) If changes or additions to assessment information result in significant changes to the resident's identified needs or preferences and choices.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61550, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61560 When does the department's case manager get a copy of the negotiated care plan? The copy of the plan must be given to the authorized department case manager each time it is completed or updated, and after it has been signed by the resident, if the resident's services are being paid fully or partially by the department.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61560, filed 5/29/98, effective 7/1/98.]

WAC 388-76-61570 How are payment rate changes authorized for residents receiving services paid for fully or partially by the department? If there is improvement or decline causing significant changes in a resident's identified needs, and the resident is receiving services paid for fully or partially by the department, the provider must notify the authorized department case manager. No payment rate change will be approved without an assessment and authorization by the department.

[Statutory Authority: RCW 70.128.040, 70.128.060, chapter 70.129 RCW and 1998 c 272, 98-12-054, § 388-76-61570, filed 5/29/98, effective 7/1/98.]

WAC 388-76-620 Provision of services and care. (1) The provider shall ensure that the resident receives necessary services and care to promote the most appropriate level of physical, mental, and psychosocial well-being consistent with resident choice.

(2) The provider shall encourage and promote resident participation in service planning and delivery.

(3) The provider shall respect the resident's right to decide negotiated care plan goals and treatment choices, including acceptance or refusal of care plan recommendations.

(4) The provider shall ensure that resident services are delivered in a manner and in an environment that:

(a) Promotes maintenance or enhancement of each resident's quality of life;

(b) Promotes the safety of all residents; and

(c) Reasonably accommodates the resident's individual needs and preferences, except when the health or safety of the resident or other residents would be endangered.

(5) The provider shall ensure that appropriate professionals provide needed services to the resident based upon the resident's assessment and negotiated care plan.

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[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-620, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-620, filed 6/19/96, effective 7/20/96.]

WAC 388-76-625 Nurse delegation—Training and registration. Before performing any delegated nursing task, adult family home staff must:

- (1) Be a nursing assistant certified or registered under chapter 18.88A RCW; and
- (2) Attend and successfully complete department designated core delegation training.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-625, filed 6/19/96, effective 7/20/96.]

WAC 388-76-630 Performance of delegated nursing care tasks. (1) Adult family home staff who have been delegated a nursing care task in compliance with requirements established by the nursing care quality assurance commission shall perform the task:

- (a) In compliance with all requirements and protocols established by the commission in WAC 246-840-910 through 246-840-980;
 - (b) Only for the specific resident who was the subject of the delegation; and
 - (c) Only with the resident's consent.
- (2) The delegated authority to perform the nursing care task is not transferable to another nurse assistant.

(3) The adult family home staff may consent to perform a delegated nursing care task, and shall be responsible for their own actions with regard to the decision to consent to the performance of the delegated task.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-630, filed 6/19/96, effective 7/20/96.]

WAC 388-76-635 Nurse delegation—Penalties. The department may impose a civil fine on any provider that knowingly performs or knowingly permits an employee to perform a nursing task except as delegated by a nurse pursuant to chapter 18.79 RCW and chapter 246-840 WAC as follows:

- (1) Two hundred fifty dollars for the first time the department finds an unlawful delegation;
- (2) Five hundred dollars for the second time the department finds an unlawful delegation; and
- (3) One thousand dollars for the third time or more the department finds an unlawful delegation.

[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-635, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-635, filed 6/19/96, effective 7/20/96.]

RESIDENT MEDICATIONS

WAC 388-76-64010 What are the rules the provider must follow in all situations involving resident medications? (1) The provider must ensure that all prescribed and OTC medications are kept in locked storage.

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(2) The provider must ensure that all prescribed and OTC medications are stored in the original containers with legible and original labels. When medication organizers are used, refer to WAC 388-76-64050.

(3) The resident always has the right to refuse any medications.

(4) When a resident who is receiving medication assistance or administration refuses or does not receive a prescribed medication, the provider must notify the prescribing practitioner unless the provider, acting within their scope of practice, is able to make a judgment about the significance of the resident's refusal.

(5) If a provider becomes aware that a resident who self-administers is refusing a prescribed medication, the provider must notify the prescribing practitioner unless the provider, acting within their scope of practice, is able to make a judgment about the significance of the resident's refusal.

(6) The provider must ensure that the negotiated care plan addresses how residents will get their medications when they are absent from the adult family home or when a family member assisting with medications is not available.

(7) The provider must have a policy addressing the disposition of resident prescribed medications that are unused, leftover, or remaining after the resident leaves the adult family home.

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64010, filed 9/18/02, effective 10/19/02.]

WAC 388-76-64015 What defines the type of help a resident may need when taking their medication? (1) The resident assessment must identify the individual's functional level related to the management of medications as referenced in WAC 388-76-61020(9).

(2) Independent with self-administration is when the resident is able to directly apply prescribed and OTC medications by ingestion, inhalation, injection or other means and no assistance is required.

(3) Self-administration with assistance (as described in chapter 246-888 WAC, Medication assistance) is when a resident is independent with self-administration but requires assistance from a non-practitioner when taking prescribed or OTC medications. This assistance does not include injectable or intravenous medications as defined in WAC 246-888-020.

(4) Medication administration is required when a resident cannot safely perform independent self-administration or self-administration with assistance. Medication administration must be performed by a practitioner as defined in chapter 69.41 RCW or by nurse delegation (WAC 246-840-910 through 246-840-970), unless performed by a family member or surrogate decision maker as defined in RCW 7.70.065.

(5) If a resident's circumstances require a combination of independent with self-administration, self-administration with assistance, or medication administration, the reason(s) for this combination must be explained in the resident's negotiated care plan.

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64015, filed 9/18/02, effective 10/19/02.]

WAC 388-76-64020 What must the provider include in the negotiated care plan for residents who are indepen-

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dent with self-administration? (1) Residents who are independent with self-administration:

(a) May administer their own prescribed and OTC medications unless otherwise stipulated in their negotiated care plan.

(b) May keep their prescribed and OTC medications securely locked in either their room or in a different area otherwise agreed upon and documented in their negotiated care plan.

(2) Residents who are independent with self-administration are not required to keep a daily medication log unless otherwise stipulated in their negotiated care plan.

(3) For purposes of emergency situations, the provider must maintain a current list of prescribed and OTC medications including name, dosage, frequency, and the name and phone number of the prescribing practitioner as needed. The provider must coordinate with the resident when there is a medication change or new order(s) and must document the changes in the resident's negotiated care plan.

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64020, filed 9/18/02, effective 10/19/02.]

WAC 388-76-64025 How do a resident and provider initiate self-administration with assistance? (1) A resident or their representative and the provider consult with a practitioner to determine the appropriateness for self-administration with assistance.

(2) The practitioner, in consultation with the resident or their representative and the provider, considers such factors as the physical and mental limitations of the resident and the setting or environment where the resident lives.

(3) While no additional separate assessment or documentation of the resident's needs is required for initiating self-administration with assistance, the provider must amend the resident's negotiated care plan to reflect this service.

(4) The provider must contact the practitioner who will determine if a reassessment is required when the resident has a change in the health status, medications, physical or mental limitations, or environment.

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64025, filed 9/18/02, effective 10/19/02.]

WAC 388-76-64030 What must the provider monitor when implementing self-administration with assistance?

(1) The provider must ensure that self-administration with assistance is occurring when a resident needs assistance from a nonpractitioner to safely facilitate self-administration of a medication.

(2) The resident must be able to put the prescribed or OTC medication into their own mouth or apply or instill the medications.

(3) The resident must be aware that they are receiving a prescribed or OTC medication, but does not necessarily need to be able to state the name of the medication, intended effects or side effects.

(4) Self-administration with assistance must occur immediately prior to the ingestion or application of a prescribed or OTC medication.

(5) Self-administration with assistance may include steadying or guiding a resident's hand while applying or instilling prescribed or OTC medications such as ointments,

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eye, ear and nasal preparations, but does not include the practice of "hand-over-hand" (total physical assistance) administration.

(6) Self-administration with assistance does not include direct assistance with intravenous and injectable medications, however, delivering a prefilled syringe to the resident is allowed providing that the resident independently self-administers the injection per WAC 246-888-020.

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64030, filed 9/18/02, effective 10/19/02.]

WAC 388-76-64035 What other situations must the provider monitor when self-administration with assistance occurs for a resident? A nonpractitioner may assist the resident to self-administer a prescribed or OTC medication through a gastrostomy or "g-tube" provided that:

(1) The prescription is written as an oral medication via "g-tube"; and

(2) The resident meets the criteria for self-administration with assistance referenced in WAC 388-76-64015(3).

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64035, filed 9/18/02, effective 10/19/02.]

WAC 388-76-64040 What must the provider do when there is a need to alter medications during self-administration with assistance? (1) If the prescribed or OTC medication is altered, the provider must have documentation for the appropriateness of the alteration by the approving practitioner or pharmacist including date, time, and name of who provided the consultation.

(2) Alteration of a prescribed or OTC medication for self-administration with assistance includes, but is not limited to, crushing tablets, cutting tablets in half, opening capsules, mixing powdered medications with food or liquids.

(3) Residents must be aware that the prescribed or OTC medication is being altered and/or added to their food.

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64040, filed 9/18/02, effective 10/19/02.]

WAC 388-76-64045 What other types of assistance can a nonpractitioner provide? Prescribed or OTC medication can be transferred from one container to another for the purpose of an individual dose such as pouring a liquid medication from the medication container to a calibrated spoon or medication cup.

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-20-005, § 388-76-64045, filed 9/18/02, effective 10/19/02.]

WAC 388-76-64050 Who can fill medication organizers and what is required? (1) A registered nurse (RN), licensed practical nurse (LPN), the resident, or the resident's family members may fill medication organizers.

(2) Prescribed medications being placed into an organizer for the resident must have already been dispensed by a pharmacist and are being removed from an original container that has been labeled for the resident by a pharmacist or pharmacy service.

(3) The medication organizer must allow prescribed and OTC medications to be readily identifiable by residents, caregivers, and the RN and LPN.

(4) Medication organizers must carry a label that clearly identifies the following information:

- (a) Name of the resident;
- (b) Name of the medication(s);
- (c) Dosage and dosage frequency.

(5) The name and phone number of the prescribing practitioner must be available when the resident takes a medication organizer out of the adult family home.

(6) When a resident has a change in medications by the prescribing practitioner, the person filling the medication organizers must replace labels with required updated information immediately.

[Statutory Authority: RCW 70.128.040, 69.41.085, 02-20-005, § 388-76-64050, filed 9/18/02, effective 10/19/02.]

WAC 388-76-64055 What documentation is the provider required to include in the resident's daily medication log? (1) The provider must ensure that every resident (unless WAC 388-76-64015(2) applies) has a daily medication log that includes the following information:

(a) A listing of all prescribed and OTC medications, the frequency, and the dosage; and

(b) The time the medication is scheduled to be taken by the resident.

(2) The provider must ensure that the person who assisted or administered prescribed or OTC medication to the resident initials the daily medication log within one hour after the medication was taken or refused.

(3) The provider must ensure that if the prescribed or OTC medication is taken outside the scheduled time, the time the medication was taken must be recorded on the medication log.

(4) If a resident refuses to take prescribed medications, the requirements in subsection (2) of this section apply including a note indicating the resident's refusal.

(5) When the prescribing practitioner makes a change to any current medications, the provider must:

(a) Ensure that the change and the date of the change are immediately documented on the daily medication log;

(b) Request from the prescribing practitioner written verification of the change by mail, facsimile, other electronic means, or a new original labeled container from the pharmacy;

(c) The provider must ensure that the changed medication is received from the pharmacy to begin the change consistent with the new order.

[Statutory Authority: RCW 70.128.040, 69.41.085, 02-20-005, § 388-76-64055, filed 9/18/02, effective 10/19/02.]

WAC 388-76-645 Resident activities. (1) The resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the adult family home.

(2) The provider shall provide and promote opportunities for the resident to participate in activities of the resident's choice which are consistent with identified resident needs and functional capacity.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.-130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-645, filed 6/19/96, effective 7/20/96.]

[Title 388 WAC—p. 402]

WAC 388-76-650 Food services. The provider shall:

(1) Ensure that food served to the resident meets the nutritional needs of the resident, and takes into consideration the resident's:

- (a) Preferences;
- (b) Caloric need;
- (c) Cultural and ethnic background; and
- (d) Any physical condition making food intake difficult;

(2) Provide a minimum of three nutritious meals in each twenty-four hour period, at regular times comparable to normal meal times in the community;

(3) Make nutritious snacks available to residents between meals and in the evening;

(4) Obtain input from residents in meal planning and scheduling;

(5) Serve nutrient concentrates, supplements, and modified diets only on the written approval of the resident's physician;

(6) Use only pasteurized milk;

(7) Ensure any home-canned foods are processed according to the latest guidelines of the county cooperative extension service;

(8) Serve meals in the home where the residents live; and

(9) When meals are prepared at a separate kitchen facility, ensure that persons preparing food have a food handler's permit and that the food is transported in airtight containers to prevent contamination. The provider or resident manager shall ensure that the food is transported and served at the appropriate and safe temperature.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.-130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-650, filed 6/19/96, effective 7/20/96.]

PART IV ADMINISTRATION

WAC 388-76-655 General management and administration. (1) The provider shall not admit or retain any resident whose needs the provider cannot meet.

(2) The provider shall ensure all of the following:

(a) That staff are competent and receive necessary training, including but not limited to any training required under chapter 388-112 WAC to perform assigned tasks;

(b) The adult family home is in compliance with the requirements of this chapter and other applicable state laws;

(c) The home employs sufficient staff to meet the needs of the residents; and

(d) That he/she is available to respond to resident needs and caregiver inquiries within a reasonable time frame. In the event a provider is unavailable (including but not limited to being on vacation), a person must be designated to respond on behalf of the provider.

(3) The provider shall ensure that all caregivers are at least eighteen years of age or older.

(4) The provider shall ensure that the provider, entity representative, resident manager and all caregivers:

(a) Are able to communicate or make provisions for communicating with the resident in his or her primary language;

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(b) Have a clear understanding of job responsibilities and knowledge of residents' negotiated care plans in order to be able to provide care specific to each resident's needs; and

(c) Not engage in the illegal use of drugs or the excessive use of alcohol when providing care to residents; and

(d) Possess a valid first-aid and CPR card prior to providing care for residents unless such care is directly supervised by a fully qualified caregiver who has a valid first-aid and CPR card.

(5) The provider shall ensure that:

(a) There is at least one caregiver present in the home whenever one or more residents are on the premises;

(b) The caregiver referred to in (a) of this subsection is capable of understanding and speaking English well enough to be able to respond appropriately to emergency situations; and

(c) At least one caregiver is accessible by phone or beeper for emergencies when there are no residents on the home's premises.

(6) An adult family home shall be exempt from subsection (5)(a) of this section if:

(a) The home provides care to residents whose primary disabilities are developmental disabilities as defined by WAC 388-76-540; and

(b) It is determined and documented in a resident's current negotiated care plan that the resident is capable and willing to be left alone unsupervised in the adult family home during normal awake hours. The maximum period of time a resident can be left alone must be documented in the negotiated care plan.

[Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-655, filed 8/22/05, effective 9/22/05; 03-14-018, § 388-76-655, filed 6/19/03, effective 7/20/03. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233, 02-15-065, § 388-76-655, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW, 98-11-095, § 388-76-655, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-655, filed 6/19/96, effective 7/20/96.]

WAC 388-76-660 Training. Adult family home individual providers, entity representatives, resident managers, and caregivers must meet the training requirements under chapter 388-112 WAC.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233, 02-15-065, § 388-76-660, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW, 98-11-095, § 388-76-660, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-660, filed 6/19/96, effective 7/20/96.]

WAC 388-76-665 Resident records. (1) The provider or resident manager shall:

(a) Keep confidential all information contained in the resident's records, regardless of the form or storage method of the records (e.g., computer files); and

(b) Protect information in the resident's record against alteration, loss, destruction, and unauthorized use.

(2) The provider or resident manager shall release information from the resident's record when required by:

(a) The resident's transfer to a health care institution;

(b) Law;

(c) Representatives of the department when acting in accordance with state law; or

(d) The resident.

(3) The provider shall ensure that caregivers in the home have access to resident records when information in those records is needed to provide care.

(4) The provider shall retain the resident's record for three years following the resident's discharge or death.

(5) The adult family home shall ensure that the resident's record includes at least the following:

(a) Resident identification including the name, address, and telephone number of the person or persons the resident designates as significant;

(b) The name, address, and telephone numbers for the resident's:

(i) Surrogate decision maker, if any; and

(ii) Health care providers;

(c) A current medical history;

(d) An inventory of personal belongings which is:

(i) Updated as additional belongings accrue; and

(ii) Dated and signed by the resident and the provider or resident manager;

(e) The resident's assessment;

(f) The current negotiated care plan;

(g) Legal documents, including but not limited to:

(i) Power of attorney (POA) if the resident has appointed a POA;

(ii) Advance health care directives if the resident has executed such directives; and

(iii) A court order, if any, appointing a legal guardian and detailing the guardian's responsibility;

(h) Financial records;

(i) Medication records;

(j) The resident's social security number; and

(k) Admission, discharge, and absences information.

(6) The provider or resident manager shall keep the resident's record at the adult family home in which the resident lives.

[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW, 98-11-095, § 388-76-665, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230, 96-14-003 (Order 3984), § 388-76-665, filed 6/19/96, effective 7/20/96.]

WAC 388-76-670 Disaster and emergency prepared-

ness. (1) The provider shall develop written plans and procedures to meet potential emergencies and disasters, such as fires, earthquakes, and floods.

(2) The provider shall ensure that all staff are trained in those emergency procedures when they begin to work at the home.

(3) The provider shall periodically review disaster and emergency procedures with staff, caregivers, and residents.

(4) In the plans (described in subsection (1) of this section), the provider shall describe how they will supply residents and household members with a seventy-two hour supply of food, accommodating any specific resident needs or food restrictions, in order to meet resident and household member needs in an emergency. In addition to this plan, the provider must also have on-site three gallons of drinking

water per person to meet resident and household member needs in an emergency.

(5) The provider shall ensure the adult family home has readily available first-aid supplies and a first-aid manual.

[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-670, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-670, filed 6/19/96, effective 7/20/96.]

WAC 388-76-675 Reporting requirements. (1) The provider and all caregivers shall immediately notify the department's toll-free complaint telephone number of any incidents involving allegations of resident abuse, neglect, exploitation or abandonment in accordance with the provisions of chapter 74.34 RCW.

(2) The provider shall keep a log of injuries and accidents to residents.

(3) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the provider shall immediately notify:

(a) The resident's family, surrogate decision maker, physician and other appropriate professionals, and other persons identified in the negotiated care plan; and

(b) The case manager, if the resident is receiving services paid for fully or partially by the department.

(4) The adult family home shall immediately report to the department's aging and disability services administration:

(a) Any event, actual or potential, requiring the evacuation or relocation of all or part of the home's residents to another address;

(b) Circumstances which threaten the home's ability to ensure continuation of services to residents; and

(c) Instances when a resident is determined to be missing.

(5) The provider shall notify local law enforcement in accordance with the provisions of RCW 74.34.035.

(6) The provider shall notify the local public health officer and the department of any occurrence of food poisoning or communicable disease as required by the state board of health.

[Statutory Authority: RCW 74.34.165, 74.34.020, and 74.34.035. 04-01-032, § 388-76-675, filed 12/8/03, effective 1/8/04. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-675, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-675, filed 6/19/96, effective 7/20/96.]

WAC 388-76-680 Infection control and communicable disease. (1) The provider or resident manager shall institute appropriate infection control measures when the resident or any household member or caregiver has, or is suspected of having, a communicable disease.

(2) The provider shall follow chapter 49.17 RCW, Washington Industrial Safety and Health Act (WISHA) requirements to protect the health and safety of residents and employees.

(3) The provider must ensure that tuberculosis screening is carried out as outlined below.

(a) Skin testing whether documented historically or performed currently, must be by intradermal (Mantoux) admin-

istration of PPD, and test results read in forty-eight to seventy-two hours by trained personnel. A positive reaction is ten or more millimeters of induration.

(b) The individual provider, entity representative, resident manager and caregiver must have, upon employment, tuberculosis skin testing to establish tuberculosis status.

(c) Baseline skin testing upon employment must be in two steps performed one to three weeks apart unless a person meets the requirements in (d) or (e) of this section.

(d) A person does not need to be skin tested for tuberculosis if he/she has:

(i) A documented history of a previous positive skin test; or

(ii) Documented evidence of adequate therapy for active disease; or

(iii) Documented evidence of adequate preventive therapy for infection.

(e) Exceptions to two-step testing. A person needs to have only a one-step skin test upon employment if he/she has any one of the following:

(i) A positive result from his/her initial first step skin test (a person who has a positive result from an initial first step skin test should not have any more skin testing); or

(ii) A documented history of a negative result from previous two-step baseline testing; or

(iii) A documented negative result from one step skin testing in the previous twelve months.

(f) A person with a positive reaction to skin testing must have a chest X ray within seven days.

(g) Persons with negative test results may be required by the public health or licensing authority to have follow-up skin testing in certain circumstances such as after exposure to active tuberculosis; when tuberculosis symptoms are present; or for periodic screening.

(h) A person who has reason to decline skin testing may submit a signed statement to the employer giving the reason for declining and evidence to support the reason.

(4) The provider or resident manager shall:

(a) Report any employee's or provider's positive chest X ray to the appropriate public health authority; and

(b) Follow precautions ordered by the public health authority, the employee's personal physician, or other licensed health care professional.

(5) The provider shall retain records of tuberculin test results, reports of X-ray findings, physician or public health official orders, and waivers in the adult family home.

(6) The provider or resident manager shall:

(a) Use infection control standards and educational material consistent with the current curriculum for infection control as defined in the department's fundamentals of caregiving training;

(b) Dispose of used syringes, razor blades, and other sharp items in a manner that will not jeopardize the health and safety of residents, staff, and the public;

(c) Ensure disposals are placed in rigid containers, impervious to liquids and penetration by puncture. These containers shall be such that they cannot be opened either intentionally or accidentally; and

(d) Use all disposable and single-service supplies and equipment as specified by the manufacturer.

[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-680, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-680, filed 6/19/96, effective 7/20/96.]

WAC 388-76-685 Criminal history disclosure and background inquiries. (1) Before the adult family home employs, directly or by contract, a resident manager, entity representative or caregiver, or accepts as a caregiver any volunteer or student, or allows a household member unsupervised access to residents, the home shall:

(a) Require the person to complete the residential care services background inquiry form which includes:

(i) A disclosure statement; and

(ii) A statement authorizing the adult family home, the department, and the Washington state patrol to conduct a background inquiry;

(b) Verbally inform the person:

(i) That he or she may request a copy of the background inquiry result; and

(ii) Of the inquiry result within ten days of receipt; and

(c) Notify the appropriate licensing or certification agency of any person resigning or terminated as a result of having a conviction record.

(2) The adult family home provider shall not employ any person, directly or by contract, or accept as a volunteer or student any person who may have unsupervised access to residents, or allow a household member unsupervised access to residents if the person or background inquiry discloses that the person was:

(a) Convicted of a crime against persons as defined under RCW 43.43.830;

(b) Convicted of a crime related to financial exploitation as defined under RCW 43.43.830;

(c) Found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor;

(d) Subject to an order of protection under chapter 74.34 RCW for abuse, neglect, abandonment or financial exploitation of a vulnerable adult;

(e) Found in a final decision issued by a disciplinary board to have:

(i) Sexually or physically abused or exploited any minor or developmentally disabled person; or

(ii) Abused, neglected, abandoned or financially exploited any vulnerable adult; or

(f) Found in any dependency action under RCW 13.34-.050(1) to have engaged in circumstances of sexual abuse or exploited any minor or to have physically abused any minor.

(3) The adult family home may choose to employ a person with a conviction of a crime only if the conviction is one of the crimes listed in RCW 43.43.842 and the required number of years has passed.

(4) An adult family home may conditionally employ a person pending the result of a background inquiry, provided the home requests the inquiry within seventy-two hours of the conditional employment.

(5) A background inquiry result is valid for two years from the date it is conducted, at which point a new background inquiry application must be submitted.

(6) The adult family home shall establish procedures ensuring:

(a) All disclosure statements and background inquiry applications and responses and all copies are maintained in a confidential and secure manner;

(b) All background inquiry results and disclosure statements are used for employment purposes only;

(c) Background inquiry results and disclosure statements are not disclosed to any person except:

(i) The person about whom the adult family home made the disclosure or background inquiry;

(ii) Authorized state and federal employees; and

(iii) The Washington state patrol auditor.

(7) A record of inquiry results shall be retained by the adult family home for eighteen months beyond the date of employment termination.

(8) The provider shall secure and submit any additional documentation and information as requested by the department to satisfy the requirements of this section.

[Statutory Authority: RCW 70.128.040. 05-17-158, § 388-76-685, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-685, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-685, filed 6/19/96, effective 7/20/96.]

WAC 388-76-690 Advance directives, guardianship, and decision making. (1) The provider or resident manager shall provide or ensure that the resident, at the time of admission, has received the department's current booklet on health care rights, in the language appropriate for the resident, if available from the department.

(2) The provider or resident manager shall:

(a) Immediately contact the local emergency medical services in the event of a resident medical emergency regardless of any order, directive, or other expression of resident wishes involving the provision of medical services;

(b) Have readily available for emergency medical services personnel the resident's advance directives if the resident has executed an advance directive;

(c) Inform the resident of the action required by subsection (2)(a) of this section; and

(d) Include the action required by subsection (2)(a) of this section in the home's operational policies.

(3) A licensed physician or registered nurse acting within his or her scope of practice shall be exempt from the provisions of subsection (2) of this section.

(4) A provider may become a guardian for a resident if two criteria are met:

(a) The court authorizes you under Washington state's guardianship law (chapter 11.88 RCW) to be a resident's guardian; and

(b) You inform the court in writing, through a petition, that you care for the resident in your adult family home, and you request the court to direct payment from the funds of the resident for care, maintenance, and education to you. This is required by RCW 11.92.040(6), a section in Washington state's guardianship law.

(5) A provider can not act as power of attorney for health care for a resident. Washington state's power of attorney law (chapter 11.94 RCW) says that owners, administrators, or

employees of the adult family home where the resident resides or receives care can not act as power of attorney for health care for a resident, unless they are also the spouse, adult child, brother or sister of the resident.

(6) The adult family home shall provide care and services in compliance with the federal patient self determination act and with applicable state statutes related to surrogate and health care decision making, including chapters 7.70, 70.122, 11.88, 11.92, and 11.94 RCW.

[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-690, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-690, filed 6/19/96, effective 7/20/96.]

WAC 388-76-695 Protection of resident funds—Liquidation or transfer. (1) Upon the death of a resident, the adult family home shall promptly convey the resident's personal funds held by the adult family home with a final accounting of such funds to the department or to the individual or probate jurisdiction administering the resident's estate no later than forty-five calendar days after the date of the resident's death.

(2) If the deceased resident was a recipient of long-term care services paid for in whole or part by the state of Washington, then the personal funds held by the adult family home and the final accounting should be paid to the secretary, department of social and health services and mailed to the office of financial recovery, estate recovery unit, P.O. Box 9501, Olympia, WA 98507-9501 or such address as may be directed by the department in the future:

(a) The check and final accounting accompanying the payment shall contain the name and social security number of the deceased individual from whose personal funds account the monies are being paid; and

(b) The department of social and health services shall establish a release procedure for use of funds necessary for burial expenses.

(3) In situations where the resident is absent from the adult family home for an extended time without notifying the home, and the resident's whereabouts is unknown:

(a) The adult family home shall make a reasonable effort to find the missing resident; and

(b) If the resident cannot be located after ninety days, the home shall notify the department of revenue of the existence of "abandoned property," outlined in chapter 63.29 RCW. The home shall deliver to the department of revenue the balance of the resident's personal funds within twenty days following such notification.

(4) Prior to the sale or other transfer of ownership of the adult family home the provider shall:

(a) Provide each resident with a written accounting of any personal funds held by the home;

(b) Provide the new provider with a written accounting of all resident funds being transferred; and

(c) Obtain a written receipt for those funds from the new provider.

[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-695, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-695, filed 6/19/96, effective 7/20/96.]

WAC 388-76-700 Resident relocation due to closure.

(1) When the department revokes, suspends, or does not renew the license for an adult family home, the department shall:

(a) Notify residents and, when appropriate, residents' surrogate decision makers of the action; and

(b) Assist with residents' relocation and specify the location of possible residential alternatives.

(2) When the resident's relocation occurs due to the adult family home's voluntary license relinquishment:

(a) The provider shall send written notification, thirty days before ceasing operation, to the appropriate adult family home area manager and to all residents except when shorter notice is required due to emergency circumstances;

(b) The provider shall provide appropriate discharge planning and coordination for all residents;

(c) The department shall provide relocation assistance to department clients; and

(d) The department may provide relocation assistance to residents whose cost of care is not fully or partially paid for by the department.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-700, filed 6/19/96, effective 7/20/96.]

PART V

REMEDIES AND DISPUTE RESOLUTION

WAC 388-76-705 Remedies. (1) The department may take one or more of the actions listed in subsection (3)(a) of this section in any case in which the department finds that an adult family home provider has:

(a) Failed or refused to comply with the applicable requirements of chapters 70.128 and 70.129 RCW or of this chapter;

(b) Operated without a license or under a revoked license;

(c) Knowingly, or with reason to know, made a false statement of material fact on his or her application for a license or any data attached thereto, or in any matter under investigation by the department;

(d) Willfully prevented, interfered with, or failed to cooperate with any inspection or investigation by the department; or

(e) Failed to comply with:

(i) A condition imposed on a license; or

(ii) A stop placement order.

(2)(a) For failure or refusal to comply with any applicable requirements of chapters 70.128 and 70.129 RCW or of this chapter, the department may provide consultation and shall allow the provider a reasonable opportunity to correct before imposing remedies under subsection (3)(a) unless the violations pose a serious risk to residents, are recurring or have been uncorrected.

(b) When violations of this chapter pose a serious risk to a resident, are recurring or have been uncorrected, the department shall impose a remedy or remedies listed under subsection (3)(a). In determining which remedy or remedies to impose, the department shall take into account the severity of the potential or actual impact of the violations on residents

and which remedy or remedies are likely to improve resident outcomes and satisfaction in a timely manner.

(3)(a) Actions and remedies the department may impose include:

- (i) Denial of an application for a license;
- (ii) Imposition of reasonable conditions on a license, such as correction within a specified time, training, and limits on the type of residents the provider may admit or serve;
- (iii) Imposition of civil penalties of not more than one hundred dollars per day per violation except that:
 - (A) Fines of up to one thousand dollars can be issued for willful interference with a representative of the long-term care ombudsman per RCW 70.128.150; and
 - (B) Fines of up to three thousand dollars can be issued for retaliation against a resident, employee, or any other person for making a complaint, providing information to, or cooperating with, the ombudsman, the department, the attorney's general office, or a law enforcement agency per RCW 74.39A.060(7).
- (iv) Suspension or revocation of a license; or
- (v) Order stop placement.
- (b) When the department orders stop placement, the adult family home shall not admit any person until the stop placement order is terminated. The department may approve readmission of a resident to the adult family home from a hospital or nursing home during the stop placement. The department shall terminate the stop placement when the department determines that:
 - (i) The violations necessitating the stop placement have been corrected; and
 - (ii) The provider exhibits the capacity to maintain adequate care and service.
- (c) Conditions the department may impose on a license include, but are not limited to the following:
 - (i) Correction within a specified time;
 - (ii) Training related to the violations;
 - (iii) Limits on the type of residents the provider may admit or serve;
 - (iv) Discharge of any resident when the department determines discharge is needed to meet that resident's needs or for the protection of other residents;
 - (v) Change in the license capacity;
 - (vi) Removal of the adult family home's designation as a specialized home;
 - (vii) Prohibition of access to residents by a specified person; and
 - (viii) Demonstration of ability to meet financial obligations necessary to continue operation.
- (d) When a provider fails to pay a fine when due under this chapter, the department may, in addition to other remedies, withhold an amount equal to the fine plus interest, if any, from any contract payment due to the provider from the department.
- (e) When the department finds that a licensed provider also operates an unlicensed adult family home, the department may impose a remedy listed under subsection (3)(a) of this section on the provider and the provider's licensed adult family home or homes.
- (f) When the department determines that violations existing in an adult family home are of such a nature as to present a serious risk of harm to residents of other homes

operated by the same provider, the department may impose remedies on those other homes.

[Statutory Authority: RCW 70.128.040, chapters 70.128 and 70.129 RCW. 98-11-095, § 388-76-705, filed 5/20/98, effective 7/1/98. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-705, filed 6/19/96, effective 7/20/96.]

WAC 388-76-710 Notice, hearing rights, and effective dates relating to imposition of remedies. (1) Chapter 34.05 RCW applies to department actions under this chapter and chapter 70.128 RCW, except that orders of the department imposing license suspension, stop placement, or conditions on a license are effective immediately upon notice and shall continue pending a final administrative decision on the merits.

(2) Civil monetary penalties shall become due twenty-eight days after the provider or the owner or operator of an unlicensed adult family home is served with a notice of the penalty unless the provider requests a hearing in compliance with chapter 34.05 RCW and RCW 43.20A.215. If a hearing is requested, the penalty becomes due ten days after a final decision in the department's favor is issued. Interest shall accrue beginning thirty days after the department serves the provider with notice of the penalty at a rate of one percent per month in accordance with RCW 43.20B.695.

(3) A person contesting any decision by the department to impose a remedy shall within twenty-eight days of receipt of the decision:

(a) File a written application for an adjudicative proceeding by a method showing proof of receipt with the board of appeals at the mailing address contained in WAC 388-02-0030; and

(b) Include in or with the application:

(i) The grounds for contesting the department decision; and

(ii) A copy of the contested department decision.

(4) Administrative proceedings shall be governed by chapter 34.05 RCW, RCW 43.20A.215, where applicable, this section, and chapter 388-02 WAC. If any provision in this section conflicts with chapter 388-02 WAC, the provision in this section governs.

[Statutory Authority: RCW 70.128.040, 69.41.085. 02-15-081, § 388-76-710, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-710, filed 6/19/96, effective 7/20/96.]

WAC 388-76-715 Dispute resolution. (1) When a provider disagrees with the department's finding of a violation under this chapter, the provider shall have the right to have the violation reviewed by the department under the department's dispute resolution process. The purpose of the review is to give the provider an opportunity to present information which might warrant modification or deletion of a finding of a violation. The provider may submit a written statement for review. In addition to a written statement, the provider may request to present the information in person to a department designee. Requests for review shall be made to the department at the address provided in the department's certified letter within ten days of receipt of the written finding of a violation.

(2) When requested by a provider, the department shall expedite the dispute resolution process to review violations upon which a department order imposing license suspension, stop placement, or a condition on a license is based.

(3) Orders of the department imposing license suspension, stop placement, or conditions on a license are effective immediately upon notice and shall continue pending dispute resolution.

[Statutory Authority: RCW 70.128.040, 05-17-158, § 388-76-715, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-715, filed 6/19/96, effective 7/20/96.]

PART VI PHYSICAL PLANT REQUIREMENTS

WAC 388-76-720 Common use areas. The provider shall provide, within the adult family home, sufficient common use space, such as a living room, recreation area, or entertainment area, to create a homelike environment and meet the needs of the residents.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-720, filed 6/19/96, effective 7/20/96.]

WAC 388-76-725 Bedrooms. (1) Every resident bedroom shall be an outside room permitting entrance of natural light.

(2) Window screens shall be:

(a) Of such design that emergency escape is not hindered; and

(b) Adequate to prevent entrance of flies and other insects.

(3) The provider shall ensure that residents' bedrooms have direct access to hallways and corridors, and unrestricted access to living rooms, day rooms, and common use areas.

(4) The provider shall make separate sleeping quarters available for each sex and shall make reasonable efforts to accommodate residents wanting to share the same room.

(5) Single occupancy bedrooms shall be at least eighty square feet or more of floor space.

(6) Double occupancy bedrooms shall be at least one-hundred twenty square feet or more of floor space exclusive of closets.

(7) There shall not be more than two residents to a bedroom.

(8) Unless the resident chooses to provide his or her own furniture and bedding, the provider shall provide each resident a bed thirty-six inches or more wide with:

(a) A clean, comfortable mattress with waterproof cover for use when needed or requested by the resident;

(b) Clean sheets and pillow cases;

(c) Adequate blankets; and

(d) Clean pillows.

(9) The provider shall not use the upper bunk of double-deck beds for a resident's bed.

(10) If the provider's bedroom is not within hearing distance of resident bedrooms, the department may require the provider provide a call bell or intercom system.

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(11) The provider, resident manager, or family members shall not use as bedrooms those areas of the home designated as common use areas, or share bedrooms with residents.

(12) A resident may not share a bedroom with a person under eighteen years of age, unless it is the resident's own child.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-725, filed 6/19/96, effective 7/20/96.]

WAC 388-76-730 Toilets and bathing facilities. The adult family home shall be equipped with toilet and bathing facilities that provide residents with privacy and include:

(1) One indoor flush toilet for each five persons in the home;

(2) A bathing facility with securely fastened, conveniently located grab bars or other safety measures; and

(3) A sink with hot and cold running water.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-730, filed 6/19/96, effective 7/20/96.]

WAC 388-76-735 Kitchen facilities. The adult family home shall:

(1) Provide kitchen facilities that allow for proper food storage, preparation, and service; and

(2) Ensure the premises and equipment are maintained in a clean and sanitary manner including proper food handling.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-735, filed 6/19/96, effective 7/20/96.]

WAC 388-76-740 Telephones. The provider shall ensure that residents have reasonable access to at least one operating, nonpay telephone on the premises where calls may be made and received in privacy.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-740, filed 6/19/96, effective 7/20/96.]

WAC 388-76-745 Storage. The provider shall:

(1) Provide adequate space for resident's storage of clothing and a reasonable amount of personal possessions;

(2) Upon request, provide the resident with a lockable container or other lockable storage space for small items of personal property, unless the resident's individual room is lockable by the resident.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-745, filed 6/19/96, effective 7/20/96.]

WAC 388-76-750 Laundry. (1) For each licensed home, the provider shall provide laundry services as needed; and

(2) The provider shall launder sheets and pillowcases weekly or more frequently as needed.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-750, filed 6/19/96, effective 7/20/96.]

(2007 Ed.)

WAC 388-76-755 Local ordinances. The adult family home shall meet all applicable building and housing codes, and state and local fire safety regulations as they pertain to a single family residence. The provider shall be responsible for checking with local authorities to ensure all local codes are met.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-755, filed 6/19/96, effective 7/20/96.]

WAC 388-76-760 Site. An adult family home shall be located on a well-drained site free from hazardous conditions, excessive noise, dust, smoke or odors, and be accessible to other facilities or services necessary to carry out the program.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-760, filed 6/19/96, effective 7/20/96.]

EMERGENCY EVACUATION AND SAFETY REQUIREMENTS

WAC 388-76-76505 What physical structure requirements must the provider ensure that the home meets? (1) Each adult family home must meet applicable local licensing, zoning, building, and housing codes, and state and local fire safety regulations as they pertain to a single-family dwelling.

(2) It is the responsibility of the provider to check with local authorities to ensure all local codes are met.

(3) Effective July 1, 2004, the following adult family homes must meet requirements in WAC 51-51-0324 Section R324, Adult family homes as established by the Washington state building code council:

(a) Any single-family dwelling that has been newly constructed meeting all current applicable building codes, that has never been occupied, and that has a pending adult family home license application with the department;

(b) Any single-family dwelling being converted for use as an adult family home.

(4) WAC 51-51-0324 Section R324 - Adult family homes does not apply to adult family homes licensed before July 1, 2004, that are being sold or transferred for the purpose continuing the operation of a licensed adult family home under new ownership.

(5) Windows in every room used by residents must be free of obstructions.

(6) When resident bedroom windows are fitted with storm windows, the provider must equip the storm windows with release mechanisms that are easily opened from the inside without the use of a key or special knowledge or effort.

(7) The provider must ensure that every occupied area used by residents receiving care and services has access to one or more exit and must not pass through a room, garage, or other space subject to being locked or blocked from the opposite side.

(8) Every occupied area used by residents must not be accessible only by ladder, folding stairs, or trap door.

(9) The provider must ensure that every bathroom door lock opens from the outside in an emergency.

(10) The provider must ensure that every closet door opens from the inside and outside.

(2007 Ed.)

(11) The provider must ensure that exit doors leading to the outside will open from the inside without the use of a key or any special knowledge or effort.

[Statutory Authority: RCW 70.128.040 and chapter 70.128 RCW. 05-07-137, § 388-76-76505, filed 3/22/05, effective 4/22/05. Statutory Authority: RCW 70.128.040, 70.128.130, and 70.128.140. 02-20-004, § 388-76-76505, filed 9/18/02, effective 10/19/02.]

WAC 388-76-76510 What are the resident emergency evacuation requirements that providers must address? (1) Before a resident is admitted, the provider must disclose in writing and in a language understood by the prospective resident and/or their representative the following information:

(a) Whether or not the resident bedrooms in the home comply with current building code including evacuation standards;

(b) The source of and plan for on-site fire protection if the home is located outside a public fire district;

(c) All residents must participate in at least one household emergency evacuation drill per year involving a full evacuation from the home to a safe location.

(2) The resident's preliminary service plan (WAC 388-76-61030) and negotiated care plan (WAC 388-76-61500) must identify the resident's level of evacuation capability as defined by the following:

(a) Level 1: The resident is physically and mentally capable of self-preservation and walking or traversing a normal path to safety, including the ascent and descent of stairs, without the physical assistance of another person.

(b) Level 2: The resident is physically and mentally capable of traversing a normal path to safety with the use of mobility aids, but unable to ascend or descend stairs without the physical assistance of another person.

(c) Level 3: The resident physically or mentally is unable to walk or traverse a normal path to safety without the physical assistance of another person.

(3) The provider must ensure that residents who have an evacuation capability of Level 2 or Level 3 have their bedroom located on a grade level floor of the home. This grade level floor must have no less than two means of egress that do not require the use of stairs, elevator, or platform lift to exit.

(4) The provider must not admit or retain any residents who cannot be safely evacuated according to the provider's evacuation plan required under WAC 388-76-76520.

(5) For residents who are hearing and/or visually impaired, the provider must ensure that alternative emergency evacuation protections appropriate for hearing and/or visually impaired are installed as needed.

[Statutory Authority: RCW 70.128.040, 70.128.130, and 70.128.140. 02-20-004, § 388-76-76510, filed 9/18/02, effective 10/19/02.]

WAC 388-76-76515 What fire safety and emergency requirements must the provider have in the home? (1) The provider must provide and have readily available an approved 2-A:10-B:C rated (five pound) fire extinguisher in proper operating condition on each floor of living space of the adult family home. Where local fire authorities require installation of a different type or size of fire extinguisher, the requirement of the local authority shall prevail.

(2) The provider must ensure that each required fire extinguisher is inspected and serviced annually by a qualified inspector.

(3) If the home is not located in a public fire district, the provider must have written verification of adequate fire protection from the county fire authority.

(4) Every adult family home must have an approved automatic smoke detector in the following locations of the home:

(a) Every bedroom used by a resident;

(b) In proximity to the area where any resident or caregiver sleeps; and

(c) On every level of a home that is multilevel.

(5) Smoke detectors must be installed in such a manner so that the fire warning may be audible in all parts of the home upon activation of a single detector.

(6) The provider must ensure that all smoke detectors are maintained and in working condition at all times.

(7) The provider must not locate a stove or heater where the stove or heater blocks a resident's escape.

(8) Portable oil, gas, kerosene, and electric space heaters must not be used in the home except in the case of a power outage and the portable space heater is the home's only safe source of heat.

(9) The location of the adult family home must be accessible at all times for emergency vehicles.

(10) The provider must report to the department any fire and/or emergency evacuation in the adult family home in accordance with WAC 388-76-675 (4)(a).

[Statutory Authority: RCW 70.128.040, 70.128.130, and 70.128.140. 02-20-004, § 388-76-76515, filed 9/18/02, effective 10/19/02.]

WAC 388-76-76520 What is required of the provider for emergency evacuation drills? (1) The provider must develop a plan for emergency evacuation that reasonably ensures safe evacuation of all residents. The provider will determine the length of time necessary to safely evacuate all residents; however, the length of time shall not exceed five minutes. This emergency plan shall be written and posted and be operational at all times.

(2) All staff, caregivers and residents must be instructed in emergency evacuation procedures at the time of hire or admission.

(3) The provider must ensure that all residents participate in at least one household emergency evacuation drill every calendar year involving full evacuation from the home to a safe location.

(4) The provider must ensure that emergency evacuation drills are conducted at least every two months.

(5) The provider must document emergency evacuation drills recording the following information:

(a) Names of residents and staff involved including the person conducting the drill;

(b) Date and time of the drill; and

(c) The length of time required for evacuating all residents.

[Statutory Authority: RCW 70.128.040, 70.128.130, and 70.128.140. 02-20-004, § 388-76-76520, filed 9/18/02, effective 10/19/02.]

WAC 388-76-770 Safety and maintenance. The provider shall ensure:

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(1) The adult family home is maintained to provide a safe, clean, comfortable, and homelike environment;

(2) The adult family home is maintained internally and externally in good repair and condition, and free of hazards;

(3) The home has clean, functioning, safe, adequate household items and furnishings to provide for the needs of the residents;

(4) The home has safe and functioning systems for heating, cooling, hot and cold water, electricity, plumbing, garbage disposal, sewage, cooking, laundry, artificial and natural light, ventilation and any other feature of the home;

(5) Water temperature does not exceed one hundred twenty degrees Fahrenheit at fixtures used by residents, such as tub, shower, and lavatory facilities;

(6) Toxic substances, poisons, and other hazardous materials are stored in a place not accessible to residents except under supervision;

(7) Emergency lighting devices, such as flashlights are in working order and are available and easily accessible to caregivers and residents;

(8) Steps are provided with handrails;

(9) The provider is able to gain rapid access to any bedroom, toilet room, shower room, bathroom, or other room occupied by residents should emergency need arise;

(10) Residents do not use or have access to swimming or other pools, hot tubs, saunas, spas, or any outdoor body of water either on or off the premises without supervision;

(11) That any firearms are kept in locked storage and accessible only to authorized persons; and

(12) The adult family premises are kept free from rodents, flies, cockroaches, and other vermin.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.-130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-770, filed 6/19/96, effective 7/20/96.]

WAC 388-76-775 Pets. The provider shall ensure:

(1) Any animal visiting or living on the premises has a suitable temperament, is clean and healthy, and otherwise poses no significant health or safety risks to residents, staff, or visitors; and

(2) Pets residing on the premises have up-to-date rabies vaccinations.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.-130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-775, filed 6/19/96, effective 7/20/96.]

WAC 388-76-780 Lighting. The provider shall:

(1) Ensure lighting is adequate and comfortable for the functions being conducted in each area of the home; and

(2) Locate light fixtures to provide for the comfort and safety of the residents.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.-130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-780, filed 6/19/96, effective 7/20/96.]

WAC 388-76-785 Temperature and ventilation. The adult family home shall:

(1) Maintain room temperature within the home at sixty-eight degrees Fahrenheit or more during waking hours and sixty degrees Fahrenheit or more during sleeping hours; and

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(2) Be adequately ventilated to ensure the health and comfort of residents.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-785, filed 6/19/96, effective 7/20/96.]

WAC 388-76-790 Water supply. (1) If an adult family home has a private water supply, the provider shall have it approved by the local health authority; and

(2) The provider shall label nonpotable water on the premises to avoid use.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-790, filed 6/19/96, effective 7/20/96.]

WAC 388-76-795 Sewage and liquid wastes. The provider shall ensure sewage and liquid wastes are discharged into a public sewer system or into an independent sewage system approved by the local health authority or department of health.

[Statutory Authority: RCW 70.128.040, 70.128.060, 70.128.120, 70.128.130, 43.43.842, 18.88A.210 and 18.88A.230. 96-14-003 (Order 3984), § 388-76-795, filed 6/19/96, effective 7/20/96.]

Chapter 388-78A WAC

BOARDING HOME LICENSING RULES

(Formerly chapter 246-316 WAC)

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER			
388-78A-0010	Purpose. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0010, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0120	Resident participation in assessments. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0120, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0020	Definitions. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0020, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0130	Service agreement planning. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0130, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0030	Applicability. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0030, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0140	Negotiated service agreement contents. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0140, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0040	Other requirements. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0040, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0150	Signing negotiated service agreement. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0150, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0050	Resident characteristics. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0050, filed 7/31/03, effective 9/1/04.] Repealed by		

388-78A-0160	Basic boarding home services. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0160, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.		
388-78A-0170	Activities. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0170, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0270	Food and nutrition services. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0270, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0180	Medication services. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0180, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0280	Need to provide nursing services. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0280, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0190	Prescribed medication authorizations. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0190, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0290	Tube feeding. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0290, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-020	Licensure—Initial, renewal, day care approval respite care, modifications. [Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-020, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-020, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-020, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.43.830 through 43.43.842. 93-16-030 (Order 381), § 246-316-020, filed 7/26/93, effective 8/26/93. Statutory Authority: RCW 18.20.090 and 34.05.220. 92-02-018 (Order 224), § 246-316-020, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-020, filed 12/27/90, effective 1/31/91. Statutory Authority: Chapter 34.05 RCW, RCW 34.05.220 (1)(a) and 18.20.909 [18.20.090]. 90-06-019 (Order 039), § 248-16-031, filed 2/28/90, effective 3/1/90. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-031, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-030	Responsibilities and rights—Licensee and department. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-030, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-030, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-030, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-030, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-033, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-0200	Medication refusal. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0200, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0300	Supervision of nursing services. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0300, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0210	Nonavailability of medications. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0210, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0310	Responsibilities of nursing supervisor. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0310, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0220	Alteration of medications. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0220, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0320	Resident-arranged services. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0320, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0230	Storing, securing, and accounting for medications. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0230, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0330	Coordination of health care services. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0330, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0240	Resident controlled medications. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0240, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0340	Implementation of negotiated service agreement. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0340, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0250	Medication organizers. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0250, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0350	Monitoring residents' well-being. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0350, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0260	Family assistance with medication. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0260, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04.	388-78A-0360	Adult day care. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0360, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
		388-78A-0370	Dementia care. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0370, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
		388-78A-0380	Restricted egress. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0380, filed 7/31/03, effective 9/1/04.] Repealed by 04-

	16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0480	TB tests. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0480, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0390	Resident records. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0390, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0490	Specialized training for developmental disabilities. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0490, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-040	Administrator. [Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-040, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-040, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-040, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.43.830 through 43.43.842. 93-16-030 (Order 381), § 246-316-040, filed 7/26/93, effective 8/26/93. Statutory Authority: RCW 18.20.090. 92-02-018 (Order 224), § 246-316-040, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-040, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-036, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-050	Staff. [Statutory Authority: RCW 18.20.090. 70.128.-040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-78A-050, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-050, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-050, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-050, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.43.830 through 43.43.842. 93-16-030 (Order 381), § 246-316-050, filed 7/26/93, effective 8/26/93. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-050, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-046, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-0400	Protection of resident records. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0400, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0500	Specialized training for mental illness. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0500, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0410	Content of resident records. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0410, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0510	Specialized training for dementia. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0510, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0420	Format of resident records. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0420, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0520	Administrator qualifications. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0520, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0430	Record retention. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0430, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0530	Qualifying administrator training program. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0530, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0440	Resident review of records. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0440, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0540	Administrator training requirements. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0540, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-045	Criminal history, disclosure, and background inquiries. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-045, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-045, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.43.830 through 43.43.842. 93-16-030 (Order 381), § 246-316-045, filed 7/26/93, effective 8/26/93.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-055	Policies and procedures. [Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-055, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-055, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-055, filed 6/21/94, effective 7/22/94.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-0450	Resident register. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0450, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0550	Administrator training documentation. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0550, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0460	Staff. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0460, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0560	Administrator responsibilities. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0560, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0470	Criminal history background checks. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0470, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0570	Notification of change in administrator. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0570, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.

388-78A-0580	Use of home health/home care. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0580, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0680	Safety measures and disaster preparedness. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0680, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0590	Management agreements. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0590, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0690	Disclosure of services. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0690, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-060	HIV/AIDS education and training. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-060, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-060, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-060, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 70.24.310. 89-21-038 (Order 3), § 248-16-048, filed 10/12/89, effective 11/12/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-070	Construction. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-070, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-070, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-070, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-070, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-057, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-0600	Policies and procedures. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0600, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0700	Timing of disclosure. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0700, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0605	Pets. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0605, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0710	Licensee qualifications. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0710, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0610	Infection control. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0610, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0720	Necessary information. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0720, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0620	Reporting abuse and neglect. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0620, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0730	Application process. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0730, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0630	Reporting significant change in a resident's condition. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0630, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0740	Requirements to change boarding home licensee. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0740, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0635	Reporting fires and incidents. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0635, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0750	Annual renewal. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0750, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0640	Resident rights. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0640, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0760	Licensee's responsibilities. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0760, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0650	Services by resident for boarding home. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0650, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0770	Change in licensee. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0770, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0660	Boarding home use of audio and video monitoring. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0660, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0780	Changes in licensed bed capacity. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0780, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0670	Resident use of electronic monitoring. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0670, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0790	Criteria for increasing licensed bed capacity. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0790, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.

388-78A-080	Communication system. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-080, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-080, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-080, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-060, filed 4/14/89; 83-13-068 (Order 264), § 248-16-060, filed 6/16/83; Order 147, § 248-16-060, filed 6/29/77; Regulation.16.060, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	248-16-070, filed 6/16/83; Order 147, § 248-16-070, filed 6/29/77; Regulation .16.070, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	
388-78A-0800	Building requirements and exemptions. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0800, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0900	Area for nursing supplies and equipment. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0900, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0810	Conversion of licensed nursing homes. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0810, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0910	Communication system. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0910, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0820	Licenses for multiple buildings. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0820, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0920	Two-way intercom systems. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0920, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0830	Required reviews of building plans. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0830, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0930	Water supply. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0930, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0840	Relocation of residents during construction. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0840, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0940	Sewage and liquid waste disposal. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0940, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0850	Vacant buildings. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0850, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0950	Garbage and refuse disposal. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0950, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0860	Changing use of rooms. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0860, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0960	Lighting. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0960, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0870	Time frame for approval. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0870, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0970	Heating-cooling—Temperature. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0970, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0880	Retention of approved construction documents. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0880, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0980	Ventilation. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0980, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-0890	Applicable building codes. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0890, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-0990	Resident room—Room furnishings-storage. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-0990, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-090	Water supply. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-090, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-090, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-090, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-090, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-070, filed 4/14/89; 83-13-068 (Order 264), §	388-78A-1000	Calculating floor space. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1000, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
		388-78A-1010	Toilet rooms and bathrooms. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1010, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
		388-78A-1020	Laundry. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1020, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
		388-78A-1030	Day rooms. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1030, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed

	7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.		Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1040	Storage space. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1040, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-1130	Communication during inspections. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1130, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1050	Stairs—Ramps. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1050, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-1140	Communication following inspections. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1140, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1060	Guardrails—Handrails. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1060, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-1150	Statements of deficiencies and plans of correction. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1150, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1070	Maintenance and housekeeping. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1070, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-1160	Authorized enforcement remedies. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1160, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1080	Safe storage of supplies and equipment. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1080, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-1170	Statutory circumstances resulting in discretionary enforcement remedies. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1170, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1090	Areas for cleaning and storing soiled equipment, supplies and laundry. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1090, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-1180	Circumstances resulting in required enforcement remedies. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1180, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1100	Sewage and liquid waste disposal. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-1100, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-100, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-100, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-100, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-080, filed 4/14/89; Order 147, § 248-16-080, filed 6/29/77; Regulation .16.080, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-1190	Statutorily required enforcement remedies; denial, suspension, revocation, or nonrenewal of license. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1190, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1110	Garbage and refuse disposal. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-1110, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-110, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-110, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-090, filed 4/14/89; 83-13-068 (Order 264), § 248-16-090, filed 6/16/83; Order 147, § 248-16-090, filed 6/29/77; Regulation .16.090, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-1200	Lighting. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-1200, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-120, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-120, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-105, filed 4/14/89; 83-13-068 (Order 264), § 248-16-105, filed 6/16/83.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-1100	Areas for handling and storing clean supplies and equipment. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1100, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-1210	Other circumstances resulting in discretionary enforcement remedies. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1200, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1110	Plant restrictions. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1110, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.	388-78A-1220	Informal dispute resolution. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1210, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
388-78A-1120	Responsibilities during inspections. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1120, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04.	388-78A-1230	Appeal rights. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1220, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
		388-78A-130	Fees. [Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW. 03-16-047, § 388-78A-1230, filed 7/31/03, effective 9/1/04.] Repealed by 04-16-065, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW.
			Heating—Temperature. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-130,

	filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-130, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-130, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-110, filed 4/14/89; 83-13-068 (Order 264), § 248-16-110, filed 6/16/83; Order 147, § 248-16-110, filed 6/29/77; Regulation .16.110, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	
388-78A-140	Ventilation. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-140, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-140, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-140, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-115, filed 4/14/89; 83-13-068 (Order 264), § 248-16-115, filed 6/16/83.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-200
388-78A-150	Resident room—Room furnishings—Storage. [Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-150, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-150, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-150, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-150, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.-040. 91-02-049 (Order 121), recodified as § 246-316-150, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-121, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-210
388-78A-160	Toilet rooms and bathrooms. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-160, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-160, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-160, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-131, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-220
388-78A-170	Food and nutrition services. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-170, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-170, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-170, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-170, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-141, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-230
388-78A-180	Day rooms. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-180, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.-090. 94-13-180, § 246-316-180, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-180, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-150, filed 4/14/89; 83-13-068 (Order 264), § 248-16-150, filed 6/16/83; Order 147, § 248-16-150, filed 6/29/77; § 248-16-150, filed 10/3/67; Emergency Regulation, filed 8/4/67; Regulation .16.150, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-240
388-78A-190	Laundry. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-190, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-190, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-190, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-160, filed	388-78A-250
	4/14/89; 83-13-068 (Order 264), § 248-16-160, filed 6/16/83; Regulation .16.160, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	
	Storage space. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-200, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.-090. 94-13-180, § 246-316-200, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-200, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-200, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-170, filed 4/14/89; 83-13-068 (Order 264), § 248-16-170, filed 6/16/83; Regulation .16.170, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	
	Stairs—Ramps. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-210, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-210, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-210, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-180, filed 4/14/89; 83-13-068 (Order 264), § 248-16-180, filed 6/16/83; Regulation .16.180, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	
	Guardrails—Handrails. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-220, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-220, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-220, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-190, filed 4/14/89; 83-13-068 (Order 264), § 248-16-190, filed 6/16/83; Regulation .16.190, effective 3/11/60.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	
	Maintenance and housekeeping. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-230, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-230, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-230, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-202, filed 4/14/89; 83-13-068 (Order 264), § 248-16-202, filed 6/16/83; Order 147, § 248-16-202, filed 6/29/77.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	
	Criteria for accepting and retaining residents. [Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-240, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-240, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-240, filed 6/21/94, effective 7/22/94; 94-01-058, § 246-316-240, filed 12/8/93, effective 1/8/94; 92-02-018 (Order 224), § 246-316-240, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.-040. 91-02-049 (Order 121), recodified as § 246-316-240, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-213, filed 4/14/89; 83-13-068 (Order 264), § 248-16-213, filed 6/16/83; Order 147, § 248-16-213, filed 6/29/77.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	
	Resident rights. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-250, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.-090. 94-13-180, § 246-316-250, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-250, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-215, filed 4/14/89; 83-13-068 (Order 264), § 248-16-215, filed	

	6/16/83; Order 147, § 248-16-215, filed 6/29/77; Order 116, § 248-16-215, filed 5/23/75; § 248-16-215, filed 10/3/67; Emergency Regulation, filed 8/4/67.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.		tion 1, filed 5/31/61.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-260	Resident services. [Statutory Authority: RCW 18.20.-240. 98-20-021, recodified as § 388-78A-260, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-260, filed 6/21/94, effective 7/22/94; 94-01-058, § 246-316-260, filed 12/8/93, effective 1/8/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-260, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-216, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-320	Resident health record. [Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-320, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-320, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-320, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-320, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-320, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-235, filed 4/14/89; 83-13-068 (Order 264), § 248-16-235, filed 6/16/83.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-265	Limited nursing services. [Statutory Authority: RCW 18.20.090. 02-17-027, § 388-78A-265, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 18.20.-240. 99-15-067, § 388-78A-265, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-265, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-265, filed 6/21/94, effective 7/22/94.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-330	Adult day care. [Statutory Authority: RCW 18.20.240. 99-15-067, § 388-78A-330, filed 7/19/99, effective 8/19/99; 98-20-021, recodified as § 388-78A-330, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-330, filed 6/21/94, effective 7/22/94; 92-02-018 (Order 224), § 246-316-330, filed 12/23/91, effective 1/23/92. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-330, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-300, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-268	Health care services—Resident-arranged. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-268, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-268, filed 6/21/94, effective 7/22/94.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-335	Residents—Dementia care. [Statutory Authority: RCW 18.20.090. 00-01-086, § 388-78A-335, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 18.20.-240. 98-20-021, recodified as § 388-78A-335, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-335, filed 6/21/94, effective 7/22/94.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-280	Notification—Change in resident's condition. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-280, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-280, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-280, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-223, filed 4/14/89; 83-13-068 (Order 264), § 248-16-223, filed 6/16/83; Order 147, § 248-16-223, filed 6/29/77.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-340	Exemptions. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-340, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.-090. 94-13-180, § 246-316-340, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-340, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-900, filed 4/14/89. Statutory Authority: 1985 c 213. 86-08-002 (Order 2348), § 248-16-900, filed 3/20/86; Order 147, § 248-16-900, filed 6/29/77.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-290	Safety measures and quality assurance. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-290, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-290, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-290, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-226, filed 4/14/89; 83-13-068 (Order 264), § 248-16-226, filed 6/16/83; Order 147, § 248-16-226, filed 6/29/77.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.	388-78A-990	Fees. [Statutory Authority: RCW 18.20.090 and 18.20.240. 98-24-038, § 388-78A-990, filed 11/24/98, effective 1/1/99. Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-990, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.-050, 43.70.110 and 43.70.250. 98-01-165, § 246-316-990, filed 12/22/97, effective 1/22/98; 96-12-027, § 246-316-990, filed 5/30/96, effective 6/30/96. Statutory Authority: RCW 43.70.250, 43.70.110 and 43.20B.020. 95-12-097, § 246-316-990, filed 6/7/95, effective 7/8/95. Statutory Authority: RCW 43.70.110 and 43.70.250. 94-13-180, § 246-316-990, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.-250. 92-12-086 (Order 276), § 246-316-990, filed 6/2/92, effective 7/1/92. Statutory Authority: RCW 43.70.040. 91-02-050 (Order 122), § 246-316-990, filed 12/27/90, effective 1/31/91.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.
388-78A-300	Medication services. [Statutory Authority: RCW 18.20.240. 98-20-021, recodified as § 388-78A-300, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-300, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-300, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-229, filed 4/14/89.] Repealed by 03-16-047, filed 7/31/03, effective 9/1/04. Statutory Authority: RCW 18.20.090 and chapter 18.20 RCW.		
388-78A-310	Resident register. [Statutory Authority: RCW 18.20.-240. 98-20-021, recodified as § 388-78A-310, filed 9/25/98, effective 9/25/98. Statutory Authority: RCW 18.20.090. 94-13-180, § 246-316-310, filed 6/21/94, effective 7/22/94. Statutory Authority: RCW 43.70.040. 91-02-049 (Order 121), recodified as § 246-316-310, filed 12/27/90, effective 1/31/91. Statutory Authority: RCW 18.20.090. 89-09-034 (Order 2786), § 248-16-230, filed 4/14/89; 83-13-068 (Order 264), § 248-16-230, filed 6/16/83; Order 147, § 248-16-230, filed 6/29/77; Order 116, § 248-16-230, filed 5/23/75; § 248-16-230, filed 10/3/67; Emergency Regulation, filed 8/4/67; Regulation .16.230, effective 3/11/60; Subsec-		

GENERAL

WAC 388-78A-2010 Purpose. This chapter is written to implement chapter 18.20 RCW, to promote the safety and well-being of boarding home residents, to specify standards for boarding home operators, and to further establish requirements for the operation of boarding homes.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2010, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2020 Definitions. "Abandonment" means action or inaction by a person with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a resident. In instances of abuse of a resident who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a resident, which have the following meanings:

(1) **"Mental abuse"** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a resident from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing;

(2) **"Physical abuse"** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints;

(3) **"Sexual abuse"** means any form of nonconsensual sexual contact, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person and a resident, whether or not it is consensual;

(4) **"Exploitation"** means an act of forcing, compelling, or exerting undue influence over a resident causing the resident to act in a way that is inconsistent with relevant past behavior, or causing the resident to perform services for the benefit of another;

(5) **"Financial exploitation"** means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage.

"Activities of daily living" means the following tasks related to basic personal care: Bathing; toileting; dressing; personal hygiene; mobility; transferring; and eating.

"Adult day services" means care and services provided to a nonresident individual by the boarding home on the boarding home premises, for a period of time not to exceed ten continuous hours, and does not involve an overnight stay.

"Ambulatory" means capable of walking or traversing a normal path to safety without the physical assistance of another individual:

(1) **"Nonambulatory"** means unable to walk or traverse a normal path to safety without the physical assistance of another individual;

(2) **"Semiambulatory"** means physically and mentally capable of traversing a normal path to safety with the use of mobility aids, but unable to ascend or descend stairs without the physical assistance of another individual.

"Applicant" means the person, as defined in this section, that has submitted, or is in the process of submitting, an application for a boarding home license.

"Basic services" means housekeeping services, meals, nutritious snacks, laundry, and activities.

"Bathing fixture" means a bathtub, shower or sit-down shower.

"Bathroom" means a room containing at least one bathing fixture.

"Boarding home" means any home or other institution, however named, which is advertised, announced, or maintained for the express or implied purpose of providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents, and may also provide domiciliary care, consistent with this chapter to seven or more residents after July 1, 2000. However, a boarding home that is licensed for three to six residents prior to or on July 1, 2000, may maintain its boarding home license as long as it is continually licensed as a boarding home. "Boarding home" does not include facilities certified as group training homes pursuant to RCW 71A.22.040, nor any home, institution or section thereof which is otherwise licensed and regulated under the provisions of state law providing specifically for the licensing and regulation of such home, institution or section thereof. Nor shall it include any independent senior housing, independent living units in continuing care retirement communities, or other similar living situations including those subsidized by the Department of Housing and Urban Development. "Boarding home" may also include persons associated with the boarding home to carry out its duties under this chapter.

"Building code" means the building codes and standards adopted by the Washington state building code council.

"Caregiver" means anyone providing hands-on personal care to another person including, but not limited to: Cuing, reminding or supervision of residents, on behalf of a boarding home, except volunteers who are directly supervised. Direct supervision means oversight by a person who has demonstrated competency in the basic training (and specialty training if required), or who has been exempted from the basic training requirements, is on the premises, and is quickly and easily available to the caregiver.

"Construction review services" means the office of construction review services within the Washington state department of health.

"Continuing care contract" means, as stated in RCW 70.38.025, a contract providing a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related, or personal care services, which is conditioned upon the transfer of property, the payment of an entrance fee to the provider of such services, or the payment of periodic charges for the care and services involved. A continuing care contract is not excluded from this definition because the contract is mutually terminable or because shelter and services are not provided at the same location.

"Continuing care retirement community" means, as stated in RCW 70.38.025, an entity which provides shelter and services under continuing care contracts with its members and which sponsors or includes a health care facility or a health service.

"Contractor" means an agency or person who contracts with a licensee to provide resident care, services or equipment.

"Crimes relating to financial exploitation" means the same as "crimes relating to financial exploitation" as defined in RCW 43.43.830 or 43.43.842.

"Department" means the Washington state department of social and health services.

"Dietitian" means an individual certified under chapter 18.138 RCW.

"Document" means to record, with signature, title, date and time:

(1) Information about medication administration, medication assistance or disposal, a nursing care procedure, accident, occurrence or change in resident condition that may affect the care or needs of a resident; and

(2) Processes, events or activities that are required by law, rule or policy.

"Domiciliary care" means:

(1) Assistance with activities of daily living provided by the boarding home either directly or indirectly; or

(2) Health support services, if provided directly or indirectly by the boarding home; or

(3) Intermittent nursing services, if provided directly or indirectly by the boarding home.

"Enforcement remedy" means one or more of the department's responses to a boarding home's noncompliance with chapter 18.20 RCW and this chapter, as authorized by RCW 18.20.190.

"Food service worker" means according to chapter 246-217 WAC an individual who works (or intends to work) with or without pay in a food service establishment and handles unwrapped or unpackaged food or who may contribute to the transmission of infectious diseases through the nature of his/her contact with food products and/or equipment and facilities. This does not include persons who simply assist residents with meals.

"General responsibility for the safety and well-being of the resident" means the provision of the following:

(1) Prescribed general low sodium diets;

(2) Prescribed general diabetic diets;

(3) Prescribed mechanical soft foods;

(4) Emergency assistance;

(5) Monitoring of the resident;

(6) Arranging health care appointments with outside health care providers and reminding residents of such appointments as necessary;

(7) Coordinating health care services with outside health care providers consistent with WAC 388-78A-2350;

(8) Assisting the resident to obtain and maintain glasses, hearing aids, dentures, canes, crutches, walkers, wheelchairs, and assistive communication devices;

(9) Observation of the resident for changes in overall functioning;

(10) Blood pressure checks as scheduled;

(11) Responding appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning; or

(12) Medication assistance as permitted under RCW 69.41.085 and as described in RCW 69.41.010 and chapter 246-888 WAC.

"Harm" means a physical or mental or emotional injury or damage to a resident including those resulting from neglect or violations of a resident's rights.

"Health support services" means any of the following optional services:

(1) Blood glucose testing;

(2) Puree diets;

(3) Calorie controlled diabetic diets;

(4) Dementia care;

(5) Mental health care; or

(6) Developmental disabilities care.

"Independent living unit" means:

(1) Independent senior housing;

(2) Independent living unit in a continuing care retirement community or other similar living environments;

(3) Boarding home unit where domiciliary services are not provided; or

(4) Boarding home unit where one or more items listed under "general responsibilities" are not provided.

"Independent senior housing" means an independent living unit occupied by an individual or individuals sixty or more years of age.

"Infectious" means capable of causing infection or disease by entrance of organisms into the body, which grow and multiply there, including, but not limited to, bacteria, viruses, protozoans, and fungi.

"Licensee" means the person, as defined in this chapter, to whom the department issues the boarding home license.

"Licensed resident bed capacity" means the resident occupancy level requested by the licensee and approved by the department. All residents receiving domiciliary care or the items or services listed under general responsibility for the safety and well-being of the resident as defined in this section count towards the licensed resident bed capacity. Adult day services clients do not count towards the licensed resident bed capacity.

"Majority owner" means any person that owns:

(1) More than fifty percent interest; or

(2) If no one person owns more than fifty percent interest, the largest interest portion; or

(3) If more than one person owns equal largest interest portions, then all persons owning those equal largest interest portions.

"Manager" means the person defined in this chapter, providing management services on behalf of the licensee.

"Management agreement" means a written, executed agreement between the licensee and the manager regarding the provision of certain services on behalf of the licensee.

"Maximum facility capacity" means the maximum number of individuals that the boarding home may serve at any one time, as determined by the department.

(1) The maximum facility capacity includes all residents and respite care residents and adult day services clients.

(2) The maximum facility capacity is equal to the lesser of:

(a) The sum of the number of approved bed spaces for all resident rooms (total number of approved bed spaces), except as specified in subsection (3); or

(b) Twice the seating capacity of the dining area(s) consistent with WAC 388-78A-2300 (1)(h); or

(c) The number of residents permitted by calculating the ratios of toilets, sinks, and bathing fixtures to residents consistent with WAC 388-78A-3030; or

(d) For boarding homes licensed on or before December 31, 1988, the total day room area in square feet divided by ten square feet, consistent with WAC 388-78A-3050; or

(e) For boarding homes licensed after December 31, 1988, the total day room area in square feet divided by twenty square feet, consistent with WAC 388-78A-3050.

(3) For the purposes of providing adult day services consistent with WAC 388-78A-2360, one additional adult day services client may be served, beyond the total number of approved bed spaces, for each additional sixty square feet of day room area greater than the area produced by multiplying the total number of approved bed spaces by twenty square feet, provided that:

(a) There is a least one toilet and one hand washing sink accessible to adult day services clients for every eight adult day services clients or fraction thereof;

(b) The total number of residents and adult day services clients does not exceed twice the seating capacity of the dining area(s) consistent with WAC 388-78A-2300 (1)(h); and

(c) The adult day services program area(s) and building do not exceed the occupancy load as determined by the local building official or state fire marshal.

"Medication administration" means the direct application of a prescribed medication whether by injection, inhalation, ingestion, or other means, to the body of the resident by an individual legally authorized to do so.

"Medication assistance" means assistance with self-administration of medication rendered by a nonpractitioner to a resident of a boarding home in accordance with chapter 246-888 WAC.

"Medication organizer" means a container with separate compartments for storing oral medications organized in daily doses.

"Medication service" means any service provided either directly or indirectly by a boarding home related to medication administration, medication administration provided through nurse delegation, medication assistance, or resident self-administration of medication.

"Neglect" means:

(1) A pattern of conduct or inaction resulting in the failure to provide the goods and services that maintain physical or mental health of a resident, or that fails to avoid or prevent physical or mental harm or pain to a resident; or

(2) An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the resident's health, welfare, or safety.

"Nonresident individual" means an individual who resides in independent senior housing, independent living units in continuing care retirement communities, or in other similar living environments or in a boarding home and may receive one or more of the services listed in WAC 388-78A-2030 (2)(a) through (g). A nonresident individual may not receive domiciliary care as defined in this section, directly or indirectly by the boarding home, and may not receive the items or services listed under general responsibility for the safety and well-being of the resident as defined in this section, except during the time the person is receiving adult day services as defined in this section.

tion, except during the time the person is receiving adult day services as defined in this section.

"Nonpractitioner" means any individual who is not a practitioner as defined in WAC 388-78A-2020 and chapter 69.41 RCW.

"Nurse" means an individual currently licensed under chapter 18.79 RCW as either a:

(1) **"Licensed practical nurse"** (LPN); or

(2) **"Registered nurse"** (RN).

"Over-the-counter (OTC) medication" means any medication that may be legally purchased without a prescriptive order, including, but not limited to, aspirin, antacids, vitamins, minerals, or herbal preparations.

"Person" means any individual, firm, partnership, corporation, company, association, joint stock association or any other legal or commercial entity.

"Physician" means an individual licensed under chapter 18.57 or 18.71 RCW.

"Practitioner" includes a licensed physician, osteopathic physician, podiatric physician, pharmacist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, dentist, and physician assistant. Refer to chapter 69.41 RCW for a complete listing of practitioners.

"Prescribed medication" means any medication (legend drug, controlled substance, and over-the-counter) that is prescribed by an authorized practitioner.

"Prescriber" means a health care practitioner authorized by Washington state law to prescribe drugs.

"Problem" means a violation of any WAC or RCW applicable to the operation of a boarding home:

(1) **"Recurring problem"** means, for all purposes other than those described in RCW 18.20.400, that the department has cited the boarding home for a violation of WAC or RCW and the circumstances of (a) or (b) of this subsection are present:

(a) The department previously imposed an enforcement remedy for a violation of the same section of WAC or RCW for substantially the same problem following any type of inspection within the preceding thirty-six months; or

(b) The department previously cited a violation under the same section of WAC or RCW for substantially the same problem following any type of inspection on two occasions within the preceding thirty-six months.

(c) If the previous violation in (a) or (b) of this subsection was pursuant to WAC or RCW that has changed at the time of the new violation, citation to the equivalent current WAC or RCW section is sufficient.

(d) When there is a change in licensees between the first and the second or third citations, the new licensee must accept, and the department will consider, the prior licensee's compliance and enforcement record as part of the new licensee's compliance record at that boarding home if any person affiliated with the new licensee was affiliated with the prior licensee at the same boarding home. A person is considered affiliated with the licensee if the person is an applicant for the boarding home license, or is listed on the license application as a partner, officer, director, or majority owner of the applicant.

(2) **"Serious problem"** means:

(a) There has been a violation of a WAC or RCW; and

(b) Significant harm has actually occurred to a resident;
or

(c) It is likely that significant harm or death will occur to a resident.

(3) **"Uncorrected problem"** means the department has cited a violation of WAC or RCW following any type of inspection and the violation remains uncorrected at the time the department makes a subsequent inspection for the specific purpose of verifying whether such violation has been corrected. When a change in licensees occurs, the new licensee is responsible for correcting any remaining violations that may exist, including complying with any plan of correction in effect immediately prior to the change in licensees.

"Prospective resident" means an individual who is seeking admission to a licensed boarding home and who has completed and signed an application for admission, or such application for admission has been completed and signed in their behalf by their legal representative if any, and if not, then the designated representative if any.

"Reasonable accommodation" and **"reasonably accommodate"** have the meaning given in federal and state antidiscrimination laws and regulations which include, but are not limited to, the following:

(1) Reasonable accommodation means that the boarding home must:

(a) Not impose admission criteria that excludes individuals unless the criteria is necessary for the provision of boarding home services;

(b) Make reasonable modification to its policies, practices or procedures if the modifications are necessary to accommodate the needs of the resident;

(c) Provide additional aids and services to the resident.

(2) Reasonable accommodations are not required if:

(a) The resident or individual applying for admission presents a significant risk to the health or safety of others that cannot be eliminated by the reasonable accommodation;

(b) The reasonable accommodations would fundamentally alter the nature of the services provided by the boarding home; or

(c) The reasonable accommodations would cause an undue burden, meaning a significant financial or administrative burden.

"RCW" means Revised Code of Washington.

"Records" means:

(1) **"Active records"** means the current, relevant documentation regarding residents necessary to provide care and services to residents; or

(2) **"Inactive records"** means historical documentation regarding the provision of care and services to residents that is no longer relevant to the current delivery of services and has been thinned from the active record.

"Resident" means an individual who:

(1) Chooses to reside in a boarding home, including an individual receiving respite care;

(2) Is not related by blood or marriage to the operator of the boarding home;

(3) Receives basic services; and

(4) Receives one or more of the services listed under general responsibility for the safety and well-being of the resident, and may receive domiciliary care or respite care provided directly, or indirectly, by the boarding home.

"Resident's representative" means:

(1) The legal representative who is the person or persons identified in RCW 7.70.065 and who may act on behalf of the resident pursuant to the scope of their legal authority. The legal representative shall not be affiliated with the licensee, boarding home, or management company, unless the affiliated person is a family member of the resident; or

(2) If there is no legal representative, a person designated voluntarily by a competent resident in writing, to act in the resident's behalf concerning the care and services provided by the boarding home and to receive information from the boarding home if there is no legal representative. The resident's representative may not be affiliated with the licensee, boarding home, or management company, unless the affiliated person is a family member of the resident. The resident's representative under this subsection shall not have authority to act on behalf of the resident once the resident is no longer competent. The resident's competence shall be determined using the criteria in RCW 11.88.010 (1)(e).

"Respite care" means short-term care for any period in excess of twenty-four continuous hours for a resident to temporarily relieve the family or other caregiver of providing that care.

"Restraint" means any method or device used to prevent or limit free body movement, including, but not limited to:

(1) Confinement, unless agreed to as provided in WAC 388-78A-2370;

(2) **"Chemical restraint"** which means a psychopharmacologic drug that is used for discipline or convenience and not required to treat the resident's medical symptoms; and

(3) **"Physical restraint"** which means a manual method, obstacle, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that restricts freedom of movement or access to his or her body, is used for discipline or convenience, and not required to treat the resident's medical symptoms.

"Room" means a space set apart by floor to ceiling partitions on all sides with all openings provided with doors or windows.

(1) **"Sleeping room"** means a room where a resident is customarily expected to sleep and contains a resident's bed.

(2) **"Resident living room"** means the common space in a resident unit that is not a sleeping room, bathroom or closet.

"Significant change" means a change in the resident's physical, mental, or psychosocial status that causes either life-threatening conditions or clinical complications.

"Special needs" means a developmental disability, mental illness, or dementia.

"Staff person" means any boarding home employee or temporary employee or contractor, whether employed or retained by the licensee or any management company, or volunteer.

"State fire marshal" means the director of fire protection under the direction of the chief of the Washington state patrol.

"Toilet" means a disposal apparatus used for urination and defecation, fitted with a seat and flushing device.

"Volunteer" means an individual who interacts with residents without reimbursement.

"Vulnerable adult" means "vulnerable adult" as defined in chapter 74.34 RCW. For the purposes of requesting and receiving background checks pursuant to RCW 43.43.832, it shall also include adults of any age who lack the functional, mental, or physical ability to care for themselves.

"WAC" means Washington Administrative Code.

"WISHA" means the Washington Industrial Safety and Health Act, chapter 49.17 RCW administered by the Washington state department of labor and industries.

[Statutory Authority: RCW 18.20.090 and 2006 c 242, 06-13-028, § 388-78A-2020, filed 6/13/06, effective 7/14/06. Statutory Authority: RCW 18.20.090, 06-01-047, § 388-78A-2020, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW, 04-16-065, § 388-78A-2020, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2030 Applicability. (1) A person must have a boarding home license issued by the department under chapter 18.20 RCW and this chapter, except as otherwise exempted by RCW 18.20.170 and subsection (2) of this section, if the person advertises as, or operates, or maintains a facility that meets the definition of a "boarding home" in this chapter, within Washington state and provides housing, one or more basic services, and one or more of the following:

- (a) Assumes general responsibility for the safety and well-being of the residents;
- (b) Provides assistance with activities of daily living, either directly or indirectly;
- (c) Provides health support services, either directly or indirectly; or
- (d) Provides intermittent nursing services, either directly or indirectly.

(2) A boarding home license is not required for one or more of the following services that may be provided to a nonresident individual. These services may not include continual care or supervision of a nonresident individual without a boarding home license:

- (a) Emergency assistance provided on an intermittent or nonroutine basis to any nonresident individual; or
- (b) Systems employed by independent senior housing, or independent living units in continuing care retirement communities, to respond to the potential need for emergency services for nonresident individuals; or
- (c) Infrequent, voluntary, and nonscheduled blood pressure checks for nonresident individuals; or
- (d) Nurse referral services provided at the request of a nonresident individual to determine whether referral to an outside health care provider is recommended; or
- (e) Making health care appointments at the request of nonresident individuals; or
- (f) Preadmission assessment, at the request of the nonresident individual; or
- (g) Services customarily provided under landlord tenant agreements governed by the Residential Landlord-Tenant Act, chapter 59.18 RCW; or
- (h) Housing nonresident individuals who, without ongoing assistance from the boarding home, initiate and arrange for services with a practitioner licensed under Title 18 RCW or a home health, hospice, or home care agency licensed under chapter 70.127 RCW, or other persons as permitted by the boarding home.

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(3) This section does not prohibit a boarding home from furnishing written information concerning available community resources to nonresident individuals or the individual's family members or legal representatives. However, the boarding home may not require the use of any particular service provider.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW, 04-16-065, § 388-78A-2030, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2040 Other requirements. (1) The boarding home must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

(2) The boarding home must have its building approved by the Washington state fire marshal in order to be licensed.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW, 04-16-065, § 388-78A-2040, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2050 Resident characteristics. The boarding home may admit and retain an individual as a resident in a boarding home only if:

(1) The boarding home can safely and appropriately serve the individual with appropriate available staff providing:

(a) The scope of care and services described in the boarding home's disclosure information, except if the boarding home chooses to provide additional services consistent with RCW 18.20.300(4); and

(b) The reasonable accommodations required by state or federal law, including providing any specialized training to caregivers that may be required according to WAC 388-78A-2490 through 388-78A-2510;

(2) The individual does not require the frequent presence and frequent evaluation of a registered nurse, excluding those individuals who are receiving hospice care or individuals who have a short-term illness that is expected to be resolved within fourteen days as long as the boarding home has the capacity to meet the individual's identified needs; and

(3) The individual is ambulatory, unless the boarding home is approved by the Washington state director of fire protection to care for semiambulatory or nonambulatory residents.

[Statutory Authority: RCW 18.20.090, 06-01-047, § 388-78A-2050, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW, 04-16-065, § 388-78A-2050, filed 7/30/04, effective 9/1/04.]

ASSESSMENT AND MONITORING

WAC 388-78A-2060 Preadmission assessment. The boarding home must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the boarding home:

- (1) Medical history;
- (2) Necessary and contraindicated medications;
- (3) A licensed medical or health professional's diagnosis, unless the individual objects for religious reasons;
- (4) Significant known behaviors or symptoms that may cause concern or require special care;

- (5) Mental illness diagnosis, except where protected by confidentiality laws;
- (6) Level of personal care needs;
- (7) Activities and service preferences; and
- (8) Preferences regarding other issues important to the applicant, such as food and daily routine.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2060, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2070 Timing of preadmission assessment. (1) Unless there is an emergency, the boarding home must complete the preadmission assessment of the prospective resident before each prospective resident moves into the boarding home.

(2) The boarding home must ensure the preadmission assessment is completed within five calendar days of the resident moving into the boarding home when the resident moves in under emergency conditions.

(3) For the purposes of this section, "emergency" means any circumstances when the prospective resident would otherwise need to remain in an unsafe setting or be without adequate and safe housing.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2070, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2080 Qualified assessor. The boarding home must ensure the person responsible for completing a preadmission assessment of a prospective resident:

(1) Has a master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or

(2) Has a bachelor's degree in social services, human services, behavioral sciences, or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or

(3) Has a valid Washington state license to practice nursing, in accordance with chapters 18.79 RCW and 246-840 WAC; or

(4) Is a physician with a valid state license to practice medicine; or

(5) Has three years of successful experience acquired prior to September 1, 2004, assessing prospective and current boarding home residents in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2080, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2090 Full assessment topics. The boarding home must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

- (a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;
- (b) Chronic, current, and potential skin conditions; or
- (c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the boarding home premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the boarding home unsupervised; and

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the boarding home.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the boarding home must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the boarding home.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2090, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2100 On-going assessments. The boarding home must:

(1) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(2) Complete an assessment specifically focused on a resident's identified problems and related issues:

(a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120;

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(c) When the resident has an injury requiring the intervention of a practitioner.

(3) Ensure the staff person performing the on-going assessments is qualified to perform them.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2100, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2100, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2110 Resident participation in assessments. The boarding home must directly involve each resident or prospective resident, to the extent possible, along with any appropriate resident representative to the extent he or she is willing and capable, in the preadmission assessment and on-going assessment process.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2110, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2120 Monitoring residents' well-being. The boarding home must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

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(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2120, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2120, filed 7/30/04, effective 9/1/04.]

NEGOTIATED SERVICE AGREEMENT

WAC 388-78A-2130 Service agreement planning.

The boarding home must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into a boarding home. The boarding home must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120:

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

(4) Review and update each resident's negotiated service agreement as necessary following an annual full assessment;

(5) Involve the following persons in the process of developing and updating a negotiated service agreement:

(a) The resident;

(b) The resident's representative to the extent he or she is willing and capable, if the resident has one;

(c) Other individuals the resident wants included;

(d) The department's case manager, if the resident is a recipient of Medicaid assistance, or any private case manager, if available; and

(e) Staff designated by the boarding home.

(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

(2007 Ed.)

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate and agree upon the care and services to be provided to support the resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2130, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2140 Negotiated service agreement contents. The boarding home must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the boarding home;

(c) The plan to provide necessary intermittent nursing services, if provided by the boarding home;

(d) The plan to provide necessary health support services, if provided by the boarding home;

(e) The resident's preferences for how services will be provided, supported and accommodated by the boarding home.

(2) Clearly defined respective roles and responsibilities of the resident, the boarding home staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340(5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the boarding home, the boarding home must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The boarding home may develop an alternate plan:

(a) Exclusively for the individual resident; or

(b) Based on standard policies and procedures in the boarding home provided that they are consistent with the reasonable accommodation requirements of state and federal law.

(3) The times services will be delivered, including frequency and approximate time of day, as appropriate;

(4) The resident's preferences for activities and how those preferences will be supported;

(5) Appropriate behavioral interventions, if needed;

(6) A communication plan, if special communication needs are present;

(7) The resident's ability to leave the boarding home premises unsupervised; and

(8) The boarding home must not require or ask the resident or the resident's representative to sign any negotiated service or risk agreement, that purports to waive any rights of the resident or that purports to place responsibility or liability for losses of personal property or injury on the resident.

(2007 Ed.)

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2140, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2150 Signing negotiated service agreement. The boarding home must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the boarding home duly authorized by the boarding home to sign on its behalf; and

(3) Any public or private case manager for the resident, if available.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2150, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2160 Implementation of negotiated service agreement. The boarding home must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the boarding home and the resident or the resident's representative at the time the care or services are scheduled.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2160, filed 7/30/04, effective 9/1/04.]

BOARDING HOME SERVICES

WAC 388-78A-2170 Required boarding home services. (1) The boarding home must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

(2) The boarding homes must provide each resident with the following basic services, consistent with the resident's assessed needs and negotiated service agreement:

(a) **Activities** - Arranging for activities in accordance with WAC 388-78A-2180;

(b) **Housekeeping** - Providing a safe, clean and comfortable environment for each resident, including personal living quarters and all other resident accessible areas of the building;

(c) **Laundry** - Keeping the resident's clothing clean and in good repair, and laundering towels, washcloths, bed linens on a weekly basis or more often as necessary to maintain cleanliness;

(d) **Meals** - Providing meals in accordance with WAC 388-78A-2300; and

(e) **Nutritious snacks** - Providing nutritious snack items on a scheduled and nonscheduled basis, and providing nutritious snacks in accordance with WAC 388-78A-2300.

(3) The boarding home must:

(a) Provide care and services to each resident by staff persons who are able to communicate with the resident in a language the resident understands; or

(b) Make provisions for communications between staff persons and residents to ensure an accurate exchange of information.

(4) The boarding home must ensure each resident is able to obtain individually preferred personal care items when:

(a) The preferred personal care items are reasonably available; and

(b) The resident is willing and able to pay for obtaining the preferred items.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2170, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2180 Activities. The boarding home must:

(1) Provide space and staff support necessary for:

(a) Each resident to engage in independent or self-directed activities that are appropriate to the setting, consistent with the resident's assessed interests, functional abilities, preferences, and negotiated service agreement; and

(b) Group activities at least three times per week that may be planned and facilitated by caregivers consistent with the collective interests of a group of residents.

(2) Make available routine supplies and equipment necessary for activities described in subsection (1) of this section.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2180, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2190 Activities of daily living. Assistance with activities of daily living is an optional service that the boarding home may provide.

(1) If a boarding home chooses not to provide assistance with activities of daily living:

(a) The boarding home must admit or retain only those residents who are independent in activities of daily living; except that

(b) A resident, or the resident's representative, may independently arrange for outside services to assist with activities of daily living.

(2) When a boarding home chooses to provide, either directly or indirectly, assistance with activities of daily living, the boarding home must provide that assistance consistent with the reasonable accommodation requirements in state and federal laws.

(3) When a boarding home chooses to provide, either directly or indirectly, assistance with activities of daily living, the boarding home must provide to each resident, consistent with the resident's assessed needs, minimal assistance with the following activities of daily living:

(a) **Bathing:** Minimal assistance with bathing means the boarding home must provide the resident with occasional:

(i) Reminding or cuing to wash and dry all areas of the body as needed;

(ii) Stand-by assistance getting into and out of the tub or shower; and

(iii) Physical assistance limited to steadying the resident during the activity.

(b) **Dressing:** Minimal assistance with dressing means the boarding home must provide the resident with occasional:

(i) Reminding or cuing to put on, take off, or lay out clothing, including prostheses when the assistance of a licensed nurse is not required;

(ii) Stand-by assistance during the activity; and

(iii) Physical assistance limited to steadying the resident during the activity.

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(c) **Eating:** Minimal assistance with eating means the boarding home must provide the resident with occasional:

(i) Reminding or cuing to eat and drink; and

(ii) Physical assistance limited to cutting food up, preparing food and beverages, and bringing food and fluids to the resident.

(d) **Personal hygiene:** Minimal assistance with personal hygiene means the boarding home must provide the resident with occasional:

(i) Reminding and cuing to comb hair, perform oral care and brush teeth, shave, apply makeup, and wash and dry face, hands and other areas of the body;

(ii) Stand-by assistance during the activity; and

(iii) Physical assistance limited to steadying the resident during the activity.

(e) **Transferring:** Minimal assistance in transferring means the boarding home must provide the resident with occasional:

(i) Reminders or cuing to move between surfaces, for example to and from the bed, chair and standing;

(ii) Stand-by assistance during the activity; and

(iii) Physical assistance limited to steadying the resident during self-transfers.

(f) **Toileting:** Minimal assistance in toileting means the boarding home must provide the resident with occasional:

(i) Reminders and cuing to toilet, including resident self-care of ostomy or catheter, to wipe and cleanse, and to change and adjust clothing, protective garments and pads;

(ii) Stand-by assistance during the activity; and

(iii) Physical assistance limited to steadying the resident during the activity.

(g) **Mobility:** Minimal assistance in mobility means the boarding home must provide the resident with occasional:

(i) Reminding or cuing to move between locations on the boarding home premises;

(ii) Stand-by assistance during the activity; and

(iii) Physical assistance limited to steadying the resident during the activity.

(4) The boarding home may choose to provide more than minimal assistance with activities of daily living consistent with state and federal law.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2190, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2200 Health support services. Health support services are an optional service that the boarding home may provide. The boarding home may choose to provide any of the following health support services; however, a boarding home may or may not need to provide additional health support services to comply with the reasonable accommodation requirements in federal and state law. The boarding home may provide:

(1) Blood glucose testing;

(2) Puree diets;

(3) Calorie controlled diabetic diets;

(4) Dementia care;

(5) Mental health care; and

(6) Developmental disabilities care.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2200, filed 7/30/04, effective 9/1/04.]

(2007 Ed.)

Medications

WAC 388-78A-2210 Medication services. (1) A boarding home providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs—Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The boarding home must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250:

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the boarding home will provide medication assistance; and

(b) If the boarding home provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the boarding home will provide medication administration.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2210, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2220 Prescribed medication authorizations. (1) Before the boarding home may provide medication assistance or medication administration to a resident for prescribed medications, the boarding home must have one of the following:

(a) A prescription label completed by a licensed pharmacy;

(b) A written order from the prescriber;

(c) A facsimile or other electronic transmission of the order from the prescriber; or

(d) Written documentation by a nurse of a telephone order from the prescriber.

(2) The documentation required above in subsection (1) of this section must include the following information:

(a) The name of the resident;

(b) The name of the medication;

(c) The dosage and dosage frequency of the medication; and

(d) The name of the prescriber.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2220, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2230 Medication refusal. (1) When a resident who is receiving medication assistance or medication administration services from the boarding home chooses to not take his or her medications, the boarding home must:

(a) Respect the resident's right to choose not to take medication;

(b) Document the time, date and medication the resident did not take;

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(2007 Ed.)

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

(2) The boarding home must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the boarding home with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The boarding home documents such directions; and

(c) The boarding home is able to fully comply with such directions.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2230, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2240 Nonavailability of medications.

When the boarding home has assumed responsibility for obtaining a resident's prescribed medications, the boarding home must obtain them in a correct and timely manner.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2240, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2250 Alteration of medications. The boarding home must generally provide medications in the form they are prescribed when administering medications or providing medication assistance to a resident. The boarding home may provide medications in an altered form consistent with the following:

(1) Alteration includes, but is not limited to, crushing tablets, cutting tablets in half, opening capsules, mixing powdered medications with foods or liquids, or mixing tablets or capsules with foods or liquids.

(2) Residents must be aware that the medication is being altered or added to their food.

(3) A pharmacist or other practitioner practicing within their scope of practice must determine that it is safe to alter a medication.

(4) If the medication is altered, documentation of the appropriateness of the alteration must be on the prescription container, or in the resident's record.

(5) Alteration of medications for self-administration with assistance is provided in accordance with chapter 246-888 WAC.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2250, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2260 Storing, securing, and accounting for medications. (1) The boarding home must secure medications for residents who are not capable of safely storing their own medications.

(2) The boarding home must ensure all medications under the boarding home's control are properly stored:

(a) In containers with pharmacist-prepared label or original manufacturer's label;

(b) Together for each resident and physically separated from other residents' medications;

(c) Separate from food or toxic chemicals;

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

(e) In environments recommended on the medication label.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2260, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2270 Resident controlled medications. (1) The boarding home must ensure all medications are stored in a manner that prevents each resident from gaining access to another resident's medications.

(2) The boarding home must allow a resident to control and secure the medications that he or she self-administers or self-administers with assistance if the boarding home assesses the resident to be capable of safely and appropriately storing his or her own medications and the resident desires to do so.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2270, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2270, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2280 Medication organizers. (1) The boarding home must ensure no staff person other than a nurse or licensed pharmacist fills medication organizers for residents.

(2) The boarding home must ensure that any nurse who fills a medication organizer for a resident labels the medication organizer with:

- (a) The name of the resident;
- (b) The name of the medications in the organizer; and
- (c) The frequency of the dosage.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2280, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2280, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2290 Family assistance with medications and treatments. (1) A boarding home may permit a resident's family member to administer medications or treatments or to provide medication or treatment assistance, including obtaining medications or treatment supplies, to the resident.

(2) The boarding home must disclose to the department, residents, the residents' legal representatives, if any, and if not the residents' representative if any, and to interested consumers upon request, information describing whether the boarding home permits such family administration or assistance and, if so, the extent of any limitations or conditions.

(3) If the boarding home allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the boarding home must request that the family member submit to the boarding home a written plan for such assistance or administration that includes at a minimum:

- (a) By name, the family member who will provide the medication or treatment assistance or administration;
- (b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the boarding home observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the boarding home.

(4) The plan for family assistance with medications or treatments must be signed and dated by:

- (a) The resident, if able;
- (b) The resident's representative, if any;
- (c) The resident's family member responsible for implementing the plan; and

(d) A representative of the boarding home authorized by the boarding home to sign on its behalf.

(5) The boarding home may, through policy or procedure, require the resident's family member to immediately notify the boarding home of any changes in the medication or treatment plans for family assistance or administration.

(6) The boarding home must require that whenever a resident's family provides medication assistance or medication administration services, the resident's significant medications remain on the boarding home premises whenever the resident is on the boarding home premises.

(7) The boarding home's duty of care shall be limited to: Observation of the resident for changes in overall functioning consistent with RCW 18.20.280; notification to the person or persons identified in RCW 70.129.030 when there are observed changes in the resident's overall functioning or condition, or when the boarding home is aware that both the primary and alternate plan are not implemented; and appropriately responding to obtain needed assistance when there are observable or reported changes in the resident's physical or mental functioning.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2290, filed 7/30/04, effective 9/1/04.]

Food

WAC 388-78A-2300 Food and nutrition services. (1) The boarding home must:

- (a) Provide a minimum of three meals a day:
 - (i) At regular intervals;
 - (ii) With no more than fourteen hours between the evening meal and breakfast, unless the boarding home provides a nutritious snack after the evening meal and before breakfast.
- (b) Provide sufficient time and staff support for residents to consume meals;
- (c) Ensure all menus:
 - (i) Are written at least one week in advance and delivered to residents' rooms or posted where residents can see them, except as specified in (f) of this subsection;
 - (ii) Indicate the date, day of week, month and year;
 - (iii) Include all food and snacks served that contribute to nutritional requirements;
 - (iv) Are kept at least six months;
 - (v) Provide a variety of foods; and
 - (vi) Are not repeated for at least three weeks, except that breakfast menus in boarding homes that provide a variety of

daily choices of hot and cold foods are not required to have a minimum three-week cycle.

(d) Prepare on-site, or provide through a contract with a food service establishment located in the vicinity and that meets the requirements of chapter 246-215 WAC, palatable, attractively served meals and nourishments that meet the current recommended dietary allowances established by the Food and Nutrition Board, National Research Council, adjusted for:

- (i) Age, gender and activities, unless medically contraindicated; and
- (ii) Individual preferences to the extent reasonably possible.

(e) Substitute foods, when changes in the current day's menu are necessary, of equal nutrient value and record changes on the original menu;

(f) Make available and known to residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The boarding home is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

(g) Develop, make known to residents, and implement a process for residents to express their views and comment on the food services; and

(h) Maintain a dining area or areas approved by the department with a seating capacity for fifty percent or more of the residents per meal setting, or ten square feet times the licensed resident bed capacity, whichever is greater.

(2) The boarding home must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The boarding home must ensure the diet manual is:

- (i) Available to and used by staff persons responsible for food preparation;
- (ii) Approved by a dietitian; and
- (iii) Reviewed and updated as necessary or at least every five years.

(b) Prescribed nutrient concentrates and supplements when prescribed in writing by a health care practitioner.

(3) The boarding home may provide to a resident at his or her request and as agreed upon in the resident's negotiated service agreement, nonprescribed:

- (a) Modified or therapeutic diets;
- (b) Nutritional concentrates or supplements.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2300, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2300, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2305 Food sanitation. The boarding home must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

(2) Ensure employees working as food service workers obtain a food worker card according to chapter 246-217 WAC; and

(2007 Ed.)

(3) Ensure a resident obtains a food worker card according to chapter 246-217 WAC whenever:

- (a) The resident is routinely or regularly involved in the preparation of food to be served to other residents;
- (b) The resident is paid for helping to prepare food; or
- (c) The resident is preparing food to be served to other residents as part of an employment-training program.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2305, filed 12/15/05, effective 1/15/06.]

Intermittent Nursing Services and Resident-Arranged Services

WAC 388-78A-2310 Intermittent nursing services.

(1) Intermittent nursing services are an optional service that the boarding home may provide.

(2) The boarding home may choose to provide any of the following intermittent nursing services through appropriately licensed and credentialed staff; however, the facility may or may not need to provide additional intermittent nursing services to comply with the reasonable accommodation requirements in federal or state law:

- (a) Medication administration;
- (b) Administration of health treatments;
- (c) Diabetic management;
- (d) Nonroutine ostomy care;
- (e) Tube feeding; and
- (f) Nurse delegation consistent with chapter 18.79 RCW.

(3) The boarding home must clarify on the disclosure form any limitations, additional services, or conditions that may apply under this section.

(4) In providing intermittent nursing services, the boarding home must observe the resident for changes in overall functioning and respond appropriately when there are observable or reported changes in the resident's physical, mental or emotional functioning.

(5) The boarding home may provide intermittent nursing services to the extent permitted by RCW 18.20.160.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2310, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2320 Intermittent nursing services systems. (1) When a boarding home provides intermittent nursing services to any resident, either directly or indirectly, the boarding home must:

- (a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and
- (b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The boarding home providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

- (a) Nursing services supervision;
- (b) Nurse delegation, if provided;
- (c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

(e) Implementation of the nursing component of each resident's negotiated service agreement; and

(f) Availability of the supervisor, in person, by pager, or by telephone, to respond to residents' needs on the boarding home premises as necessary.

(3) The boarding home must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

- (a) Chapter 18.79 RCW, Nursing care;
- (b) Chapter 18.88A RCW, Nursing assistants;
- (c) Chapter 246-840 WAC, Practical and registered nursing;
- (d) Chapter 246-841 WAC, Nursing assistants; and
- (e) Chapter 246-888 WAC, Medication assistance.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2320, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2330 Tube feeding. (1) Tube feeding services are an optional service that a boarding home may provide.

(2) The boarding home must provide intermittent nursing services to develop and implement the nursing component of the negotiated service agreement, administer feedings and necessary medications, and provide routine care of the tube insertion site whenever any resident requiring tube feeding is not able to:

- (a) Independently and safely manage:
 - (i) Maintenance of the tube insertion site;
 - (ii) Necessary medication administration through the tube; and
 - (iii) Feeding administration through the tube.
- (b) Arrange for an outside resource to provide:
 - (i) Maintenance of the tube insertion site;
 - (ii) Necessary medication administration through the tube; and
 - (iii) Feeding administration through the tube.

(3) The boarding home is not required to provide nursing services to a resident simply because the resident requires tube feeding if the resident can either independently manage or arrange for an outside resource to perform the tasks specified in subsection (2)(a) and (b) of this section.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2330, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2340 Resident-arranged services. (1) The boarding home must allow a resident to arrange to receive on-site care and services from:

- (a) A practitioner, licensed under Title 18 RCW regulating health care professions; and
- (b) A home health, hospice, or home care agency licensed under chapter 70.127 RCW.

(2) The boarding home may permit the resident or the resident's legal representative, if any, to independently arrange for other persons to provide on-site care and services to the resident.

(3) The boarding home is not required to supervise the activities of a person providing care or services to a resident when the resident or resident's representative has independently arranged for or contracted with the person.

(4) The boarding home may establish policies and procedures that describe reasonable limitations, conditions, or

requirements that must be met prior to an outside service provider being allowed on-site.

(5) When the resident or the resident's representative, if any, independently arranges for outside services under subsection (1) of this section, the boarding home's duty of care, and any negligence that may be attributed thereto, shall be limited to: The responsibilities described under subsection (3) of this section; observation of the resident for changes in overall functioning, consistent with RCW 18.20.280; notification to the person or persons identified in RCW 70.129.030 when there are observed changes in the resident's overall functioning or condition; and appropriately responding to obtain needed assistance when there are observable or reported changes in the resident's physical or mental functioning.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2340, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2350 Coordination of health care services. (1) The boarding home must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

(2) The boarding home must develop, implement and inform residents of the boarding home's policies regarding how the boarding home interacts with external health care providers, including:

- (a) The conditions under which health care information regarding a resident will be shared with external health care providers, consistent with chapter 70.02 RCW; and
- (b) How residents' rights to privacy will be protected, including provisions for residents to authorize the release of health care information.

(3) The boarding home may disclose health care information about a resident to external health care providers without the resident's authorization if the conditions in RCW 70.02.050 are met.

(4) If the conditions in RCW 70.02.050 are not met, the boarding home must request, but may not require, a resident to authorize the boarding home and the external health care provider to share the resident's health care information when:

- (a) The boarding home becomes aware that a resident is receiving health care services from a source other than the boarding home; and
- (b) The resident has not previously authorized the boarding home to release health care information to an external health care provider.

(5) When a resident authorizes the release of health care information or resident authorization is not required under RCW 70.02.050, the boarding home must contact the external health care provider and coordinate services.

(6) When authorizations to release health care information are not obtained, or when an external health care provider is unresponsive to the boarding home's efforts to coordinate services, the boarding home must:

- (a) Document the boarding home's actions to coordinate services;
- (b) Provide notice to the resident of the risks of not allowing the boarding home to coordinate care with the external provider; and
- (c) Address known associated risks in the resident's negotiated service agreement.

(7) When coordinating care or services, the boarding home must:

(a) Integrate relevant information from the external provider into the resident's preadmission assessment and reassessment, and when appropriate, negotiated service agreement; and

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2350, filed 7/30/04, effective 9/1/04.]

Service Delivery and Monitoring

Adult Day Services

WAC 388-78A-2360 Adult day services. (1) The boarding home may, but is not required to, provide an adult day services program for nonresidents.

(2) If adult day services are provided, the boarding home must:

(a) Ensure each adult day services client receives appropriate supervision and agreed upon care and services during the time spent in the day services program;

(b) Ensure the care and services provided to adult day services clients do not compromise the care and services provided to boarding home residents;

(c) Ensure the total number of residents plus adult day services clients does not exceed the boarding home's maximum facility capacity;

(d) Only accept adult day services clients who are appropriate for boarding home care and services, consistent with WAC 388-78A-2050;

(e) Provide sufficient furniture for the comfort of day services clients, in addition to furniture provided for residents;

(f) Notify appropriate individuals specified in the client's record and consistent with WAC 388-78A-2640 when there is a significant change in the condition of an adult day services client;

(g) Investigate and document incidents and accidents involving adult day services clients consistent with WAC 388-78A-2700;

(h) Maintain a separate register of adult day services clients; and

(i) Maintain a record for each adult day services client.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2360, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2360, filed 7/30/04, effective 9/1/04.]

Dementia Care

WAC 388-78A-2370 Dementia care. (1) The boarding home must, to the fullest extent reasonably possible, obtain for each resident who has symptoms consistent with dementia as assessed per WAC 388-78A-2090(7):

(a) Information regarding the resident's significant life experiences, including:

(i) Family members or other significant relationships;

(ii) Education and training;

(iii) Employment and career experiences;

(iv) Religious or spiritual preferences;

(v) Familiar roles or sources of pride and pleasure.

(b) Information regarding the resident's ability or inability to:

(i) Articulate his or her personal needs; and

(ii) Initiate activity.

(c) Information regarding any patterns of resident behavior that express the resident's needs or concerns that the resident is not able to verbalize. Examples of such behaviors include, but are not limited to:

(i) Agitation;

(ii) Wandering;

(iii) Resistance to care;

(iv) Social isolation; and

(v) Aggression.

(2) The boarding home, in consultation with the resident's family or others familiar with the resident, must evaluate the significance and implications of the information obtained per subsection (1) of this section and integrate appropriate aspects into an individualized negotiated service agreement for the resident.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2370, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2380 Restricted egress. A boarding home must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(1) Each resident, or a person authorized under RCW 7.70.065 to provide consent on behalf of the resident, consents to living in such unit or building.

(2) Each resident assessed as being cognitively and physically able to safely leave the boarding home is able to do so independently without restriction.

(3) Each resident, assessed as being cognitively able to safely leave the boarding home and who has physical challenges that make exiting difficult, is able to leave the boarding home when the resident desires and in a manner consistent with the resident's negotiated service agreement.

(4) Each resident who is assessed as being unsafe to leave the boarding home unescorted is able to leave the boarding home consistent with his or her negotiated service agreement.

(5) Areas from which egress is restricted are equipped throughout with an approved automatic fire detection system and automatic fire sprinkler system electrically interconnected with a fire alarm system that transmits an alarm off site to a twenty-four hour monitoring station.

(6) Installation of special egress control devices in all proposed construction issued a project number by construction review services on or after September 1, 2004 for construction related to this section, must conform to standards adopted by the state building code council.

(7) Installation of special egress control devices in all construction issued a project number by construction review services before September 1, 2004 for construction related to this section, must conform to the following:

(a) The egress control device must automatically deactivate upon activation of either the sprinkler system or the smoke detection system.

(b) The egress control device must automatically deactivate upon loss of electrical power to any one of the following:

- (i) The egress control device itself;
- (ii) The smoke detection system; or
- (iii) The means of egress illumination.

(c) The egress control device must be capable of being deactivated by a signal from a switch located in an approved location.

(d) An irreversible process which will deactivate the egress control device must be initiated whenever a manual force of not more than fifteen pounds is applied for two seconds to the panic bar or other door-latching hardware. The egress control device must deactivate within an approved time period not to exceed a total of fifteen seconds. The time delay must not be field adjustable.

(e) Actuation of the panic bar or other door-latching hardware must activate an audible signal at the door.

(f) The unlatching must not require more than one operation.

(g) A sign must be provided on the door located above and within twelve inches of the panic bar or other door-latching hardware reading:

"Keep pushing. The door will open in fifteen seconds. Alarm will sound."

The sign lettering must be at least one inch in height and must have a stroke of not less than one-eighth inch.

(h) Regardless of the means of deactivation, relocking of the egress control device must be by manual means only at the door.

(8) The boarding home must have a system in place to inform and permit visitors, staff persons and appropriate residents how they can exit without sounding the alarm.

(9) Units or buildings from which egress is restricted are equipped with a secured outdoor space for walking which:

- (a) Is accessible to residents without staff assistance;
- (b) Is surrounded by walls or fences at least seventy-two inches high;
- (c) Has areas protected from direct sunshine and rain throughout the day;
- (d) Has walking surfaces that are firm, stable, slip-resistant and free from abrupt changes and are suitable for individuals using wheelchairs and walkers; and
- (e) Has suitable outdoor furniture.

[Statutory Authority: RCW 18.20.090, 06-01-047, § 388-78A-2380, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW, 04-16-065, § 388-78A-2380, filed 7/30/04, effective 9/1/04.]

Resident Records

WAC 388-78A-2390 Resident records. The boarding home must maintain adequate records concerning residents to enable the boarding home:

- (1) To effectively provide the care and services agreed upon with the resident; and
- (2) To respond appropriately in emergency situations.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW, 04-16-065, § 388-78A-2390, filed 7/30/04, effective 9/1/04.]

[Title 388 WAC—p. 434]

WAC 388-78A-2400 Protection of resident records.

The boarding home must:

(1) Maintain a systematic and secure method of identifying and filing resident records for easy access;

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

(3) Allow authorized representatives of the department and other authorized regulatory agencies access to resident records;

(4) Provide any resident or other individual or organization access to resident records upon written consent of the resident or the resident's representative, unless state or federal law provide for broader access;

(5) Allow authorized agents, such as a management company, to use resident records solely for the purpose of providing care and services to residents and ensure that agents do not disclose such records except in a manner consistent with law; and

(6) Maintain ownership and control of resident records, except that resident records may be transferred to a subsequent person licensed by the department to operate the boarding home.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW, 04-16-065, § 388-78A-2400, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2410 Content of resident records. The boarding home must organize and maintain resident records in a format that the boarding home determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(1) Resident identifying information, including resident's:

- (a) Name;
- (b) Birth date;
- (c) Move-in date; and
- (d) Sleeping room identification.

(2) Current name, address, and telephone number of:

- (a) Resident's primary health care provider;
- (b) Resident's representative, if the resident has one;
- (c) Individual(s) to contact in case of emergency, illness or death; and

(d) Family members or others, if any, the resident requests to be involved in the development or delivery of services for the resident.

(3) Resident's written acknowledgment of receipt of:

- (a) Required disclosure information prior to moving into the boarding home; and
- (b) Information required by long-term care resident rights per RCW 70.129.030.

(4) The resident's assessment and reassessment information.

(5) Clinical information such as admission weight, height, blood pressure, temperature, blood sugar and other laboratory tests required by the negotiated service agreement.

(6) The resident's negotiated service agreement consistent with WAC 388-78A-2140.

(7) Any orders for medications, treatments, and modified or therapeutic diets, including any directions for addressing a

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resident's refusal of medications, treatments, and prescribed diets.

(8) Medical and nursing services provided by the boarding home for a resident, including:

(a) A record of providing medication assistance and medication administration, which contains:

(i) The medication name, dose, and route of administration;

(ii) The time and date of any medication assistance or administration;

(iii) The signature or initials of the person providing any medication assistance or administration; and

(iv) Documentation of a resident choosing to not take his or her medications.

(b) A record of any nursing treatments, including the signature or initials of the person providing them.

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

(10) Staff interventions or responses to subsection (9) of this section, including any modifications made to the resident's negotiated service agreement.

(11) Notices of and reasons for relocation as specified in RCW 70.129.110.

(12) The individuals who were notified of a significant change in the resident's condition and the time and date of the notification.

(13) When available, a copy of any legal documents in which:

(a) The resident has appointed another individual to make his or her health care, financial, or other decisions;

(b) The resident has created an advance directive or other legal document that establishes a surrogate decision maker in the future and/or provides directions to health care providers; and

(c) A court has established guardianship on behalf of the resident.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2410, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2420 Record retention. (1) The boarding home must maintain on the boarding home premises in a resident's active record(s) all relevant information and documentation necessary for meeting a resident's current assessed needs.

(2) The boarding home may remove outdated information from the resident's active records that is no longer significant or relevant to the resident's current assessed service and care needs, and maintain it in an inactive record that must remain on the boarding home premises as long as the resident remains in the boarding home.

(3) The boarding home must maintain all documentation filed in a closed resident record, on the boarding home premises for six months after the date the resident leaves the boarding home and on the boarding home premises or another location for five years after the date the resident leaves the boarding home.

(4) All active, inactive, and closed resident records must be available for review by department staff and other authorized persons.

(5) If a boarding home ceases to operate as a licensed boarding home, the most recent licensee must make arrange-

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ments to ensure that the former residents' records are retained according to the times specified in this section and are available for review by department staff and other authorized individuals.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2420, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2430 Resident review of records. (1)

The boarding home must assemble all records pertaining to a resident and make them available to a resident within twenty-four hours of the resident's or the resident's representative's request to review the resident's records per RCW 70.129.030.

(2) The boarding home must provide to the resident or the resident's representative, photocopies of the records or any portions of the records pertaining to the resident, within two working days of the resident's or resident's representative's request for the records.

(a) For the purposes of this section, "working days" means Monday through Friday, except for legal holidays.

(b) The boarding home may charge the resident or the resident's representative a fee not to exceed twenty-five cents per page for the cost of photocopying the resident's record.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2430, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2440 Resident register. (1)

The boarding home must maintain in the boarding home a single current roster of all boarding home residents, their roommates and identification of the rooms in which such persons reside or sleep.

(2) The boarding home must make this roster immediately available to:

(a) Authorized department staff;

(b) Representatives of the long-term care ombudsman's office; and

(c) Representatives of the Washington state fire protection bureau when conducting fire safety inspections.

(3) The boarding home must maintain a readily available permanent, current book, computer file, or register with entries in ink or typewritten, of all former boarding home residents within the past five years, including:

(a) Date of moving in;

(b) Full name;

(c) Date of birth;

(d) Date of moving out;

(e) Reason for moving out; and

(f) New address if known.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2440, filed 7/30/04, effective 9/1/04.]

ADMINISTRATION

Staff

WAC 388-78A-2450 Staff. (1) Each boarding home must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the boarding home free of safety hazards; and

(c) Implement fire and disaster plans.

(2) The boarding home must:

(a) Develop and maintain written job descriptions for the administrator and each staff position and provide each staff person with a copy of his or her job description before or upon the start of employment;

(b) Verify staff persons' work references prior to hiring;

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

(d) Document and retain for twelve weeks, weekly staffing schedules, as planned and worked;

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times;

(i) When one or more residents are present on the boarding home premises; and

(ii) During boarding home activities off of the boarding home premises.

(g) Ensure caregiver provides on-site supervision of any resident voluntarily providing services for the boarding home;

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of boarding home;

(ii) Physical boarding home layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and boarding home policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

(i) Develop and implement a process to ensure caregivers:

(i) Acquire the necessary information from the preadmission assessment, on-going assessment and negotiated service agreement relevant to providing services to each resident with whom the caregiver works;

(ii) Are informed of changes in the negotiated service agreement of each resident with whom the caregiver works; and

(iii) Are given an opportunity to provide information to responsible staff regarding the resident when assessments and negotiated service agreements are updated for each resident with whom the caregiver works.

(j) Ensure all caregivers have access to resident records relevant to effectively providing care and services to the resident.

(3) The boarding home must:

(a) Ensure that staff persons meet the training requirements specified in chapter 388-112 WAC;

(b) Protect all residents by ensuring any staff person suspected or accused of abuse does not have access to any resident until the boarding home investigates and takes action to ensure resident safety;

(c) Not interfere with the investigation of a complaint, coerce a resident or staff person regarding cooperating with a complaint investigation, or conceal or destroy evidence of alleged improprieties occurring within the boarding home;

(d) Prohibit staff persons from being directly employed by a resident or a resident's family during the hours the staff person is working for the boarding home;

(e) Maintain the following documentation on the boarding home premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training pertinent to duties, including, but not limited to:

(A) Training required by chapter 388-112 WAC, including as appropriate for each staff person, orientation, basic training or modified basic training, specialty training, nurse delegation core training, and continuing education;

(B) Cardiopulmonary resuscitation;

(C) First aid; and

(D) HIV/AIDS training.

(ii) Criminal history disclosure and background checks as required in WAC 388-78A-2470; and

(iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (1) of this section.

(4) The boarding home is not required to keep on the boarding home premises, staff records that are unrelated to staff performance of duties. Such records include, but are not limited to, pay records, and health and insurance benefits for staff.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2450, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2460 Quality assurance committee.

(1) To ensure the proper delivery of services and the maintenance and improvement in quality of care through self-review, any boarding home licensed under this chapter may maintain a quality assurance committee that, at a minimum, includes:

(a) A licensed registered nurse under chapter 18.79 RCW;

(b) The administrator; and

(c) Three other members from the staff of the boarding home.

(2) When established, the quality assurance committee shall meet at least quarterly to identify issues that may adversely affect quality of care and services to residents and to develop and implement plans of action to correct identified quality concerns or deficiencies in the quality of care provided to residents.

(3) To promote quality of care through self-review without the fear of reprisal, and to enhance the objectivity of the review process, the department shall not require, and the long-term care ombudsman program shall not request, disclosure of any quality assurance committee records or reports,

unless the disclosure is related to the committee's compliance with this section, if:

(a) The records or reports are not maintained pursuant to statutory or regulatory mandate; and

(b) The records or reports are created for and collected and maintained by the committee.

(4) If the boarding home refuses to release records or reports that would otherwise be protected under this section, the department may then request only that information that is necessary to determine whether the boarding home has a quality assurance committee and to determine that it is operating in compliance with this section. However, if the boarding home offers the department documents generated by, or for, the quality assurance committee as evidence of compliance with boarding home requirements, the documents are not protected as quality assurance committee documents when in the possession of the department.

(5) Good faith attempts by the committee to identify and correct quality deficiencies shall not be used as a basis for sanctions.

(6) Any records that are created for and collected and maintained by the quality assurance committee shall not be discoverable or admitted into evidence in a civil action brought against a boarding home.

(7) Notwithstanding any records created for the quality assurance committee, the facility shall fully set forth in the resident's records, available to the resident, the department, and others as permitted by law, the facts concerning any incident of injury or loss to the resident, the steps taken by the facility to address the resident's needs, and the resident outcome.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2460, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2470 Criminal history background checks. (1) This section applies to any individual associated with the licensee or boarding home who may have unsupervised access to residents, including but not limited to:

- (a) Employees;
- (b) Managers;
- (c) Volunteers who are not residents;
- (d) Contractors; and
- (e) Students.

(2) The boarding home must:

(a) Ensure any individual associated with the licensee or boarding home who may have unsupervised access to residents has had a background check of conviction records, pending charges and disciplinary board decisions completed within the past two years, and is repeated every two years thereafter, and that individual has not been:

- (i) Convicted of a crime against children or other persons as defined in RCW 43.43.830 or 43.43.842;
- (ii) Convicted of crimes relating to financial exploitation as defined in RCW 43.43.830 or 43.43.842;
- (iii) Found in any disciplinary board final decision to have abused a vulnerable adult as defined in RCW 43.43.830;
- (iv) The subject in a protective proceeding under chapter 74.34 RCW;
- (v) Convicted of criminal mistreatment; or
- (vi) Found by the department to have abused, neglected, or exploited a minor or vulnerable person, provided the indi-

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vidual was offered an administrative hearing to contest the finding, and the finding was upheld, or the individual failed to timely appeal the finding.

(b) Not hire or retain, directly or by contract, or accept as a volunteer, any individual prohibited from having unsupervised access to residents under (a) of this subsection, except as provided in subsection (6) of this section and RCW 43.43.842.

(3) Prior to first starting his or her duties, the boarding home must:

(a) Require each prospective employee, manager, volunteer, contractor and student associated with the licensee or boarding home who may have unsupervised access to residents to disclose, consistent with RCW 43.43.834(2), whether he or she:

(i) Has been convicted of a crime, including any of the following as defined in RCW 43.43.830:

- (A) All crimes against children or their persons;
- (B) All crimes relating to financial exploitation; and
- (C) All crimes relating to drugs;

(ii) Has had findings made against him or her in any civil adjudicative proceeding as defined in RCW 43.43.830; or

(iii) Has both convictions for (i) and findings made against him or her under (ii).

(b) Require each individual making the disclosures required in subsection (3)(a) of this section:

- (i) To make the disclosures in writing;
- (ii) To swear under penalty of perjury that the contents of the disclosure are accurate; and
- (iii) To sign the disclosure statement.

(4) Prior to first starting his or her duties, the boarding home must take one or more of the following three actions for each prospective employee, manager, volunteer, contractor and student associated with the licensee or boarding home who may have unsupervised access to residents:

(a) Initiate a background check on the individual through the department, which includes taking the following actions:

(i) Informing the individual that a background check is required.

(ii) Requiring the individual to complete and sign a DSHS background authorization form prior to the individual having unsupervised access to residents;

(iii) Submitting all background check authorization forms to the department's:

(A) Aging and disability services administration with the initial application for licensure; and

(B) Background check central unit for currently licensed boarding homes.

(iv) Verbally informing the named individual of his/her individual background check results and offering to provide him or her a copy of the background check results within ten days of receipt.

(b) Obtain from the individual's prior employer a copy of the completed criminal background inquiry information for the individual, subject to the following conditions:

(i) The prior employer was a nursing home licensed under chapter 18.51 RCW, a boarding home licensed under chapter 18.20 RCW, or an adult family home licensed under chapter 70.128 RCW;

(ii) The nursing home, boarding home or adult family home providing completed criminal background inquiry

information for the individual is reasonably known to be the individual's most recent employer;

(iii) No more than twelve months has elapsed from the date the individual was employed by the nursing home, boarding home or adult family home and the date of the individual's current application;

(iv) The background inquiry for the individual is no more than two years old; and

(v) The boarding home has no reason to believe the individual has or may have a disqualifying conviction or finding as described in RCW 43.43.842.

(c) When using staff persons from a home health, hospice, or home care agency licensed under chapter 70.127 RCW, or a nursing pool registered under chapter 18.52C RCW, the boarding home must establish, maintain and follow a written agreement with the agency or pool to ensure the requirements of subsection (2) of this section are met for the agency or pool staff who may work in the boarding home.

(5) The boarding home must ensure that all disclosure statements, and background check results obtained by the boarding home, are:

(a) Maintained on-site in a confidential and secure manner;

(b) Used for employment purposes only;

(c) Not disclosed to any individual except:

(i) The individual named on the background check result;

(ii) Authorized state and federal employees;

(iii) The Washington state patrol auditor; and

(iv) As otherwise authorized in chapter 43.43 RCW.

(d) Retained and available for department review:

(i) During the individual's employment or association with a facility; and

(ii) At least two years following termination of employment or association with a facility.

(6) The boarding home may conditionally hire, directly or by contract, an individual having unsupervised access to residents pending a background inquiry, provided the boarding home:

(a) Obtains a criminal history background check authorization form from the individual prior to the individual beginning work;

(b) Submits the criminal history background check authorization form to the department no later than one business day after the individual started working; and

(c) Has received three positive references for the individual.

(7) The department may require the boarding home or any other individual associated with the boarding home who has unsupervised access to residents to complete additional disclosure statements or background inquiries if the department has reason to believe that offenses specified under RCW 43.43.830 have occurred since completion of the previous disclosure statement or background inquiry.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2470, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2470, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2480 TB tests. (1) The boarding home must ensure each staff person, except for volunteers and contractors, is screened for tuberculosis, as follows:

(a) Except when a staff person provided the boarding home with documentation of a previous positive Mantoux skin test, a staff person hired before September 1, 2004 must have had:

(i) A tuberculin skin test by the Mantoux method within six months preceding the date of employment in the boarding home; and

(ii) A second tuberculin skin test within one to three weeks after a negative Mantoux test if the staff person was thirty-five years of age or older at the time of hiring.

(b) A staff person hired on or after September 1, 2004 must have a baseline two-step skin test initiated within three days of being hired unless the staff person meets the requirements in (c) or (d) of this subsection. The skin tests must be:

(i) Given no less than one and no more than three weeks apart;

(ii) By intradermal (Mantoux) administration of purified protein derivative (PPD);

(iii) Read between forty-eight and seventy-two hours following administration, by trained personnel; and

(iv) Recorded in millimeters of induration.

(c) A staff person needs to have only a one-step skin test within three days of being hired if:

(i) There is documented history of a negative result from previous two-step testing; or

(ii) There was a documented negative result from one-step skin testing in the previous twelve months.

(d) A staff person does not need to be skin tested for tuberculosis if he/she has:

(i) Documented history of a previous positive skin test consisting of ten or more millimeters of induration; or

(ii) Documented evidence of adequate therapy for active disease; or

(iii) Documented evidence of adequate preventive therapy for infection.

(e) If a skin test results in a positive reaction, the boarding home must:

(i) Ensure that the staff person has a chest X ray within seven days;

(ii) Report positive chest X rays to the appropriate public health authority; and

(iii) Follow precautions ordered by a physician or public health authority.

(2) The boarding home must:

(a) Keep in the boarding home for the duration of the staff person's employment, and at least two years following termination of employment, records of:

(i) Tuberculin test results;

(ii) Reports of X-ray findings; and

(iii) Physician or public health official orders.

(b) Provide staff persons with a copy of the records specified in (a) of this subsection:

(i) During the time the staff person is employed in the boarding home, limited to one copy per report; and

(ii) When requested by the staff person.

(3) The boarding home must ensure that caregivers caring for a resident with suspected tuberculosis comply with the WISHA standard for respiratory protection.

[Statutory Authority: RCW 18.20.090. 06-24-073, § 388-78A-2480, filed 12/4/06, effective 1/4/07; 06-01-047, § 388-78A-2480, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2480, filed 7/30/04, effective 9/1/04.]

Specialized Training

WAC 388-78A-2490 Specialized training for developmental disabilities. (1) The boarding home must provide caregivers with specialized training, consistent with chapter 388-112 WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the boarding home has a developmental disability as defined in WAC 388-823-0040, that is the resident's primary special need.

(2) Nothing in this section is intended to require additional specialty training beyond that required by WAC 388-112-0115.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2490, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2490, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2500 Specialized training for mental illness. (1) The boarding home must provide caregivers with specialized training, consistent with chapter 388-112 WAC, to serve residents with mental illness, whenever at least one of the residents in the boarding home has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, and:

(a) Who has received the diagnosis or treatment within the previous two years; and

(b) Whose diagnosis was made by, or treatment provided by, one of the following:

(i) A licensed physician;

(ii) A mental health professional;

(iii) A psychiatric advanced registered nurse practitioner; or

(iv) A licensed psychologist.

(2) Nothing in this section is intended to require additional specialty training beyond that required by WAC 388-112-0115.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2500, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2500, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2510 Specialized training for dementia. (1) The boarding home must provide caregivers with specialized training, consistent with chapter 388-112 WAC, to serve residents with dementia, whenever at least one of the residents in the boarding home has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090(7).

(2) Nothing in this section is intended to require additional specialty training beyond that required by WAC 388-112-0115.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2510, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2510, filed 7/30/04, effective 9/1/04.]

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Administrator

WAC 388-78A-2520 Administrator qualifications.

(1) The licensee must appoint an administrator who is at least twenty-one years old and who is not a resident, and is qualified to perform the administrator's duties specified in WAC 388-78A-2560.

(2) The licensee must only appoint as a boarding home administrator an individual who meets at least one of the following qualifications listed in (a) through (f) of this subsection:

(a) The individual was actively employed as a boarding home administrator and met existing qualifications on September 1, 2004;

(b) The individual holds a current Washington state nursing home administrator license in good standing;

(c) Prior to assuming duties as a boarding home administrator, the individual has met the qualifications listed in both (c)(i) and (ii) of this subsection:

(i) Obtained certification of completing a recognized administrator training course consisting of a minimum of twenty-four hours of instruction or equivalent on-line training or certification of passing an administrator examination, from or endorsed by a department-recognized national accreditation health or personal care organization such as:

(A) The American Association of Homes and Services for the Aging; or

(B) The American College of Health Care Administrators; or

(C) The American Health Care Association; or

(D) The Assisted Living Federation of America; or

(E) The National Association of Board of Examiners of Long Term Care Administrators.

(ii) Three years paid experience:

(A) Providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living; and/or

(B) Managing persons providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

(d) The individual holds an associate degree in a related field of study such as health, social work, or business administration and meets the qualifications listed in either (d)(i), (ii) or (iii) of this subsection:

(i) Obtains certification of completing a recognized administrator training course consisting of a minimum of twenty-four hours of instruction or equivalent on-line training, or certification of passing an administrator examination, within six months of beginning duties as the administrator, from or endorsed by a department-recognized national accreditation health or personal care organization such as:

(A) The American Association of Homes and Services for the Aging; or

(B) The American College of Health Care Administrators; or

(C) The American Health Care Association; or
 (D) The Assisted Living Federation of America; or
 (E) The National Association of Board of Examiners of Long Term Care Administrators.

(ii) Has two years paid experience:

(A) Providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living; and/or

(B) Managing persons providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

(iii) Has completed a qualifying administrator training program supervised by a qualified administrator according to WAC 388-78A-2530.

(e) The individual holds a bachelor's degree in a related field of study such as health, social work, or business administration and meets the qualifications listed in either (e)(i), (ii) or (iii) of this subsection:

(i) Obtains certification of completing a recognized administrator training course consisting of a minimum of twenty-four hours of instruction or equivalent on-line training, or certification of passing an administrator examination, within six months of beginning duties as the administrator, from or endorsed by a department-recognized national accreditation health or personal care organization such as:

(A) The American Association of Homes and Services for the Aging; or

(B) The American College of Health Care Administrators; or

(C) The American Health Care Association; or

(D) The Assisted Living Federation of America; or

(E) The National Association of Board of Examiners of Long Term Care Administrators.

(ii) Has one year paid experience:

(A) Providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living; and/or

(B) Managing persons providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

(iii) Has completed a qualifying administrator training program supervised by a qualified administrator according to WAC 388-78A-2530.

(f) Before assuming duties as an administrator, the individual has five years of paid experience:

(i) Providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social

service agency for the provision of care to vulnerable adults, such as supported living; and/or

(ii) Managing persons providing direct care to vulnerable adults in a setting licensed by a state agency for the care of vulnerable adults, such as a nursing home, boarding home, or adult family home, or a setting having a contract with a recognized social service agency for the provision of care to vulnerable adults, such as supported living.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2520, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2520, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2530 Qualifying administrator training program. Before the licensee appoints an individual who must have completed a qualifying administrator training program in order to qualify as a boarding home administrator, the licensee must verify the individual has completed the training and obtain documentation from the individual that the training program met the following requirements:

(1) The department was notified of the beginning date of the administrator training program;

(2) The administrator training program was at least six months in duration following notification of the department;

(3) Only training, supervision, and experience occurring following notification of the department were credited to the qualifying training;

(4) The supervising administrator met the qualifications to be an administrator specified in WAC 388-78A-2520;

(5) The trainee was a full-time employee of a boarding home and spent at least forty percent of his/her time for six months of the training program performing administrative duties customarily assigned to boarding home administrators or included in the job description of the administrator for the boarding home in which the training occurred;

(6) The supervising administrator was present on-site at the boarding home during the time the trainee performed administrator duties;

(7) The supervising administrator spent a minimum of one hundred direct contact hours with the trainee during the six months supervising and consulting with the trainee;

(8) Both the trainee and supervising administrator signed documentation of the trainee's qualifying experience and the supervising administrator's performance of required oversight duties; and

(9) The individual completing the qualifying administrator training program maintains the documentation of completing the program.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2530, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2540 Administrator training requirements. The licensee must ensure the boarding home administrator:

(1) Meets the training requirements of chapter 388-112 WAC; and

(2) Completes department training on Washington state statutes and administrative rules related to the operation of a boarding home.

(a) The training must include, but is not limited to, an overview of:

- (i) Chapter 18.20 RCW, Boarding homes;
- (ii) Chapter 43.43 RCW, Criminal history background checks;
- (iii) Chapter 74.34 RCW, Abuse of vulnerable adults;
- (iv) Chapter 70.129 RCW, Long-term care resident rights;
- (v) Chapter 388-78A WAC, Boarding home licensing rules; and
- (vi) Chapter 388-112 WAC, Long-term care services training.

(b) Individuals hired as boarding home administrators after September 1, 2004, must complete department required training within thirty days of assuming duties as a boarding home administrator.

(c) Individuals employed as boarding home administrators on September 1, 2004, must complete department required training by November 1, 2004.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2540, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2550 Administrator training documentation. The boarding home must maintain for department review, documentation of the administrator completing:

- (1) Training required per chapter 388-112 WAC, Long-term care services training;
- (2) Department training in an overview of Washington state statutes and administrative rules related to the operation of a boarding home;
- (3) As applicable, certification from a department-recognized national accreditation health or personal care organization; and
- (4) As applicable, the qualifying administrator-training program.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2550, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2560 Administrator responsibilities. The licensee must ensure the administrator:

- (1) Directs and supervises the overall twenty-four-hour-per-day operation of the boarding home;
- (2) Ensures residents receive adequate care and services that meet the standards of this chapter;
- (3) Is readily accessible to meet with residents;
- (4) Complies with the boarding home's policies;
- (5) When the administrator is not available on the premises, either:
 - (a) Is available by telephone or electronic pager; or
 - (b) Designates a person approved by the licensee to act in place of the administrator. The designee must be:
 - (i) Qualified by experience to assume designated duties; and
 - (ii) Authorized to make necessary decisions and direct operations of the boarding home during the administrator's absence.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2560, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in

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the boarding home administrator. The notice must include the full name of the new administrator and the effective date of the change.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2570, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2580 Use of home health/home care. If a boarding home licensee also has a home health or home care license, the licensee may not provide care or services to nonresident individuals living in independent living units on the boarding home premises under the home health or home care license if:

- (1) The licensee assumes general responsibility for the safety and well-being of the individual;
- (2) The individual requiring such services is not able to receive them in his or her own home and is required to move to another room as a condition for receiving such services;
- (3) The individual receiving such services is required to receive them from the licensee as a condition for residing in the building, and is not free to receive such services from any appropriately licensed provider of his or her choice; or
- (4) The licensee provides other care or services to the individual that falls under the jurisdiction of boarding home licensing and this chapter.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2580, filed 7/30/04, effective 9/1/04.]

Management Agreements

WAC 388-78A-2590 Management agreements. (1) If the licensee uses a manager, the licensee must have a written management agreement approved by the department that is consistent with this section.

(2) The licensee may enter into a management agreement only if the management agreement creates a principal/agent relationship between the licensee and the manager.

(3) The licensee must ensure the manager acts in conformance with a department-approved management agreement with the boarding home licensee.

(4) A licensee must not delegate the following to a manager:

- (a) The licensee's responsibility to ensure that the boarding home is operated in a manner consistent with all laws and rules applicable to boarding homes;
- (b) The licensee's responsibility to review, acknowledge and sign all boarding home initial and renewal license applications.

(5) The licensee must ensure that its manager does not represent itself as, or give the appearance that it is the licensee.

(6) A duly authorized manager may execute resident leases or agreements on behalf of the licensee, but all such resident leases or agreements must be between the licensee and the resident.

(7) The licensee must notify the department of its use of a manager and provide a copy of any written management agreement to the department upon the following:

- (a) Initial application for a license;
- (b) Retention of a manager following initial application;
- (c) Change of managers; or
- (d) Modification of existing management agreement.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2590, filed 7/30/04, effective 9/1/04.]

Policies and Procedures

WAC 388-78A-2600 Policies and procedures. (1) The boarding home must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the boarding home; and

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70, 11.88, 11.92, 11.94, 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

(2) The boarding home must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abuse, neglect, or exploitation of any resident;

(b) When there is reason to believe a resident is not capable of making necessary decisions and no substitute decision maker is available;

(c) When a substitute decision maker is no longer appropriate;

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

(e) When a resident does not have a personal physician or health care provider;

(f) In response to medical emergencies;

(g) When there are urgent situations in the boarding home requiring additional staff support;

(h) In the event of an internal or external disaster, consistent with WAC 388-78A-2700;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

(j) To appropriately respond to aggressive or assaultive residents, including, but not limited to:

(i) Actions to take if a resident becomes violent;

(ii) Actions to take to protect other residents; and

(iii) When and how to seek outside intervention.

(k) To prevent and limit the spread of infections consistent with WAC 388-78A-2610;

(l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290; sending medications with a resident when the resident leaves the premises;

(m) When services related to medications and treatments are provided under the delegation of a registered nurse consistent with chapter 246-840 WAC;

(n) Related to food services consistent with chapter 246-215 WAC and WAC 388-78A-2300;

(o) Regarding the safe operation of any boarding home vehicles used to transport residents, and the qualifications of the drivers;

(p) To coordinate services and share resident information with outside resources, consistent with WAC 388-78A-2350;

(q) Regarding the management of pets in the boarding home, if permitted, consistent with WAC 388-78A-2620; and

(r) When receiving and responding to resident grievances consistent with RCW 70.129.060.

(3) The boarding home must make the policies and procedures specified in subsection (2) of this section available to staff persons at all times and must inform residents and residents' representatives of their availability and make them available upon request.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2600, filed 7/30/04, effective 9/1/04.]

Infection Control

WAC 388-78A-2610 Infection control. (1) The boarding home must institute appropriate infection control practices in the boarding home to prevent and limit the spread of infections.

(2) The boarding home must:

(a) Develop and implement a system to identify and manage infections;

(b) Restrict a staff person's contact with residents when the staff person has a known communicable disease in the infectious stage that is likely to be spread in the boarding home setting or by casual contact;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2610, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2620 Pets. If a boarding home allows pets to live on the premises, the boarding home must:

(1) Develop, implement and disclose to potential and current residents, policies regarding:

(a) The types of pets that are permitted in the boarding home; and

(b) The conditions under which pets may be in the boarding home.

(2) Ensure animals living on the boarding home premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

(c) Are restricted from central food preparation areas.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2620, filed 7/30/04, effective 9/1/04.]

Reporting Requirements**WAC 388-78A-2630 Reporting abuse and neglect.** (1)

The boarding home must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

(2) The boarding home must prominently post so it is readily visible to staff, residents and visitors, the department's toll-free telephone number for reporting resident abuse and neglect.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2630, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2640 Reporting significant change in a resident's condition. (1) The boarding home must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

(c) The resident dies.

(2) The boarding home must notify any agency responsible for paying for the resident's care and services as soon as possible whenever:

(a) The resident is relocated to a hospital or other health care facility; or

(b) The resident dies.

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the boarding home must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

(4) In case of a resident's death, the boarding home must notify the coroner if required by RCW 68.50.010.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2640, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2650 Reporting fires and incidents.

The boarding home must immediately report to the department's aging and disability services administration:

(1) Any accidental or unintended fire, or any deliberately set but improper fire, such as arson, in the boarding home;

(2) Any unusual incident that required implementation of the boarding home's disaster plan, including any evacuation of all or part of the residents to another area of the boarding home or to another address; and

(3) Circumstances which threaten the boarding home's ability to ensure continuation of services to residents.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2650, filed 7/30/04, effective 9/1/04.]

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Resident Rights

WAC 388-78A-2660 Resident rights. The boarding home must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(3) Not use restraints on any resident;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

(5) Provide care and services to each resident in compliance with applicable state statutes related to substitute health care decision making, including chapters 7.70, 70.122, 11.88, 11.92, and 11.94 RCW;

(6) Reasonably accommodate residents consistent with applicable state and/or federal law; and

(7) Not allow any staff person to abuse or neglect any resident.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2660, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2660, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2670 Services by resident for boarding home. If a resident performs services for the boarding home, the boarding home must ensure:

(1) The resident freely volunteers to perform the services without coercion or pressure from staff persons;

(2) The resident performing services does not supervise, or is not placed in charge of, other residents; and

(3) If the resident regularly performs voluntary services for the benefit of the boarding home, the volunteer activity is addressed in the resident's negotiated service agreement.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2670, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2680 Boarding home use of audio and video monitoring. (1) Except as provided for in WAC 388-78A-2690, the boarding home must not use:

(a) Any audio monitoring on the boarding home premises; or

(b) Any audio monitoring used in combination with video monitoring.

(2) The boarding home may video monitor and/or video record activity on the boarding home premises, without an audio component, only in the following areas:

(a) Boarding home entrances and exits if the camera(s) is:

(i) Focused only on the entrance/exit doorways; and

(ii) Not focused on areas where residents may congregate.

(b) Areas used exclusively by staff persons such as, but not limited to, medication storage areas or food preparation areas, if residents do not go into these areas;

(c) Outdoor areas not commonly used by residents, such as, but not limited to, delivery areas; and

(d) Designated smoking areas excluding resident rooms, subject to the following conditions:

(i) When the area is being used by residents assessed as needing supervision for smoking, a staff person must watch

the video monitor at any time the area is being used by such residents for smoking;

(ii) The video camera must be placed in a clearly visible area;

(iii) The video monitor must be placed where it cannot be viewed by the general public; and

(iv) All residents in the facility must be notified of the use of the video monitoring.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2680, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2690 Resident use of electronic monitoring. (1) The boarding home must limit the use of resident-initiated video or audio monitoring to the sleeping room or apartment of the resident who requested the monitoring.

(2) If a resident requests video or audio monitoring in his/her sleeping room or apartment, before any monitoring occurs the boarding home must ensure:

(a) Appropriate actions are taken to ensure monitoring is consistent with and does not violate chapter 9.73 RCW;

(b) The resident has identified a threat to his or her safety or health, or the safety of his or her possessions, and has requested electronic monitoring;

(c) The resident's roommate has provided written consent to the monitoring, if the resident has a roommate; and

(d) The resident and the boarding home have agreed upon a specific duration for the use of the monitoring, and the boarding home has documented the agreement.

(3) The boarding home must reevaluate the need for resident-initiated electronic monitoring with the resident at least quarterly or more often as appropriate.

(4) The boarding home must discontinue the use of resident-initiated electronic monitoring immediately if:

(a) The resident no longer desires it;

(b) The roommate objects to the use; or

(c) The resident becomes unable to give consent.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2690, filed 7/30/04, effective 9/1/04.]

Safety and Disaster Preparedness

WAC 388-78A-2700 Safety measures and disaster preparedness. (1) The boarding home must take necessary action to promote the safety of each resident whenever the resident is on the boarding home premises or under the supervision of staff persons, consistent with the resident's negotiated service agreement.

(2) The boarding home must:

(a) Maintain the premises free of hazards;

(b) Maintain any vehicles used for transporting residents in a safe condition;

(c) Investigate and document investigative actions and findings for any alleged or suspected neglect or abuse or exploitation, accident or incident jeopardizing or affecting a resident's health or life. The boarding home must:

(i) Determine the circumstances of the event;

(ii) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(iii) Protect other residents during the course of the investigation.

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(d) Provide appropriate hardware on doors of storage rooms, closets and other rooms to prevent residents from being accidentally locked in;

(e) Provide, and tell staff persons of, a means of emergency access to resident-occupied bedrooms, toilet rooms, bathing rooms, and other rooms;

(f) Provide emergency lighting or flashlights in all areas of the boarding home. For all boarding homes first issued a project number by construction review services on or after September 1, 2004 for construction related to this section, the boarding home must provide emergency lighting in all areas of the boarding home;

(g) Make sure first-aid supplies are:

(i) Readily available and not locked;

(ii) Clearly marked;

(iii) Able to be moved to the location where needed; and

(iv) Stored in containers that protect them from damage, deterioration, or contamination.

(h) Make sure first-aid supplies are appropriate for:

(i) The size of the boarding home;

(ii) The services provided;

(iii) The residents served; and

(iv) The response time of emergency medical services.

(i) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(ii) Provisions for summoning emergency assistance;

(iii) Plans for evacuating residents from area or building;

(iv) Alternative resident accommodations;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

(vi) Emergency communication plan.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2700, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2700, filed 7/30/04, effective 9/1/04.]

Disclosure

WAC 388-78A-2710 Disclosure of services. (1) The boarding home must disclose to residents, the resident's representative, if any, and interested consumers upon request, the scope of care and services it offers, on the department's approved disclosure forms. The disclosure form shall not be construed as an implied or express contract between the boarding home and the resident, but is intended to assist consumers in selecting boarding home services.

(2) The boarding home must provide the services disclosed.

(3) The boarding home must provide a minimum of thirty days written notice to the residents and the residents' representatives, if any:

(a) Before the effective date of any decrease in the scope of care or services provided by the boarding home, due to circumstances beyond the boarding home's control; and

(b) Before the effective date of any voluntary decrease in the scope of care or services provided by the boarding home, and any such decrease in the scope of services provided will not result in the discharge of one or more residents.

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(4) The boarding home must provide a minimum of ninety days written notice to the residents and the residents' representative, if any, before the effective date of any voluntary decrease in the scope of care or services provided by the boarding home, and any such decrease in the scope of services provided will result in the discharge of one or more residents.

(5) If the boarding home increases the scope of services that it chooses to provide, the boarding home must promptly provide written notice to the residents and residents' representative, if any, and must indicate the date on which the increase in the scope of care or services is effective.

(6) When the care needs of a resident exceed the disclosed scope of care or services that a boarding home provides, the boarding home may exceed the care or services disclosed consistent with RCW 70.129.030(3) and 70.129.110(3)(a).

(7) Even though the boarding home may disclose that it can provide certain care or services to residents or prospective residents or residents' representative, if any, the boarding home may deny admission to a prospective resident when the boarding home determines that the needs of the prospective resident cannot be met, as long as the boarding home operates in compliance with state and federal law, including reasonable accommodation requirements and RCW 70.129.030(3).

(8) The boarding home must notify prospective residents of their rights regarding health care decision making consistent with applicable state and federal laws and rules, before or at the time the individual moves into the boarding home.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2710, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2720 Timing of disclosure. (1) The boarding home must provide the disclosure form completed by the boarding home:

(a) In response to a request by a prospective resident or his or her representative, if any, for written information about the boarding home's services and capabilities; or

(b) At the time the boarding home provides an application for residency, an admission agreement or contract, if not previously received by the prospective resident or his or her representative, if any.

(2) The boarding home is not required to provide the disclosure of care and services contained on the department's approved disclosure forms:

(a) In advertisements;

(b) In general marketing information to the public; or

(c) To persons seeking general information regarding residential care resources in the community.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2720, filed 7/30/04, effective 9/1/04.]

Licensing

WAC 388-78A-2730 Licensee's responsibilities. (1) The boarding home licensee is responsible for:

(a) The operation of the boarding home;

(b) Complying with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(c) The care and services provided to the boarding home residents.

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(2) The licensee must:

(a) Maintain the occupancy level at or below the licensed resident bed capacity of the boarding home;

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the boarding home premises:

(i) A current boarding home license, including any related conditions on the license;

(ii) The name, address and telephone number of:

(A) The department;

(B) Appropriate resident advocacy groups; and

(C) The state and local long-term care ombudsman with a brief description of ombudsman services.

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department.

(c) Ensure any party responsible for holding or managing residents' personal funds is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds; and provides proof of bond or insurance to the department.

(3) The licensee must not delegate to any person responsibilities that are so extensive that the licensee is relieved of responsibility for the daily operations and provisions of services in the boarding home.

(4) The licensee must act in accord with any department-approved management agreement, if the licensee has entered into a management agreement.

(5) The licensee must appoint the boarding home administrator consistent with WAC 388-78A-2520.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2730, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2740 Licensee qualifications. The department must consider separately and jointly as applicants each person named in the application for a boarding home license.

(1) If the department finds any person unqualified as specified in WAC 388-78A-3190, the department must deny, terminate, or not renew the license.

(2) If the department finds any person unqualified as specified in WAC 388-78A-3170, the department may deny, terminate, or not renew the license.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2740, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2750 Application process. To apply for a boarding home license, a person must:

(1) Submit to the department a complete license application on forms designated by the department at least ninety days prior to the proposed effective date of the license;

(2) Submit all relevant attachments specified in the application;

(3) Submit criminal history background requests as required in WAC 388-78A-2470;

(4) Sign the application;

(5) Submit the license fee as specified in WAC 388-78A-3230;

(6) Submit verification that construction plans have been approved by construction review services;

(7) Submit a revised application before the license is issued if any information has changed since the initial license application was submitted;

(8) Submit a revised application containing current information about the proposed licensee or any other persons named in the application, if a license application is pending for more than one year; and

(9) If the licensee's agent prepares an application on the licensee's behalf, the licensee must review, sign and attest to the accuracy of the information contained in the application.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2750, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2760 Necessary information. In making a determination whether to issue a boarding home license, in addition to the information for each person named in the application, the department may review other documents and information the department deems relevant, including inspection and complaint investigation findings for each facility with which the applicant or any partner, officer, director, managerial employee, or owner of five percent or more of the applicant has been affiliated.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2760, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2770 Change in licensee. (1) The licensee of a boarding home must change whenever the following events occur, including, but not limited to:

(a) The licensee's form of legal organization is changed (e.g., a sole proprietor forms a partnership or corporation);

(b) The licensee transfers ownership of the boarding home business enterprise to another party regardless of whether ownership of some or all of the real property and/or personal property assets of the boarding home is also transferred;

(c) The licensee dissolves, or consolidates or merges with another legal organization and the licensee's legal organization does not survive;

(d) If, during any continuous twenty-four-month period, fifty percent or more of the "**licensed entity**" is transferred, whether by a single transaction or multiple transactions, to:

(i) A different person (e.g., new or former shareholders or partners); or

(ii) A person that had less than a five percent ownership interest in the boarding home at the time of the first transaction.

(e) Any other event or combination of events that results in a substitution, elimination, or withdrawal of the licensee's control of the boarding home. As used in this section, "control" means the possession, directly or indirectly, of the power to direct the management, operation and/or policies of the licensee or boarding home, whether through ownership, voting control, by agreement, by contract or otherwise.

(2) The licensee is not required to change when the following, without more, occur:

(a) The licensee contracts with a party to manage the boarding home enterprise for the licensee pursuant to an agreement as specified in WAC 388-78A-2590; or

(b) The real property or personal property assets of the boarding home are sold or leased, or a lease of the real property or personal property assets is terminated, as long as there

is not a substitution or substitution of control of the licensee or boarding home.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2770, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2780 Requirements to change boarding home licensee. (1) In order to change the licensee of a boarding home, the current licensee must notify the department and all residents of the proposed change in licensee at least ninety days prior to the proposed date of change, including the following information:

(a) Name of the present licensee and prospective licensee;

(b) Name and address of the boarding home for which the licensee is being changed;

(c) Date of proposed change; and

(d) If the boarding home contracts with the department or other public agencies that may make payments for residential care on behalf of residents, the anticipated effect the change of licensee will have on residents whose care and services are supported through these contracts.

(2) The prospective licensee must, at least ninety days prior to the proposed date of change:

(a) Sign the application;

(b) Submit the annual license fee, if a license fee is due;

(c) Submit evidence of control of the real estate on which the boarding home is located, such as a purchase and sales agreement, lease contract, or other appropriate document;

(d) Submit a revised application if any information included on the original application is no longer accurate; and

(e) Complete and submit a revised application if requested by the department.

(3) Send a letter to the department stating the licensee's intent to relinquish the boarding home license on the effective date of change in licensee.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2780, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2790 Annual renewal. To renew a boarding home license, the boarding home must:

(1) Submit a completed license renewal application on forms designated by the department, at least thirty days prior to the license expiration date;

(2) Sign the application;

(3) Submit the annual license fee as specified in WAC 388-78A-3230; and

(4) If the licensee's agent prepares a renewal application on the licensee's behalf, the licensee must review, sign and attest to the accuracy of the information contained on the renewal application.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2790, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2800 Changes in licensed bed capacity. To change the licensed bed capacity in a boarding home, the boarding home must:

(1) Submit a completed request for approval to the department at least one day before the intended change;

(2) Submit the prorated fee required according to WAC 388-78A-3230; and

(3) Post an amended license obtained from the department, indicating the new bed capacity.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2800, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2810 Criteria for increasing licensed bed capacity. Before the licensed bed capacity in a boarding home may be increased, the boarding home must:

(1) Obtain construction review services' review and approval of the additional rooms or beds, and related auxiliary spaces, if not previously reviewed and approved; and

(2) Ensure the increased licensed bed capacity does not exceed the maximum facility capacity as determined by the department.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2810, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2820 Building requirements and exemptions. (1) To get a building approved for licensing, a person must:

(a) Design plans according to the building code, local codes and ordinances, and this chapter;

(b) Submit construction documents, including any change orders and addenda to:

(i) Construction review services per WAC 388-78A-2850 and include:

(A) A minimum of two sets of final construction drawings complying with the requirements of this chapter, stamped by a Washington state licensed architect or engineer; and

(B) A functional program description; and

(ii) Local county or municipal building departments per local codes to obtain necessary building permits.

(c) Conform to the approved construction documents during construction in accordance with chapter 18.20 RCW;

(d) Obtain written approval from construction review services prior to deviating from approved construction documents;

(e) Provide construction review services with a:

(i) Written notice of completion date;

(ii) Copy of reduced floor plan(s); and

(iii) Copy of certificate of occupancy issued by the local building department; and

(f) Obtain authorization from the department prior to providing boarding home services in the new construction area.

(2) The department may exempt the boarding home from meeting a specific requirement related to the physical environment if the department determines the exemption will not:

(a) Jeopardize the health or safety of residents;

(b) Adversely affect the residents' quality of life; or

(c) Change the fundamental nature of the boarding home operation into something other than a boarding home.

(3) A boarding home wishing to request an exemption must submit a written request to the department, including:

(a) A description of the requested exemption; and

(b) The specific WAC requirement for which the exemption is sought.

(4) The boarding home may not appeal the department's denial of a request for an exemption.

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(5) The boarding home must retain a copy of each approved exemption in the boarding home.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2820, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2830 Conversion of licensed nursing homes. (1) If a person intends to convert a licensed nursing home building into a licensed boarding home, the building must meet all boarding home licensing requirements specified in this chapter and chapter 18.20 RCW unless the licensee has a contract with the department to provide enhanced adult residential care services in the boarding home per RCW 18.20.220.

(2) If the licensee provides contracted enhanced adult residential care services in the building converted from a licensed nursing home into a licensed boarding home, the boarding home licensing requirements for the physical structure are considered to be met if the most recent nursing home inspection report for the nursing home building demonstrates compliance, and compliance is maintained, with safety standards and fire regulations:

(a) As required by RCW 18.51.140; and

(b) Specified in the applicable building code, as required by RCW 18.51.145, including any waivers that may have been granted, except that the licensee must ensure the building meets the licensed boarding home standards, or their functional equivalency, for:

(i) Resident to bathing fixture ratio required per WAC 388-78A-3030;

(ii) Resident to toilet ratio required per WAC 388-78A-3030;

(iii) Corridor call system required per WAC 388-78A-2930;

(iv) Resident room door closures; and

(v) Resident room windows required per WAC 388-78A-3010.

(3) If the licensee does not continue to provide contracted enhanced adult residential care services in the boarding home converted from a licensed nursing home, the licensee must meet all boarding home licensing requirements specified in this chapter and chapter 18.20 RCW.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2830, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2840 Licenses for multiple buildings.

(1) The licensee may have multiple buildings operating under a single boarding home license if:

(a) All of the buildings are located on the same property with the same legal description; or

(b) All of the buildings are located on contiguous properties undivided by:

(i) Public streets, not including alleyways used primarily for delivery services or parking; or

(ii) Other land that is not owned and maintained by the owners of the property on which the boarding home is located.

(2) The licensee must have separate boarding homes licenses for buildings that are not located on the same or contiguous properties.

(3) Buildings that construction review services reviewed only as an addition to, or a remodel of, an existing boarding home must not have separate boarding home licenses.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2840, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2850 Required reviews of building plans. (1) A person or boarding home must notify construction review services of all planned construction regarding boarding homes prior to beginning work on any of the following:

(a) A new building or portion thereof to be used as a boarding home;

(b) An addition of, or modification or alteration to an existing boarding home, including, but not limited to, the boarding home's:

(i) Physical structure;

(ii) Electrical fixtures or systems;

(iii) Mechanical equipment or systems;

(iv) Fire alarm fixtures or systems;

(v) Fire sprinkler fixtures or systems;

(vi) Carpeting;

(vii) Wall coverings 1/28 inch thick or thicker; or

(viii) Kitchen or laundry equipment.

(c) A change in the department-approved use of an existing boarding home or portion of a boarding home; and

(d) An existing building or portion thereof to be converted for use as a boarding home.

(2) A person or boarding home does not need to notify construction review services of the following:

(a) Repair or maintenance of equipment, furnishings or fixtures;

(b) Replacement of equipment, furnishings or fixtures with equivalent equipment, furnishings or fixtures;

(c) Repair or replacement of damaged construction if the repair or replacement is performed according to construction documents approved by construction review services within eight years preceding the current repair or replacement;

(d) Painting; or

(e) Cosmetic changes that do not affect resident activities, services, or care and are performed in accordance with the current edition of the building code.

(3) The boarding home must submit plans to construction review services as directed by construction review services and consistent with WAC 388-78A-2820 for approval prior to beginning any construction. The plans must provide an analysis of likely adverse impacts on current boarding home residents and plans to eliminate or mitigate such adverse impacts.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2850, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2860 Relocation of residents during construction. (1) Prior to moving residents out of the boarding home during construction, the boarding home must:

(a) Notify the residents and the residents' representatives at least thirty days prior to the anticipated move date, of the required move and their options consistent with chapter 70.129 RCW;

(b) Notify the department at least thirty days prior to the anticipated move date, of the boarding home's plans for relocating residents, including:

(i) The location to which the residents will be relocated;

(ii) The boarding home's plans for providing care and services during the relocation;

(iii) The boarding home's plans for returning residents to the building; and

(iv) The projected time frame for completing the construction.

(c) Obtain the department's approval for the relocation plans prior to relocating residents.

(2) If the boarding home moves out all of the residents from the boarding home without first obtaining the department's approval of the relocation plans, the boarding home is closed for business and the department may revoke the licensee's boarding home license.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2860, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2870 Vacant buildings. Whenever a boarding home moves out all residents and ceases operation for reasons other than construction, as specified in WAC 388-78A-2860, the licensee must relinquish the boarding home license or the department may revoke the boarding home license.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2870, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2880 Changing use of rooms. Prior to using a room for a purpose other than what was approved by construction review services, the boarding home must:

(1) Notify construction review services:

(a) In writing;

(b) Thirty days or more before the intended change in use;

(c) Describe the current and proposed use of the room; and

(d) Provide all additional documentation as requested by construction review services.

(2) Obtain the written approval of construction review services for the new use of the room.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2880, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2890 Time frame for approval. (1) A person or the licensee must:

(a) Obtain approval by construction review services, of final construction documents prior to starting any construction, except for fire alarm plans, fire sprinkler plans, and landscaping plans.

(b) Obtain approval by construction review services, of landscaping, fire alarm and fire sprinkler plans prior to their installation.

(2) The department will not issue a boarding home license unless:

(a) Construction review services:

(i) Notifies the department that construction has been completed; and

(ii) Provides the department:

- (A) A copy of the certificate of occupancy granted by the local building official;
- (B) A copy of the functional program; and
- (C) A reduced copy of the approved floor plan indicating room numbers or names and the approved use; and
- (b) The state fire marshal has inspected and approved the boarding home for fire protection.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2890, filed 7/30/04, effective 9/1/04.]

Building

WAC 388-78A-2900 Retention of approved construction documents. The boarding home must retain on the boarding home premises:

- (1) Specification data on materials used in construction, for the life of the product;
- (2) Stamped "approved" set of construction documents.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2900, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2910 Applicable building codes. (1) Newly licensed boarding homes and construction in existing boarding homes must meet the requirements of all the current building codes and applicable sections of this chapter.

(2) Existing licensed boarding homes must continue to meet the building codes in force at the time of their initial licensing.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2910, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2910, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2920 Area for nursing supplies and equipment. (1) If the boarding home provides intermittent nursing services, the boarding home must provide on the boarding home premises for the safe and sanitary:

- (a) Storage and handling of clean and sterile nursing equipment and supplies; and
- (b) Cleaning and disinfecting of soiled nursing equipment.

(2) For all boarding homes first issued a project number by construction review services on or after September 1, 2004 for construction related to this section, in which intermittent nursing services are provided, or upon initiating intermittent nursing services within an existing boarding home, the boarding home must provide the following two separate rooms in each boarding home building, accessible only by staff persons:

(a) A "clean" utility room for the purposes of storing and preparing clean and sterile nursing supplies, equipped with:

- (i) A work counter or table;
- (ii) A handwashing sink, with soap and paper towels or other approved hand-drying device; and
- (iii) Locked medication storage, if medications are stored in this area, that is separate from all other stored items consistent with WAC 388-78A-2260.

(b) A "soiled" utility room for the purposes of storing soiled linen, cleaning and disinfecting soiled nursing care equipment, and disposing of refuse and infectious waste, equipped with:

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- (i) A work counter or table;
- (ii) A two-compartment sink for handwashing and equipment cleaning and sanitizing;
- (iii) A clinical service sink or equivalent for rinsing and disposing of waste material;
- (iv) Soap and paper towels or other approved hand-drying device; and
- (v) Locked storage for cleaning supplies, if stored in the area.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2920, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2920, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2930 Communication system. (1) The boarding home must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance:

- (i) From resident units;
- (ii) From common areas accessible to residents;
- (iii) From corridors accessible to residents; and
- (iv) For boarding homes issued a project number by construction review services on or after September 1, 2004 for construction related to this section, all bathrooms, all toilet rooms, resident living rooms and sleeping rooms.

(b) Provide residents, families, and other visitors with a means to contact a staff person inside the building from outside the building after hours.

(2) The boarding home must provide one or more non-pay telephones:

- (a) In each building located for ready access by staff persons; and
- (b) On the premises with reasonable access and privacy by residents.

(3) In boarding homes issued a project number by construction review services on or after September 1, 2004 for construction related to this section, the boarding home must equip each resident room with two telephone lines.

(4) If a boarding home that is issued a project number by construction services on or after September 1, 2004 chooses to install an intercom system, the intercom system must be equipped with a mechanism that allows a resident to control:

- (a) Whether or not announcements are broadcast into the resident's room; and
- (b) Whether or not voices or conversations within the resident's room can be monitored or listened to by persons outside the resident's room.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2930, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2930, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2940 Two-way intercom systems. The boarding home may use a two-way intercom system between staff persons and residents in other rooms only when:

- (1) A resident initiates the contact; or
- (2) Staff persons announce to the resident that the intercom has been activated at the time it is activated, and:
 - (a) The resident and any others in the room agree to continue the contact;

(b) The boarding home deactivates the intercom when the conversation is complete; and

(c) The boarding home ensures each resident is aware the intercom is operating at all times the intercom is in use in the resident's room.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2940, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2940, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2950 Water supply. The boarding home must:

(1) Provide water meeting the provisions of chapter 246-290 WAC, Group A public water supplies or chapter 246-291 WAC, Group B public water systems;

(2) Maintain the boarding home water systems free of cross-connections as specified in *Cross-Connection Control Manual, 6th Edition*, published by the Pacific Northwest Section of the American Water Works Association;

(3) Provide hot and cold water under adequate pressure readily available throughout the boarding home;

(4) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105°F and 120°F at all times; and

(5) Label or color code nonpotable water supplies "unsafe for domestic use."

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2950, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2960 Sewage and liquid waste disposal. The boarding home must:

(1) Ensure that all sewage and waste water drain into a municipal sewage disposal system according to chapter 246-271 WAC, if available; or

(2) Provide on-site sewage disposal systems designed, constructed, and maintained as required by chapters 246-272 and 173-240 WAC, and local ordinances.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2960, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2960, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2970 Garbage and refuse disposal. The boarding home must:

(1) Provide an adequate number of garbage containers to store refuse generated by the boarding home:

(a) Located in a storage area convenient for resident and staff use;

(b) Constructed of nonabsorbent material;

(c) Cleaned and maintained to prevent:

(i) Entrance of insects, rodents, birds, or other pests;

(ii) Odors; and

(iii) Other nuisances.

(2) Assure garbage and waste containers are emptied frequently to prevent hazards and nuisances; and

(3) Provide for safe and sanitary collection and disposal of:

(a) Garbage and refuse;

(b) Infectious waste; and

(c) Waste grease from the kitchen.

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[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2970, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2980 Lighting. (1) The boarding home must maintain electric light fixtures and lighting necessary for the comfort and safety of residents and for the activities of residents and staff.

(2) The boarding home must maintain lighting in common areas that meets Illuminating Engineering Society (IES) recommendations as follows:

Area	AVERAGE MAINTAINED FOOTCANDLES	
	Ambient Light	Task Light
Toilet, bathing and laundry facilities	30	50
Dining/day rooms	50	N/A
Corridors, hallways, and stairways	30	N/A
Janitor's closet and utility rooms	30	N/A
Reading rooms	100	N/A

(3) The boarding home must provide enough lighting in each resident's room to meet the resident's needs, preferences and choices.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2980, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2990 Heating-cooling—Temperature. The boarding home must:

(1) Equip each resident-occupied building with an approved heating system capable of maintaining a minimum temperature of 70°F per the building code. The boarding home must:

(a) Maintain the boarding home at a minimum temperature of 60°F during sleeping hours; and

(b) Maintain the boarding home at a minimum of 68°F during waking hours, except in rooms:

(i) Designated for activities requiring physical exertion; or

(ii) Where residents can individually control the temperature in their own living units, independent from other areas.

(2) Equip each resident-occupied building with a mechanical air cooling system or equivalent capable of maintaining a temperature of 75°F in communities where the design dry bulb temperature exceeds 85°F for one hundred seventy-five hours per year or two percent of the time, as specified in the latest edition of *Recommended Outdoor Design Temperatures—Washington State*, published by the Puget Sound chapter of the American Society of Heating, Refrigeration, and Air-Conditioning Engineers;

(3) Equip each boarding home issued a project number by construction review services on or after September 1, 2004 for construction related to this section, with a backup source of heat in enough common areas to keep all residents adequately warm during interruptions of normal heating operations;

(4) Prohibit the use of portable space heaters unless approved in writing by the Washington state director of fire protection; and

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(5) Equip each resident sleeping room and resident living room in boarding homes issued a project number by construction review services on or after September 1, 2004 for construction related to this section, with individual temperature controls located between thirty and forty-eight inches above the floor capable of maintaining room temperature plus or minus 3°F from setting, within a range of minimum 60°F to maximum 85°F.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-2990, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2990, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3000 Ventilation. The boarding home must:

- (1) Ventilate rooms to:
 - (a) Prevent excessive odors or moisture; and
 - (b) Remove smoke.
- (2) Designate and ventilate smoking areas, if smoking is permitted in the boarding home, to prevent air contamination throughout the boarding home;
- (3) Provide intact sixteen mesh screens on operable windows and openings used for ventilation; and
- (4) Prohibit screens that may restrict or hinder escape or rescue through emergency exit openings.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3000, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3010 Resident room—Room furnishings-storage. (1) The boarding home must ensure each resident has a sleeping room that has:

- (a) Eighty or more square feet of usable floor space in a one-person sleeping room;
- (b) Seventy or more square feet of usable floor space per individual in a sleeping room occupied by two or more individuals, except:
 - (i) When a resident sleeping room is located within a private apartment; and
 - (ii) The private apartment includes a resident sleeping room, a resident living room, and a private bathroom; and
 - (iii) The total square footage in the private apartment equals or exceeds two hundred twenty square feet excluding the bathroom; and
 - (iv) There are no more than two residents living in the apartment; and
 - (v) Both residents mutually agree to share the resident sleeping room; and
 - (vi) All other requirements of this section are met, then the two residents may share a sleeping room with less than one hundred forty square feet.
- (c) A maximum sleeping room occupancy of:
 - (i) Four individuals if the boarding home was licensed before July 1, 1989, and licensed continuously thereafter; and
 - (ii) Two individuals if the boarding home, after June 30, 1989:
 - (A) Applied for initial licensure; or
 - (B) Applied to increase the number of resident sleeping rooms; or
 - (C) Applied to change the use of rooms into sleeping rooms.

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(d) Unrestricted direct access to a hallway, living room, outside, or other common-use area;

(e) One or more outside windows with:

(i) Window sills at or above grade, with grade extending horizontally ten or more feet from the building; and

(ii) Adjustable curtains, shades, blinds, or equivalent for visual privacy.

(f) One or more duplex electrical outlets per bed if the boarding home was initially licensed after July 1, 1983;

(g) A light control switch located by the entrance for a light fixture in the room;

(h) An individual towel and washcloth rack or equivalent, except when there is a private bathroom attached to the resident sleeping or living room, the individual towel and washcloth rack may be located in the attached private bathroom;

(i) In all boarding homes issued a project number by construction review services on or after September 1, 2004 for construction related to this section, and when requested by a resident in a boarding home licensed on or before September 1, 2004, provide a lockable drawer, cupboard or other secure space measuring at least one-half cubic foot with a minimum dimension of four inches;

(j) Separate storage facilities for each resident in or immediately adjacent to the resident's sleeping room to adequately store a reasonable quantity of clothing and personal possessions;

(k) A configuration to permit all beds in the resident sleeping room to be spaced at least three feet from other beds unless otherwise requested by all affected residents.

(2) The boarding home must ensure each resident sleeping room contains:

(a) A comfortable bed for each resident, except when two residents mutually agree to share a bed. The bed must be thirty-six or more inches wide for a single resident and fifty-four or more inches wide for two residents, appropriate for size, age and physical condition of the resident and room dimensions, including, but not limited to:

(i) Standard household bed;

(ii) Studio couch;

(iii) Hide-a-bed;

(iv) Day bed; or

(v) Water bed, if structurally and electrically safe.

(b) A mattress for each bed which:

(i) Fits the bed frame;

(ii) Is in good condition; and

(iii) Is at least four inches thick unless otherwise requested or necessary for resident health or safety.

(c) One or more comfortable pillows for each resident;

(d) Bedding for each bed, in good repair; and

(e) Lighting at the resident's bedside when requested by the resident.

(3) The boarding home must not allow a resident sleeping room to be used as a passageway or corridor.

(4) The boarding home may use or allow use of carpets and other floor coverings only when the carpet is:

(a) Securely fastened to the floor or provided with non-skid backing; and

(b) Kept clean and free of hazards, such as curling edges or tattered sections.

(5) The boarding home must ensure each resident has either a sleeping room or resident living room that contains a sturdy, comfortable chair appropriate for the age and physical condition of the resident. This requirement does not mean a boarding home is responsible for supplying specially designed orthotic or therapeutic chairs, including those with mechanical lifts or adjustments.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-3010, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3010, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3020 Calculating floor space. Usable floor space in a resident's sleeping room is calculated by measuring from interior wall surface to interior wall surface:

- (1) Including:
 - (a) Areas under moveable furniture; and
 - (b) Areas of door swings and entryways into the sleeping room.
- (2) Excluding:
 - (a) Areas under ceilings less than seven feet six inches high;
 - (b) Closet space and built-in storage;
 - (c) Areas under counters, sinks, or appliances; and
 - (d) Bathrooms and toilet rooms.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3020, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3030 Toilet rooms and bathrooms. (1) The boarding home must provide private or common-use toilet rooms and bathrooms to meet the needs of each resident.

(2) The boarding home must provide each toilet room and bathroom with:

- (a) Water resistant, smooth, low gloss, nonslip and easily cleanable materials;
- (b) Washable walls to the height of splash or spray;
- (c) Grab bars installed and located to minimize accidental falls including one or more grab bars at each:
 - (i) Bathing fixture; and
 - (ii) Toilet.
- (d) Plumbing fixtures designed for easy use and cleaning and kept in good repair; and
- (e) Adequate ventilation to the outside of the boarding home. For boarding homes issued a project number by construction review services on or after September 1, 2004 for construction related to this section, must provide mechanical ventilation to the outside.

(3) The boarding home must provide each toilet room with a:

- (a) Toilet with a clean, nonabsorbent seat free of cracks;
- (b) Handwashing sink in or adjacent to the toilet room. For boarding homes issued a project number by construction review services on or after September 1, 2004 for construction related to this section, the handwashing sink must be in the toilet room or in an adjacent private area that is not part of a common use area of the boarding home; and
- (c) Suitable mirror with adequate lighting for general illumination.

(4) For boarding homes approved for construction or initially licensed after August 1, 1994, the boarding home must

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provide a toilet and handwashing sink in, or adjoining, each bathroom.

(5) When providing common-use toilet rooms and bathrooms, the boarding home must provide toilets and handwashing sinks for residents in the ratios of one toilet and one handwashing sink for every eight residents or fraction as listed in the following table:

Number of Residents	Number of Toilets*	Number of Handwashing Sinks
1-8	1	1
9-16	2	2
17-24	3	3
25-32	4	4
33-40	5	5
41-48	6	6
49-56	7	7
57-64	8	8
65-72	9	9
73-80	10	10
81-88	11	11
89-96	12	12
97-104	13	13
105-112	14	14
113-120	15	15
121-128	16	16
129-136	17	17
137-144	18	18
145-152	19	19
153-160	20	20
161-168	21	21
169-176	22	22
177-184	23	23

*When two or more toilets are contained in a single bathroom, they are counted as one toilet.

(6) When providing common-use toilet rooms and bathrooms, the boarding home must provide bathing fixtures for residents in the ratio of one bathing fixture for every twelve residents or fraction thereof as listed in the following table:

Number of Residents	Number of Bathing Fixtures
1-12	1
13-24	2
25-36	3
37-48	4
49-60	5
61-72	6
73-84	7
85-96	8
97-108	9
109-120	10
121-132	11
133-144	12
145-160	13
161-172	14
173-184	15
185-196	16

(7) When providing common-use toilet rooms and bathrooms, the boarding home must:

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(a) Designate toilet rooms containing more than one toilet for use by men or women;

(b) Designate bathrooms containing more than one bathing fixture for use by men or women;

(c) Equip each toilet room and bathroom designed for use by, or used by, more than one person at a time, in a manner to ensure visual privacy for each person using the room. The boarding home is not required to provide additional privacy features in private bathrooms with a single toilet and a single bathing fixture located within a private apartment;

(d) Provide a handwashing sink with soap and single use or disposable towels, blower or equivalent hand-drying device in each toilet room, except that single-use or disposable towels or blowers are not required in toilet rooms or bathrooms that are located within a private apartment;

(e) Provide reasonable access to bathrooms and toilet rooms for each resident by:

(i) Locating a toilet room on the same floor or level as the sleeping room of the resident served;

(ii) Locating a bathroom on the same floor or level, or adjacent floor or level, as the sleeping room of the resident served;

(iii) Providing access without passage through any kitchen, pantry, food preparation, food storage, or dishwashing area, or from one bedroom through another bedroom; and

(f) Provide and ensure toilet paper is available at each common-use toilet.

(8) In boarding homes issued a project number by construction review services on or after September 1, 2004 for construction related to this section, the boarding home must ensure fifty percent of all the bathing fixtures in the boarding home are roll-in type showers that have:

(a) One-half inch or less threshold;

(b) A minimum size of thirty-six inches by forty-eight inches; and

(c) Single lever faucets located within thirty-six inches of the seat so the faucets are within reach of persons seated in the shower.

[Statutory Authority: RCW 18.20.090, 06-01-047, § 388-78A-3030, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW, 04-16-065, § 388-78A-3030, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3040 Laundry. (1) The boarding home must provide laundry and linen services on the premises, or by commercial laundry.

(2) The boarding home must handle, clean, and store linen according to acceptable methods of infection control. The boarding home must:

(a) Provide separate areas for handling clean laundry and soiled laundry;

(b) Ensure clean laundry is not processed in, and does not pass through, areas where soiled laundry is handled;

(c) Ensure areas where clean laundry is stored are not exposed to contamination from other sources; and

(d) Ensure all staff persons wear gloves and uses other appropriate infection control practices when handling soiled laundry.

(3) The boarding home must use washing machines that have a continuous supply of hot water with a temperature of 140°F measured at the washing machine intake, or that auto-

matically dispense a chemical sanitizer as specified by the manufacturer, whenever the boarding home washes:

(a) Boarding home laundry;

(b) Boarding home laundry combined with residents' laundry into a single load; or

(c) More than one resident's laundry combined into a single load.

(4) The boarding home or a resident washing an individual resident's personal laundry, separate from other laundry, may wash the laundry at temperatures below 140°F and without the use of a chemical sanitizer.

(5) The boarding home must ventilate laundry rooms and areas to the outside of the boarding home, including areas or rooms where soiled laundry is held for processing by off site commercial laundry services.

(6) The boarding home must locate laundry equipment in rooms other than those used for open food storage, food preparation or food service.

(7) For all boarding homes issued a project number by construction review services on or after September 1, 2004 for construction related to this section, the boarding home must provide a laundry area where residents' may do their personal laundry that is:

(a) Equipped with:

(i) A utility sink;

(ii) A table or counter for folding clean laundry;

(iii) At least one washing machine and one clothes dryer; and

(iv) Mechanical ventilation to the outside of the boarding home.

(b) Is arranged to reduce the chances of soiled laundry contaminating clean laundry.

(8) The boarding home may combine areas for soiled laundry with other areas when consistent with WAC 388-78A-3110.

(9) The boarding home may combine areas for handling and storing clean laundry with other areas when consistent with WAC 388-78A-3120.

[Statutory Authority: RCW 18.20.090, 06-01-047, § 388-78A-3040, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW, 04-16-065, § 388-78A-3040, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3050 Day rooms. (1) The boarding home must provide one or more day room areas in which residents may participate in social and recreational activities. Day room areas include, but are not limited to:

(a) Solariums;

(b) Enclosed sun porches;

(c) Recreation rooms;

(d) Dining rooms; and

(e) Living rooms.

(2) The boarding home must provide a total minimum floor space for day room areas of:

(a) One hundred fifty square feet, or ten square feet per resident, whichever is larger, in boarding homes licensed on or before December 31, 1988; or

(b) One hundred fifty square feet, or twenty square feet per resident, whichever is larger, in boarding homes licensed after December 31, 1988.

(3) The boarding home must provide day room areas with comfortable furniture and furnishings that meet the residents' needs.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3050, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3060 Storage space. The boarding home must:

- (1) Provide adequate storage space for supplies, equipment and linens;
- (2) Provide separate, locked storage for disinfectants and poisonous compounds; and
- (3) Maintain storage space to prevent fire or safety hazards.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3060, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3070 Stairs—Ramps. The boarding home must maintain nonskid surfaces on all stairways and ramps used by residents.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3070, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3080 Guardrails—Handrails. (1) The boarding home must install and maintain sturdy handrails according to building code requirements, located:

- (a) In halls and corridors, if necessary for resident safety;
- (b) On each side of interior and exterior stairways with more than one step riser, unless the department approves in writing having a handrail on one side only; and
- (c) On each side of interior and exterior ramps with slopes greater than one to twenty.

(2) The boarding home must install guardrails if the department determines guardrails are necessary for resident safety.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3080, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3090 Maintenance and housekeeping. (1) The boarding home must:

- (a) Provide a safe, sanitary and well-maintained environment for residents;
- (b) Keep exterior grounds, boarding home structure, and common parts safe, sanitary and in good repair;
- (c) Keep facilities, equipment and furnishings clean and in good repair;
- (d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition; and
- (e) Equip a housekeeping supply area on the premises with:
 - (i) A utility sink or equivalent means of obtaining and disposing of mop water, separate from food preparation and service areas;
 - (ii) Storage for wet mops, ventilated to the outside of the boarding home; and
 - (iii) Locked storage for cleaning supplies.

(2) For boarding homes issued a project number by construction review services on or after September 1, 2004 for construction related to this section, the boarding home must provide housekeeping supply room(s):

(a) Located on each floor of the boarding home, except only one housekeeping supply room is required for boarding homes licensed for sixteen or fewer beds when there is a means other than using a stairway, for transporting mop buckets between floors;

(b) In proximity to laundry and kitchen areas; and

(c) Equipped with:

(i) A utility sink or equivalent means of obtaining and disposing of mop water, away from food preparation and service areas;

(ii) Storage for wet mops;

(iii) Locked storage for cleaning supplies; and

(iv) Mechanical ventilation to the outside of the boarding home.

[Statutory Authority: RCW 18.20.090. 06-01-047, § 388-78A-3090, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3090, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3100 Safe storage of supplies and equipment. The boarding home must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the boarding home must consider at a minimum:

- (1) The residents' characteristics and needs;
- (2) The degree of hazardousness or toxicity posed by the supplies or equipment;
- (3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and
- (4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3100, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3110 Areas for cleaning and storing soiled equipment, supplies and laundry. (1) The boarding home may combine areas used for storing, handling and cleaning soiled laundry and linens, areas used for cleaning and disinfecting soiled nursing care equipment, areas for disposing of refuse and infectious waste, and/or areas for storing housekeeping and cleaning supplies, into a single area on the premises only when the boarding home equips the area with:

- (a) A two-compartment sink for handwashing and sanitizing;
- (b) A clinical service sink or equivalent for rinsing and disposing of waste material;
- (c) A work counter or table;
- (d) Mechanical ventilation to the outside of the boarding home; and
- (e) Locked storage for cleaning supplies, if stored in the area.

(2) The boarding home must ensure that any work or function performed in or around a combined utility area as described in subsection (1) of this section is performed without significant risk of contamination to:

(a) Storing or handling clean or sterile nursing supplies or equipment;

- (b) Storing or handling clean laundry;
- (c) Providing resident care;
- (d) Food storage, preparation, or service; or
- (e) Other operations, services or functions in the boarding home sensitive to infection control practices.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3110, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3120 Areas for handling and storing clean supplies and equipment. The boarding home may combine areas used for handling and storing clean laundry, and areas used for storing, preparing and handling clean and sterile nursing supplies, equipment and medications, into a single area on the premises only when the boarding home:

- (1) Equips the area with:
 - (a) A handwashing sink; and
 - (b) A work counter or table.
- (2) Ensures that any work or function performed in the area is performed without significant risk of contamination from other sources; and
- (3) Stores medications separate from all other stored items consistent with WAC 388-78A-2260.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3120, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3130 Plant restrictions. The boarding home must not use poisonous or toxic plants in areas of the boarding home premises accessible to residents who, based on their diagnosed condition or cognitive disabilities, may ingest or have harmful contact with such plants.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3130, filed 7/30/04, effective 9/1/04.]

Inspections, Enforcement Remedies, and Appeals

WAC 388-78A-3140 Responsibilities during inspections. The boarding home must:

- (1) Cooperate with the department during any on-site inspection or complaint investigation;
- (2) Provide requested records to the representatives of the department; and
- (3) Ensure the boarding home administrator or the administrator's designee is available during any inspection or complaint investigation to respond to questions or issues identified by department staff.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3140, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3150 Statements of deficiencies and plans of correction. (1) The department must give the administrator or the administrator's designee a written statement of deficiencies specifying any violations of chapter 18.20 or 70.129 RCW or this chapter that the department found during on-site inspections and complaint investigations.

- (2) The licensee must respond to a statement of deficiencies by submitting to the department within a time acceptable to the department, a signed written plan of correction for each deficiency stated in the report. The licensee must include in the plan of correction, for each cited deficiency:

- (a) A specific plan of what will be or was done to correct the problem;
- (b) A description of what will be done to prevent future problems of this type;
- (c) Who will be responsible for monitoring the corrections to ensure the problems do not recur; and
- (d) The date by which lasting correction will be achieved.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3150, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3160 Authorized enforcement remedies. (1) Whenever the circumstances in WAC 388-78A-3170(1) are present, the department may impose any enforcement remedies authorized by RCW 18.20.050(4), 18.20.185(7) and 18.20.190 on a boarding home, including:

- (a) Denying a boarding home license;
- (b) Suspending a boarding home license;
- (c) Revoking a boarding home license;
- (d) Refusing to renew a boarding home license;
- (e) Suspending admissions to a boarding home;
- (f) Suspending admissions to a boarding home of a specific category or categories of residents as related to cited problems;
- (g) Imposing conditions on the boarding home license; and/or
- (h) Imposing civil penalties of not more than one hundred dollars per day per violation.

(2) Notwithstanding subsection (1) of this section, the department may impose a civil penalty on a boarding home of up to three thousand dollars per day per violation for interference, coercion, discrimination and/or reprisal by a boarding home as set forth in RCW 18.20.185(7).

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3160, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3170 Circumstances resulting in enforcement remedies. (1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

- (a) A history of significant noncompliance with federal or state laws or regulations in providing care or services to frail elders, vulnerable adults or children, whether as a licensee, contractor, managerial employee or otherwise. Evidence of significant noncompliance may include, without limitation:
 - (i) Citations for violation of laws or regulations imposed by regulating entities;
 - (ii) Sanctions for violation of laws or regulations imposed by regulating entities;
 - (iii) Involuntary termination, cancellation, suspension, or nonrenewal of a Medicaid contract or Medicare provider agreement, or any other agreement with a public agency for the care or treatment of children, frail elders or vulnerable adults;
 - (iv) Been denied a license relating to the care of frail elders, vulnerable adults or children; or
 - (v) Relinquished or failed to renew a license relating to care of frail elders, vulnerable adults or children following

written notification of the licensing agency's initiation of denial, suspension, cancellation or revocation of a license.

(b) Failed to provide appropriate care to frail elders, vulnerable adults or children under a contract, or having such contract terminated or not renewed by the contracting agency due to such failure;

(c) Been convicted of a felony, or a crime against a person, if the conviction reasonably relates to the competency of the person to operate a boarding home;

(d) Failed or refused to comply with the requirements of chapter 18.20 RCW, applicable provisions of chapter 70.129 RCW or this chapter;

(e) Retaliated against a staff person, resident or other individual for:

(i) Reporting suspected abuse or other alleged improprieties;

(ii) Providing information to the department during the course of the department conducting an inspection of the boarding home; or

(iii) Providing information to the department during the course of the department conducting a complaint investigation in the boarding home.

(f) Operated a facility for the care of children or adults without a current, valid license or under a defunct or revoked license;

(g) Been convicted of a crime committed on a boarding home premises; knowingly permitted, aided or abetted an illegal act on a boarding home premises; or engaged in the illegal use of drugs or the excessive use of alcohol;

(h) Abused, neglected or exploited a vulnerable adult or knowingly failed to report alleged abuse, neglect or exploitation of a vulnerable adult as required by chapter 74.34 RCW;

(i) Failed to exercise fiscal accountability and responsibility involving a resident, the department, public agencies, or the business community; or to have insufficient financial resources or unencumbered income to sustain the operation of the boarding home;

(j) Knowingly or with reason to know, made false statements of material fact in the application for the license or the renewal of the license or any data attached thereto, or in any matter under investigation by the department;

(k) Willfully prevented or interfered with or attempted to impede in any way any inspection or investigation by the department, or the work of any authorized representative of the department or the lawful enforcement of any provision of this chapter;

(l) Refused to allow department representatives or agents to examine any part of the licensed premises including the books, records and files required under this chapter;

(m) Moved all residents out of the boarding home without the department's approval and to be no longer operating as a boarding home; or

(n) Demonstrated any other factors that give evidence the applicant lacks the appropriate character, suitability and competence to provide care or services to vulnerable adults.

(2) This section applies to any boarding home:

(a) Applicant;

(b) Partner, officer or director;

(c) Manager or managerial employee; or

(d) Majority owner of the applicant or licensee:

(i) Who is involved in the management or operation of the boarding home;

(ii) Who may have direct access to boarding home residents;

(iii) Who controls or supervises the provision of care or services to boarding home residents; or

(iv) Who exercises control over daily operations of the boarding home.

(3) For other circumstances resulting in discretionary enforcement remedies, see WAC 388-78A-3200.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3170, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3180 Required enforcement remedies. The department must impose an appropriate remedy consistent with RCW 18.20.125 and as otherwise authorized by RCW 18.20.185 or 18.20.190 whenever the department finds a boarding home has:

(1) A serious problem, a recurring problem, or an uncorrected problem;

(2) Created a hazard that causes or is likely to cause death or serious harm to one or more residents;

(3) Discriminated or retaliated in any manner against a resident, employee, or any other person because that person or any other person made a complaint or provided information to the department, the attorney general, a law enforcement agency, or the long-term care ombudsman; or

(4) Willfully interfered with the performance of official duties by a long-term care ombudsman.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3180, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3190 Denial, suspension, revocation, or nonrenewal of license statutorily required. (1) The department must deny, suspend, revoke or refuse to renew a boarding home license if any person described in subsection (2) of this section who has unsupervised access to residents, is:

(a) Convicted of a crime against children or other persons or crimes relating to financial exploitation as defined under RCW 43.43.830 or 43.43.842; or

(b) Found by a court in a protection proceeding or in a civil damages lawsuit under chapter 74.34 RCW to have abused, neglected, abandoned or exploited a vulnerable adult; or

(c) Found in any dependency action under chapter 13.34 RCW to have sexually assaulted, neglected, exploited, or physically abused any minor; or

(d) Found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused, exploited, or physically abused any minor; or

(e) Found in any final decision issued by a disciplinary board to have sexually or physically abused or neglected or exploited any minor or any vulnerable adult, or has a stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority, a court of law, or entered into a state registry finding him or her guilty of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW.

- (2) This section applies to any boarding home:
- (a) Applicant;
 - (b) Partner, officer or director;
 - (c) Manager or managerial employee; or
 - (d) Owner of five percent or more of the applicant;
 - (i) Who is involved in the operation of the boarding home; or
 - (ii) Who may have direct access to the boarding home residents; or
 - (iii) Who controls or supervises the provision of care or services to the boarding home residents; or
 - (iv) Who exercises control over daily operations.

[Statutory Authority: RCW 18.20.090, 06-01-047, § 388-78A-3190, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3190, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3200 Progression of enforcement remedies. (1) When the department cites a boarding home for an initial problem that does not represent a recurring problem, serious problem or uncorrected problem, and that results in minimal or moderate harm that is limited in scope, the department may:

- (a) Require a plan of correction from the boarding home;
- (b) Impose conditions on the boarding home license; and/or

(c) Impose a civil penalty.

(2) The department may take any of the actions specified in subsection (1) of this section and/or impose a stop-placement or limited stop-placement on a boarding home when:

(a) There is a reasonable probability, at the time the stop-placement or limited stop-placement is imposed, at least a moderate degree of harm will occur or recur as a result of a single problem or by a combination of problems; and

(b) The threatening problem is more than an isolated event or occurrence.

(3) The department may take any of the actions specified in subsections (1) and (2) of this section and/or summarily suspend a boarding home's license when:

(a) There is an imminent threat that a serious degree of harm may occur to residents as a result of a single problem or a combination of problems; and

(b) The threatening problem is more than an isolated event or occurrence.

(4) The department may take any of the actions specified in subsections (1), (2) and (3) of this section and/or revoke a boarding home's license when:

(a) The department has cause to summarily suspend the boarding home's license;

(b) There is a current problem with the boarding home and the boarding home has a history of having enforcement remedies imposed by the department;

(c) There is a current problem with the boarding home and the boarding home has a history of noncompliance representing problems that were at least moderate in nature and moderate in scope;

(d) The boarding home has moved all residents out of the boarding home without the department's approval and is no longer operating as a boarding home; or

(e) There is a serious current problem, which may not warrant a summary suspension, with the boarding home that

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does not have a history of noncompliance. Examples of the types of serious current problems that may warrant license revocation include, but are not limited to:

(i) The licensee has been found or convicted by a court of competent jurisdiction to have engaged in fraudulent activity; or

(ii) The licensee is experiencing significant financial problems resulting in poor care or jeopardizing the care and services that can be provided to residents, and possible business failure; or

(f) The boarding home fails to cooperate with the department during any inspection or complaint investigation.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3200, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3210 Informal dispute resolution.

The boarding home has a right to an informal dispute resolution meeting according to department procedure and consistent with RCW 18.20.195. The boarding home must make a request for an informal dispute resolution meeting in writing within ten days of the receipt of the written notice of deficiency.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3210, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3220 Appeal rights. (1) An applicant or boarding home:

(a) May contest an enforcement remedy imposed by the department pursuant to RCW 18.20.190 according to the provisions of chapter 34.05 RCW and chapters 10-08 and 388-02 WAC;

(b) Must file any request for an adjudicative proceeding with the office of administrative hearings at the mailing address specified in the notice of imposition of an enforcement remedy within twenty-eight days of receiving the notice.

(2) Orders of the department imposing licensing suspension, stop-placement, or conditions for continuation of a license are effective immediately upon notice and shall continue pending any hearing.

[Statutory Authority: RCW 18.20.090, 06-01-047, § 388-78A-3220, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3220, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-3230 Fees. The boarding home must:

(1) Submit an annual license fee of seventy-nine dollars per bed of the licensed resident bed capacity as determined by and in accordance with RCW 18.20.050;

(2) Submit an additional one hundred fifty dollars when billed by the department for:

(a) A third on-site visit required by the boarding home's failure to adequately correct problems identified in a statement of deficiencies; and

(b) A full out-of-sequence inspection resulting from information gathered during a complaint investigation.

(3) Submit an additional late fee in the amount of ten dollars per day from the license renewal date until the date of mailing the fee, as evidenced by the postmark; and

(4) Submit to construction review services a fee for the review of the construction documents per the review fee schedule that is based on the project cost.

[Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-3230, filed 7/30/04, effective 9/1/04.]

Chapter 388-79 WAC

GUARDIANSHIP FEES FOR CLIENTS OF THE DEPARTMENT

WAC

388-79-010	Purpose.
388-79-020	Definitions.
388-79-030	Maximum fees and costs.
388-79-040	Procedure to revise award letter after June 15, 1998, but before September 1, 2003.
388-79-050	Procedure for allowing fees and costs from client participation after September 1, 2003.

WAC 388-79-010 Purpose. These rules implement RCW 11.92.180 and 43.20B.460 to the extent that those statutes require the department to establish by rule the maximum amount of guardianship fees and additional compensation for administrative costs that may be allowed by the court for a guardian or limited guardian of an incapacitated person who is a Medicaid client of the department and is thus required by federal law to contribute to the cost of the client's long-term care.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 03-16-022, § 388-79-010, filed 7/28/03, effective 8/28/03; 98-10-055, § 388-79-010, filed 4/30/98, effective 5/31/98.]

WAC 388-79-020 Definitions. "Administrative costs" or "costs" means necessary costs paid by the guardian including attorney fees.

"Client" means a person who is eligible for and is receiving Medicaid-funded long-term care.

"Guardianship fees" or "fees" means necessary fees charged by a guardian for services rendered on behalf of a client.

"Participation" means the amount the client pays from current monthly income toward the cost of the client's long-term care.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 03-16-022, § 388-79-020, filed 7/28/03, effective 8/28/03; 98-10-055, § 388-79-020, filed 4/30/98, effective 5/31/98.]

WAC 388-79-030 Maximum fees and costs. The superior court may allow guardianship fees and administrative costs in an amount set out in an order. For orders entered after June 15, 1998, where the order establishes or continues a legal guardianship for a department client, and requires a future review or accounting; then unless otherwise modified by the process described in WAC 388-79-040:

(1) The amount of guardianship fees shall not exceed one hundred seventy-five dollars per month;

(2) The amount of administrative costs directly related to establishing a guardianship for a department client shall not exceed seven hundred dollars; and

(3) The amount of administrative costs shall not exceed a total of six hundred dollars during any three-year period.

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[Statutory Authority: RCW 11.92.180, 43.20B.460, 03-16-022, § 388-79-030, filed 7/28/03, effective 8/28/03; 98-10-055, § 388-79-030, filed 4/30/98, effective 5/31/98.]

WAC 388-79-040 Procedure to revise award letter after June 15, 1998, but before September 1, 2003. After June 15, 1998, but before September 1, 2003, where a department client is subject to a guardianship then the department shall be entitled to notice of proceedings as described in RCW 11.92.150.

(1) The notice shall be given to the appropriate regional administrator of the program serving the department client. A list of the regional administrators will be available upon request.

(2) If the fees and costs requested and established by the order are equal to or lower than the maximum amount set by this rule then the award letter or document setting the department's client's participation shall be adjusted to reflect that amount upon receipt by the department of the court order setting a monthly amount.

(3) Should fees and costs above those requested in WAC 388-79-030 be requested:

(a) The appropriate regional administrator will be given notice of the hearing as described in RCW 11.92.150, and provided with copies of all supporting documents filed with the court.

(b) Should the court determine after consideration of the facts, law and evidence of the case, that fees and costs higher than normally allowed in WAC 388-79-030 are just and reasonable and should be allowed then the award letter or document setting the department client's participation shall be adjusted to reflect that amount upon receipt by the department of the court order setting a monthly amount.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 03-16-022, § 388-79-040, filed 7/28/03, effective 8/28/03; 98-10-055, § 388-79-040, filed 4/30/98, effective 5/31/98.]

WAC 388-79-050 Procedure for allowing fees and costs from client participation after September 1, 2003.

(1) After September 1, 2003, where a client is subject to a guardianship the department shall be entitled to notice of proceedings as described in RCW 11.92.150.

(2) The notice must be served to the department's regional administrator of the program that is providing services to the client. A list of the regional administrators will be furnished upon request.

(3) If the fees and costs requested and established by the order are equal to or less than the maximum amounts allowed under WAC 388-79-030, then the department will adjust the client's current participation to reflect the amounts allowed upon receipt by the department of the court order setting the monthly amounts.

(4) Should fees and costs in excess of the amounts allowed in WAC 388-79-030 be requested:

(a) At least ten days before filing the request with the court, the guardian must present the request in writing to the appropriate regional administrator to allow the department an opportunity to consider whether the request should be granted on an exceptional basis.

(b) In considering a request for extraordinary fees or costs, the department must consider the following factors:

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NURSING FACILITY MEDICAID PAYMENT SYSTEM

(i) The department's obligation under federal and state law to ensure that federal Medicaid funding is not jeopardized by noncompliance with federal regulations limiting deductions from the client's participation amount;

(ii) The usual and customary guardianship services for which the maximum fees and costs under WAC 388-79-030 must be deemed adequate for a Medicaid client, including but not limited to:

- (A) Acting as a representative payee;
- (B) Managing the client's financial affairs;
- (C) Preserving and/or disposing of property;
- (D) Making health care decisions;
- (E) Visiting and/or maintaining contact with the client;
- (F) Accessing public assistance programs on behalf of the client;

(G) Communicating with the client's service providers; and

(H) Preparing any reports or accountings required by the court.

(iii) Extraordinary services provided by the guardian, such as:

- (A) Unusually complicated property transactions;
- (B) Substantial interactions with adult protective services or criminal justice agencies;
- (C) Extensive medical services setup needs and/or emergency hospitalizations; and
- (D) Litigation other than litigating an award of guardianship fees or costs.

(c) Should the court determine after consideration of the facts and law that fees and costs in excess of the amounts allowed in WAC 388-79-030 are just and reasonable and should be allowed, then the department will adjust the client's current participation to reflect the amounts allowed upon receipt by the department of the court order setting the monthly amounts.

(5) In no event may a client's participation be prospectively or retrospectively reduced to pay fees and costs incurred before the effective date of the client's Medicaid eligibility; or during any subsequent time period when the client was not eligible for, or did not receive long-term care services; or after the client has died. There is no client participation towards DDD certified and contracted supported living services under chapter 388-820 WAC, so the department has no responsibility to reimburse the client for guardianship fees when those fees result in the client having insufficient income to pay their living expenses.

(6) If the court at a prior accounting has allowed the guardian to receive fees and costs from the client's monthly income in advance of services rendered by the guardian, and the client dies before the next accounting, the fees and costs allowed by the court at the final accounting may be less than, but may not exceed, the amounts advanced and paid to the guardian from the client's income.

(7) Guardians must furnish the regional administrator with complete packets to include all documents filed with the court and with formal notice clearly identifying the amount requested.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 03-16-022, § 388-79-050, filed 7/28/03, effective 8/28/03.]

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RCW 74.46.421 rate reduction—A nursing facility's rates.

RCW 74.46.421 nursing facility component rates below the statewide weighted average payment rate identified in the Biennial Appropriations Act.

Methodology for reducing a nursing facility's Medicaid payment rate in order to reduce the statewide weighted average nursing facility Medicaid payment rate to equal or be less than the weighted average payment rate identified in the Biennial Appropriations Act.

Nursing facilities' rate reductions pursuant to RCW 74.46.421.

388-96-738	What default case mix group and weight must the department use for case mix grouping when there is no minimum data set resident assessment for a nursing facility resident?		039 (Order 2105), § 388-96-032, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-032, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-032, filed 10/13/82. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-032, filed 6/1/78; Order 1262, § 388-96-032, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-739	How will the department determine which resident assessments are Medicaid resident assessments?		
388-96-740	Medicaid case mix index—When a facility does not meet the ninety percent minimum data set (MDS) threshold as identified in RCW 74.46.501.	388-96-100	Standards for funding patient care services in skilled nursing/intermediate care facilities. [Order 1168, § 388-96-100, filed 11/3/76.] Repealed by Order 1262, filed 12/30/77.
388-96-741	When the nursing facility does not have facility average case mix indexes for the four quarters specified in RCW 74.46.501 (7)(b) for determining the cost per case mix unit, what will the department use to determine the nursing facility's cost per case mix unit?	388-96-101	Reports. [Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-101, filed 7/23/92, effective 8/23/92. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-101, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-101, filed 9/16/83; 79-03-021 (Order 1370), § 388-96-101, filed 2/21/79; Order 1262, § 388-96-101, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-742	Licensed beds to compute the ninety percent minimum data set (MDS) threshold rather than a nursing facility's quarterly average census.		
388-96-744	How will the department set the therapy care rate and determine the median cost limit per unit of therapy?		
388-96-746	How much therapy consultant expense for each therapy type will the department allow to be added to the total allowable one-on-one therapy expense?	388-96-103	Skilled nursing care patients. [Order 1168, § 388-96-103, filed 11/3/76.] Repealed by Order 1257, filed 12/21/77.
388-96-747	Constructed, remodeled or expanded facilities.		
388-96-748	Financing allowance component rate allocation.	388-96-104	Due dates for reports. [Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-104, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-104, filed 9/16/83; 79-03-021 (Order 1370), § 388-96-104, filed 2/21/79; Order 1262, § 388-96-104, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-749	Variable return—Quartiles and percentages.		
388-96-757	Payment for veterans' homes.		
388-96-760	Upper limits to the payment rate.		
388-96-762	Allowable land.		
388-96-766	Notification.		
388-96-767	Appraisal values.		
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388-96-776	Add-ons to the property and financing allowance payment rate—Capital improvements.	388-96-106	Minimum licensed personnel requirements for skilled nursing facilities. [Order 1168, § 388-96-106, filed 11/3/76.] Repealed by Order 1257, filed 12/21/77.
388-96-777	Add-ons to the prospective rate—Initiated by the department.	388-96-109	Intermediate care facility patients. [Order 1168, § 388-96-109, filed 11/3/76.] Repealed by Order 1257, filed 12/21/77.
388-96-781	Exceptional direct care component rate allocation—Covered Medicaid residents.		
388-96-782	Exceptional therapy care and exceptional direct care—Payment.	388-96-110	Improperly completed or late reports. [Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-110, filed 7/23/92, effective 8/23/92. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-110, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-110, filed 9/16/83; 82-09-033 (Order 1791), § 388-96-110, filed 4/14/82; 80-06-122 (Order 1510), § 388-96-110, filed 5/30/80, effective 7/1/80; Order 1262, § 388-96-110, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-783	Certificate of capital authorization (CCA).		
388-96-802	May the nursing facility (NF) contractor bill the department for a Medicaid resident's day of death, discharge, or transfer from the NF?		
388-96-803	When a nursing facility (NF) contractor becomes aware of a change in the Medicaid resident's income and/or resources, must he or she report it?		
388-96-901	Disputes.		
388-96-904	Administrative review—Adjudicative proceeding.		
388-96-905	Case mix accuracy review of MDS nursing facility resident assessments.	388-96-112	Minimum licensed personnel requirements for intermediate care facilities. [Order 1168, § 388-96-112, filed 11/3/76.] Repealed by Order 1257, filed 12/21/77.
DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER		388-96-113	Completing reports and maintaining records. [Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-113, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-113, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-113, filed 7/23/92, effective 8/23/92. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-113, filed 8/19/85. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-113, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-113, filed 9/16/83; 83-05-007 (Order 1944), § 388-96-113, filed 2/4/83; 82-11-065 (Order 1808), § 388-96-113, filed 5/14/82; 80-09-083 (Order 1527), § 388-96-113, filed 7/22/80; Order 1262, § 388-96-113, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-015	Phase-in of other definitions. [Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-015, filed 2/25/81.] Repealed by 81-22-081 (Order 1712), filed 11/4/81. Statutory Authority: RCW 74.09.120.		
388-96-023	Conditions of participation. [Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-023, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-023, filed 10/29/91, effective 11/29/91; 83-19-047 (Order 2025), § 388-96-023, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-023, filed 10/13/82. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-023, filed 6/1/78; Order 1262, § 388-96-023, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.		
388-96-029	Change of ownership. [Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-029, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-029, filed 9/16/83; Order 1262, § 388-96-029, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-116	Provider classification. [Order 1169, § 388-96-116, filed 11/10/76.] Repealed by Order 1257, filed 12/21/77.
		388-96-118	Exception to dual contract. [Order 1168, § 388-96-118, filed 11/3/76.] Repealed by Order 1257, filed 12/21/77.
		388-96-125	Reporting for an abbreviated period. [Statutory Authority: RCW 74.09.120. 79-04-102 (Order 1387), § 388-96-125, filed 4/4/79; Order 1262, § 388-96-125, filed 12/30/77.] Repealed by 83-19-047 (Order 2025), filed 9/16/83. Statutory Authority: RCW 74.09.120.
388-96-032	Termination of contract. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-032, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-032, filed 8/19/85. Statutory Authority: RCW 74.46.800. 84-12-	388-96-128	Requirements for retention of records by the contractor. [Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-128, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-128, filed 9/16/83; Order

	1262, § 388-96-128, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-220	Principles of settlement. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-220, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-131, filed 9/16/83; Order 1262, § 388-96-131, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-131	Requirement for retention of reports by the department. [Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-131, filed 9/16/83; Order 1262, § 388-96-131, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-221	Preliminary settlement. [Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-221, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-221, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-221, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.120 and 74.46.800. 89-11-100 (Order 2799), § 388-96-221, filed 5/24/89. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-221, filed 12/23/87. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-221, filed 9/16/83.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-134	Disclosure of nursing home reports. [Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-134, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.120. 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-134, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-134, filed 9/16/83; Order 1262, § 388-96-134, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-222	Settlement. [Statutory Authority: RCW 74.09.120. 83-05-007 (Order 1944), § 388-96-222, filed 2/4/83; 81-22-080 (Order 1716), § 388-96-222, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-222, filed 2/25/81. Statutory Authority: RCW 74.09.120. 79-12-085 (Order 1461), § 388-96-222, filed 11/30/79; 79-04-059 (Order 1382), § 388-96-222, filed 3/28/79. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-222, filed 6/1/78; Order 1262, § 388-96-222, filed 12/30/77.] Repealed by 83-19-047 (Order 2025), filed 9/16/83. Statutory Authority: RCW 74.09.120.
388-96-200	Condition of qualification for participation in the Washington state cost-related reimbursement system. [Order 1168, § 388-96-200, filed 11/3/76.] Repealed by Order 1262, filed 12/30/77.	388-96-223	Shifting. [Statutory Authority: RCW 74.09.120. 81-15-049 (Order 1669), § 388-96-223, filed 7/15/81; 80-15-114 (Order 1561), § 388-96-223, filed 10/22/80; Order 1262, § 388-96-223, filed 12/30/77.] Repealed by 83-19-047 (Order 2025), filed 9/16/83. Statutory Authority: RCW 74.09.120.
388-96-201	Desk review. [Order 1262, § 388-96-201, filed 12/30/77.] Repealed by 83-19-047 (Order 2025), filed 9/16/83. Statutory Authority: RCW 74.09.120.	388-96-224	Final settlement. [Statutory Authority: RCW 74.46.150, [74.46.]160, [74.46.]170 and [74.46.]800. 97-17-040, § 388-96-224, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-224, filed 9/12/95, effective 10/13/95. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-224, filed 12/23/87. Statutory Authority: RCW 74.09.120 and 74.46.800. 85-13-060 (Order 2240), § 388-96-224, filed 6/18/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-224, filed 9/16/83.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-203	Initial financial survey report and budgetary report for new providers. [Order 1168, § 388-96-203, filed 11/3/76.] Repealed by Order 1262, filed 12/30/77.	388-96-225	Date settlement becomes final. [Statutory Authority: RCW 74.09.120. 83-05-007 (Order 1944), § 388-96-225, filed 2/4/83; 81-22-080 (Order 1716), § 388-96-225, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-225, filed 2/25/81; Order 1262, § 388-96-225, filed 12/30/77.] Repealed by 83-19-047 (Order 2025), filed 9/16/83. Statutory Authority: RCW 74.09.120.
388-96-204	Field audits. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-204, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-204, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-204, filed 12/23/87. Statutory Authority: RCW 74.09.120. 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-204, filed 8/19/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-204, filed 12/4/84. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-204, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-204, filed 9/16/83; Order 1262, § 388-96-204, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-226	Shifting provisions. [Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-226, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-226, filed 9/14/93, effective 10/15/93. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-226, filed 12/23/87. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-226, filed 9/16/83.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-206	Prospective daily payment. [Order 1168, § 388-96-206, filed 11/3/76.] Repealed by Order 1262, filed 12/30/77.	388-96-227	Interest on settlements. [Statutory Authority: RCW 74.09.120. 83-05-007 (Order 1944), § 388-96-227, filed 2/4/83; 81-22-080 (Order 1716), § 388-96-227, filed 11/4/81.] Repealed by 83-19-047 (Order 2025), filed 9/16/83. Statutory Authority: RCW 74.09.120.
388-96-207	Preparation for audit by the contractor. [Statutory Authority: RCW 74.09.120. 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-207, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-207, filed 9/16/83; Order 1262, § 388-96-207, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-228	Cost savings. [Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-228, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-228, filed 9/14/93, effective 10/15/93. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-228, filed 12/23/87. Statutory Authority: RCW 74.09.120. 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-228, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-228, filed
388-96-209	Flat rate payment system option. [Order 1168, § 388-96-209, filed 11/3/76.] Repealed by Order 1262, filed 12/30/77.		
388-96-210	Scope of field audits. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-210, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-210, filed 9/14/93, effective 10/15/93; 89-11-100 (Order 2799), § 388-96-210, filed 5/24/89. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-210, filed 9/16/83; Order 1262, § 388-96-210, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.		
388-96-213	Inadequate documentation. [Statutory Authority: RCW 74.09.120. 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-213, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-213, filed 9/16/83; Order 1262, § 388-96-213, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.		
388-96-216	Deadline for completion of audits. [Statutory Authority: RCW 74.09.120. 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-216, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-216, filed 9/16/83; Order 1262, § 388-96-216, filed 12/30/77.] Repealed by 95-19-037 (Order 3896), filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18.		
388-96-219	Disclosure of audit narratives and summaries. [Order 1262, § 388-96-219, filed 12/30/77.] Repealed by 83-19-047 (Order 2025), filed 9/16/83. Statutory Authority: RCW 74.09.120.		

	9/16/83.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-357	Provider records. [Order 1114, § 388-96-357, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.
388-96-229	Procedures for overpayments and underpayments. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18, 95-19-037 (Order 3896), § 388-96-229, filed 9/12/95, effective 10/13/95. Statutory Authority: 1987 c 476, 88-01-126 (Order 2573), § 388-96-229, filed 12/23/87. Statutory Authority: RCW 74.09.120, 83-19-047 (Order 2025), § 388-96-229, filed 9/16/83.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-360	Audits by the department. [Order 1114, § 388-96-360, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-300	Required reports. [Order 1205, § 388-96-300, filed 4/13/77; Order 1114, § 388-96-300, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-363	Report certification. [Order 1114, § 388-96-363, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.
388-96-302	Report dates. [Order 1205, § 388-96-302, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-387	Illustration of final settlement form. [Order 1114, § 388-96-387, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-303	Uniform reporting forms. [Order 1169, § 388-96-303, filed 11/10/76; Order 1114, § 388-96-303, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-400	The prospective cost-related reimbursement system. [Order 1168, § 388-96-400, filed 11/3/76; Order 1114, § 388-96-400, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-305	Approval required for extensions. [Order 1205, § 388-96-305, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-403	Control areas and associated cost centers. [Order 1168, § 388-96-403, filed 11/3/76; Order 1114, § 388-96-403, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-306	Short-period report procedure. [Order 1114, § 388-96-306, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-406	Payment of the actual allowable costs by cost center. [Order 1168, § 388-96-406, filed 11/3/76; Order 1114, § 388-96-406, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-308	Late reports. [Order 1205, § 388-96-308, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-409	Discretionary allowance. [Order 1114, § 388-96-409, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-309	Incorrect or false report. [Order 1114, § 388-96-309, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-412	Expense allocation procedures. [Order 1114, § 388-96-412, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-311	Forms. [Order 1205, § 388-96-311, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-415	Expense identification. [Order 1114, § 388-96-415, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-312	Amended annual or semiannual report. [Order 1114, § 388-96-312, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-418	Expense recoveries and adjustments. [Order 1114, § 388-96-418, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-314	Completion of reports. [Order 1205, § 388-96-314, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-421	Allocation of expenses. [Order 1114, § 388-96-421, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-315	Flat rate option for providers (flat rate system). [Order 1114, § 388-96-315, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-424	Multifacility provider. [Order 1114, § 388-96-424, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-317	Certification of reports. [Order 1205, § 388-96-317, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-427	Uniform system of accounting. [Order 1114, § 388-96-427, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-318	Reporting requirements. [Order 1114, § 388-96-318, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-430	Separate and distinct SNF and/or ICF. [Order 1114, § 388-96-430, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-320	False reports. [Order 1205, § 388-96-320, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-433	Combined multifacility. [Order 1114, § 388-96-433, 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-321	Extensions. [Order 1114, § 388-96-321, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-436	Prospective cost reimbursement for combined multifacility. [Order 1114, § 388-96-436, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-323	Amendments. [Order 1205, § 388-96-323, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-439	Payment of the lower of actual costs or prospective per diem rates. [Order 1114, § 388-96-439, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-324	Delinquent semiannual or annual reports. [Order 1114, § 388-96-324, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-442	Multifacility flat rate option for providers (flat rate system). [Order 1114, § 388-96-442, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-325	Abbreviated reporting period. [Order 1205, § 388-96-325, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-445	Medical recipient rates. [Order 1114, § 388-96-445, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-326	Retention of records. [Order 1205, § 388-96-326, filed 4/13/77.] Repealed by Order 1262, filed 12/30/77.	388-96-448	Medical recipient rates by level of care. [Order 1114, § 388-96-448, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-327	Determination of prospective daily payment rate. [Order 1114, § 388-96-327, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-451	Prospective daily payment rate. [Order 1114, § 388-96-451, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-330	Rate adjustments and payments. [Order 1114, § 388-96-330, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-454	Prospective rate—Inadequate data. [Order 1114, § 388-96-454, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-333	Annual report settlement. [Order 1114, § 388-96-333, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-457	Prospective rate revision. [Order 1114, § 388-96-457, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-336	Contested annual settlement. [Order 1114, § 388-96-336, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-458	Prospective rate—Projected (budgeted) cost increases. [Order 1114, § 388-96-458, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-339	Final settlement date. [Order 1114, § 388-96-339, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-460	Prospective rate—New facility. [Order 1114, § 388-96-460, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-342	Uniform system of accounting and reporting. [Order 1169, § 388-96-342, filed 11/10/76; Order 1114, § 388-96-342, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-463	Prospective rate—Change in ownership—New provider. [Order 1114, § 388-96-463, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-345	Uniform statistical reporting. [Order 1114, § 388-96-345, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-466	Prospective rate—Change in ownership—Nonarmslength transaction. [Order 1114, § 388-96-466, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-348	Method of accounting. [Order 1114, § 388-96-348, filed 4/21/76.] Repealed by Order 1205, filed 4/13/77.	388-96-470	Prospective rate—Change in ownership—Armslength transaction. [Order 1114, § 388-96-470, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-351	Nursing home reports. [Order 1239, § 388-96-351, filed 8/23/77; Order 1205, § 388-96-351, filed 4/13/77; Order 1114, § 388-96-351, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-473	Final daily settlement rate. [Order 1114, § 388-96-473, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.
388-96-354	Final settlement report. [Order 1114, § 388-96-354, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-476	Notification of prospective and final rates. [Order 1114, § 388-96-476, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.

388-96-479	Adjustments, errors, or omissions. [Order 1114, § 388-96-479, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-531	Owner or relative—Compensation. [Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-531, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-531, filed 9/16/83. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-531, filed 2/25/81; Order 1262, § 388-96-531, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-500	Provider billing instructions—Nursing home statement. [Order 1114, § 388-96-500, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-533	Maximum allowable compensation of certain administrative personnel. [Statutory Authority: RCW 74.46.-800. 94-12-043 (Order 3737), § 388-96-533, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-533, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-533, filed 12/21/88. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-533, filed 12/23/87. Statutory Authority: RCW 74.46.800. 86-10-055 (Order 2372), § 388-96-533, filed 5/7/86, effective 7/1/86; 84-12-039 (Order 2105), § 388-96-533, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-533, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-533, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-533, filed 2/25/81. Statutory Authority: RCW 74.09.120. 80-06-122 (Order 1510), § 388-96-533, filed 5/30/80, effective 7/1/80. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-533, filed 6/1/78; Order 1262, § 388-96-533, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-501	Allowable costs. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-501, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-501, filed 2/25/81. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-501, filed 6/1/78; Order 1262, § 388-96-501, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-537	Temporary contract labor. [Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-537, filed 2/25/81.] Repealed by 81-22-081 (Order 1712), filed 11/4/81. Statutory Authority: RCW 74.09.120.
388-96-503	Substance prevails over form. [Statutory Authority: RCW 74.09.120. 81-22-081 (Order 1712), § 388-96-503, filed 11/4/81. Statutory Authority: RCW 74.09.-120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-503, filed 2/25/81; Order 1262, § 388-96-503, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-539	Allowable interest. [Statutory Authority: RCW 74.09.-120. 83-19-047 (Order 2025), § 388-96-539, filed 9/16/83; 83-05-007 (Order 1944), § 388-96-539, filed 2/4/83; 81-22-081 (Order 1712), § 388-96-539, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-539, filed 2/25/81. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-539, filed 6/1/78; Order 1262, § 388-96-539, filed 12/30/77.] Repealed by 84-24-050 (Order 2172), filed 12/4/84. Statutory Authority: RCW 74.09.120.
388-96-507	Costs of meeting standards. [Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-507, filed 10/29/91, effective 11/29/91; 81-22-081 (Order 1712), § 388-96-507, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-507, filed 2/25/81. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-507, filed 6/1/78; Order 1262, § 388-96-507, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-541	Offset of interest income. [Statutory Authority: RCW 74.09.120. 81-22-081 (Order 1712), § 388-96-541, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-541, filed 2/25/81; Order 1262, § 388-96-541, filed 12/30/77.] Repealed by 84-24-050 (Order 2172), filed 12/4/84. Statutory Authority: RCW 74.09.120.
388-96-508	Travel expenses for members of trade association boards of directors. [Statutory Authority: RCW 74.46.-800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-508, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-508, filed 5/30/84.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-543	Expense for construction interest. [Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-543, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-543, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-543, filed 2/25/81; Order 1262, § 388-96-543, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-509	Boards of directors fees. [Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-509, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-509, filed 5/30/84.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-545	Operating leases of equipment. [Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-545, filed 2/25/81.] Repealed by 81-22-081 (Order 1712), filed 11/4/81. Statutory Authority: RCW 74.09.120.
388-96-510	Billing period. [Order 1114, § 388-96-510, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-547	Operating leases of facilities and equipment. [Statutory Authority: RCW 74.09.120. 81-22-081 (Order 1712), § 388-96-547, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-547, filed 2/25/81; Order 1262, § 388-96-547, filed 12/30/77.] Repealed by 84-24-050 (Order 2172), filed 12/4/84. Statutory Authority: RCW 74.09.120.
388-96-513	Limit on costs to related organizations. [Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-513, filed 9/14/93, effective 10/15/93; 81-06-024 (Order 1613), § 388-96-513, filed 2/25/81; Order 1262, § 388-96-513, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-549	Rental expense paid to related organizations. [Order 1262, § 388-96-549, filed 12/30/77.] Repealed by 84-24-050 (Order 2172), filed 12/4/84. Statutory Authority: RCW 74.09.120.
388-96-520	Suspension of reimbursement formula. [Order 1114, § 388-96-520, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.	388-96-555	Depreciation expense. [Order 1262, § 388-96-555, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-521	Start up costs. [Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-521, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-521, filed 9/16/83; Order 1262, § 388-96-521, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-557	Depreciable assets. [Statutory Authority: RCW 74.09.-120. 84-24-050 (Order 2172), § 388-96-557, filed
388-96-523	Organization costs. [Statutory Authority: RCW 74.46.-800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-523, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-523, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-523, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-523, filed 2/25/81; Order 1262, § 388-96-523, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.		
388-96-529	Total compensation—Owners, relatives, and certain administrative personnel. [Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-529, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-529, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-529, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-529, filed 2/25/81; Order 1262, § 388-96-529, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.		

	12/4/84; 83-19-047 (Order 2025), § 388-96-557, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-557, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-557, filed 2/25/81; Order 1262, § 388-96-557, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-624	Historical cost trade-ins. [Order 1114, § 388-96-624, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-563	Depreciation base of assets previously used in medical care program. [Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-563, filed 2/25/81.] Repealed by 81-22-081 (Order 1712), filed 11/4/81. Statutory Authority: RCW 74.09.120.	388-96-626	Purchase of facility as an ongoing operations. [Order 1114, § 388-96-626, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-567	Methods of depreciation. [Statutory Authority: RCW 74.46.800. 86-10-055 (Order 2372), § 388-96-567, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-567, filed 8/19/85. Statutory Authority: RCW 74.09.120. 81-22-081 (Order 1712), § 388-96-567, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-567, filed 2/25/81; Order 1262, § 388-96-567, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-628	Partial change of ownership interest. [Order 1114, § 388-96-628, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-569	Retirement of depreciable assets. [Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-569, filed 9/14/93, effective 10/15/93; 91-22-025 (Order 3270), § 388-96-569, filed 10/29/91, effective 11/29/91; 81-06-024 (Order 1613), § 388-96-569, filed 2/25/81; Order 1262, § 388-96-569, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-630	Donated assets. [Order 1114, § 388-96-630, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-571	Handling of gains and losses upon retirement of depreciable assets settlement periods prior to 1/1/81 and rate periods prior to 7/1/82. [Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-571, filed 2/25/81. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-571, filed 6/1/78; Order 1262, § 388-96-571, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-632	Capitalization vs. expense. [Order 1114, § 388-96-632, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-573	Recovery of excess over straight-line depreciation. [Statutory Authority: RCW 74.09.120. 83-05-007 (Order 1944), § 388-96-573, filed 2/4/83; Order 1262, § 388-96-573, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-634	Construction in process. [Order 1114, § 388-96-634, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-587	Phase-in of other unallowable costs. [Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-587, filed 2/25/81.] Repealed by 81-22-081 (Order 1712), filed 11/4/81. Statutory Authority: RCW 74.09.120.	388-96-636	Amortization expense of leasehold improvements. [Order 1114, § 388-96-636, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-600	Reasonable costs. [Order 1114, § 388-96-600, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-638	Leased facilities and equipment. [Order 1114, § 388-96-638, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-602	Substance of recoverable cost transactions. [Order 1114, § 388-96-602, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-640	Interest expense. [Order 1114, § 388-96-640, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-604	Costs due to changes imposed by regulatory agencies. [Order 1114, § 388-96-604, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-642	Interest rate. [Order 1114, § 388-96-642, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-606	Nonreimbursable services and expenses. [Order 1114, § 388-96-606, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-644	Recovery of interest income. [Order 1114, § 388-96-644, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-608	Recovery of expenses. [Order 1114, § 388-96-608, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-646	Interest expense—Related organization. [Order 1114, § 388-96-646, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-610	Physical property. [Order 1114, § 388-96-610, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-648	Construction interest expense. [Order 1114, § 388-96-648, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-612	Depreciation. [Order 1114, § 388-96-612, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-650	In-service educational activities. [Order 1114, § 388-96-650, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-614	Historical cost depreciation for new providers and for depreciable assets purchased subsequent to July 1, 1974. [Order 1114, § 388-96-614, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-652	Owner-administrator compensation and/or allowances. [Order 1114, § 388-96-652, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-616	Election of depreciation method for depreciable assets purchased prior to July 1, 1974, by providers entering cost reimbursement at its inception. [Order 1169, § 388-96-616, filed 11/10/76; Order 1114, § 388-96-616, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-654	Relatives of owner compensation and/or allowances. [Order 1114, § 388-96-654, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-618	Guideline lives and methods of depreciation. [Order 1114, § 388-96-618, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-656	Owner-administrator of multiple facilities (groups). [Order 1114, § 388-96-656, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-620	Disposal of depreciable assets. [Order 1114, § 388-96-620, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-658	Owner allowances. [Order 1114, § 388-96-658, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
388-96-622	Gains or losses on disposition of major-minor equipment. [Order 1114, § 388-96-622, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]	388-96-660	Preopening expenses. [Order 1114, § 388-96-660, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
		388-96-662	Discretionary allowance. [Order 1114, § 388-96-662, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
		388-96-664	Costs of related organization. [Order 1114, § 388-96-664, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
		388-96-666	Rentals or leases from related organization. [Order 1114, § 388-96-666, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
		388-96-668	Service charges from related organization. [Order 1114, § 388-96-668, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
		388-96-700	Appeals. [Order 1114, § 388-96-700, filed 4/21/76.] Repealed by Order 1262, filed 12/30/77.]
		388-96-701	Reimbursement principles. [Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-701, filed 1/9/78.] Repealed by 81-15-049 (Order 1669), filed 7/15/81. Statutory Authority: RCW 74.09.120.
		388-96-707	Program services not covered by the reimbursement rate. [Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-707, filed 10/13/82. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-707, filed 6/1/78. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-707, filed 1/9/78.] Repealed by 94-12-043 (Order 3737), filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800.
		388-96-714	Nursing facility Medicaid rate allocations—Economic trends and conditions adjustment factors. [Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-714, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-714, filed 11/30/99, effective 12/31/99.] Repealed by 04-21-027, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.-

	431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8.		Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-722, filed 4/20/87; 86-10-055 (Order 2372), § 388-96-722, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-722, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-722, filed 9/16/83; 82-11-065 and 82-13-050 (Orders 1808 and 1808A), § 388-96-722, filed 5/14/82 and 6/14/82; 81-15-049 (Order 1669), § 388-96-722, filed 7/15/81; 81-06-024 (Order 1613), § 388-96-722, filed 2/25/81; 80-06-122 (Order 1510), § 388-96-722, filed 5/30/80, effective 7/1/80; 79-12-085 (Order 1461), § 388-96-722, filed 11/30/79. Statutory Authority: RCW 18.51.310 and 74.09.120. 78-11-013 (Order 1349), § 388-96-722, filed 10/9/78. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-722, filed 6/1/78. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-722, filed 1/9/78.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	
388-96-716	Cost areas or cost centers. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-716, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-716, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.-800. 92-16-013 (Order 3424), § 388-96-716, filed 7/23/92, effective 8/23/92. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-716, filed 12/23/87. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-716, filed 12/4/84; 83-19-047 (Order 2025), § 388-96-716, filed 9/16/83; 81-15-049 (Order 1669), § 388-96-716, filed 7/15/81; 80-06-122 (Order 1510), § 388-96-716, filed 5/30/80, effective 7/1/80; 78-02-013 (Order 1264), § 388-96-716, filed 1/9/78.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.			
388-96-717	Desk review adjustments. [Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-717, filed 8/19/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-717, filed 9/16/83.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-727	Food cost area rate. [Statutory Authority: RCW 74.46.-800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-727, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-727, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-727, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-727, filed 9/16/83; 81-15-049 (Order 1669), § 388-96-727, filed 7/15/81; 79-12-085 (Order 1461), § 388-96-727, filed 11/30/79; 78-02-013 (Order 1264), § 388-96-727, filed 1/9/78.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	
388-96-719	Method of rate determination. [Statutory Authority: RCW 74.46.430. 97-17-040, § 388-96-719, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-719, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-719, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-719, filed 9/14/93, effective 10/15/93; 90-09-061 (Order 2970), § 388-96-719, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-719, filed 12/23/87. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-719, filed 8/19/85. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-719, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-719, filed 9/16/83; 82-17-071 (Order 1867), § 388-96-719, filed 8/18/82; 82-12-068 (Order 1820), § 388-96-719, filed 6/2/82; 82-04-073 (Order 1756), § 388-96-719, filed 2/3/82; 81-15-049 (Order 1669), § 388-96-719, filed 7/15/81; 80-06-122 (Order 1510), § 388-96-719, filed 5/30/80, effective 7/1/80; 79-12-085 (Order 1461), § 388-96-719, filed 11/30/79; 78-11-043 (Order 1353), § 388-96-719, filed 10/20/78. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-719, filed 6/1/78. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-719, filed 1/9/78.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-728	How will the nursing facility's "hold harmless" direct care rate be determined? [Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 25 and RCW 74.46.800. 98-20-023, § 388-96-728, filed 9/25/98, effective 10/1/98.] Repealed by 04-21-027, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8.	
		388-96-729	When will the department use the "hold harmless rate" to pay for direct care services? [Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 25 and RCW 74.46.800. 98-20-023, § 388-96-729, filed 9/25/98, effective 10/1/98.] Repealed by 04-21-027, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8.	
		388-96-732	How will the department determine whether its notice pursuant to WAC 388-96-724 was timely? [Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-732, filed 5/29/01, effective 6/29/01.] Repealed by 04-21-027, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8.	
388-96-720	Redistribution pool. [Statutory Authority: RCW 74.09.120. 82-11-065 (Order 1808), § 388-96-720, filed 5/14/82.] Repealed by 83-19-047 (Order 2025), filed 9/16/83. Statutory Authority: RCW 74.09.120.	388-96-735	Administrative cost area rate. [Statutory Authority: RCW 74.46.800. 97-17-040, § 388-96-735, filed 8/14/97, effective 9/14/97; 96-15-056, § 388-96-735, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-735, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-735, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-735, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-735, filed 12/4/84; 83-19-047 (Order 2025), § 388-96-735, filed 9/16/83; 82-11-065 (Order 1808), § 388-96-735, filed 5/14/82; 81-15-049 (Order 1669), § 388-96-735, filed 7/15/81; 80-06-122 (Order 1510), § 388-96-735, filed 5/30/80, effective 7/1/80; 79-12-085 (Order 1461), § 388-96-735, filed 11/30/79; 78-02-013 (Order 1264), § 388-96-735, filed 1/9/78.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	
388-96-721	Priorities in establishing rates and responding to appeals of desk-review adjustments. [Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-721, filed 5/30/84.] Repealed by 94-12-043 (Order 3737), filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800.			
388-96-722	Nursing services cost area rate. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-722, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-722, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-722, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-722, filed 7/23/92, effective 8/23/92. Statutory Authority: RCW 74.09.180 and 74.46.800. 91-22-025 (Order 3270), § 388-96-722, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 74.46.800 and 74.09.120. 91-12-026 (Order 3185), § 388-96-722, filed 5/31/91, effective 7/1/91. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-722, filed 12/21/88. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-722, filed 12/23/87. Statutory	388-96-737	Operational cost area rate. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-737, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-737, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-737, filed	

	9/14/93, effective 10/15/93.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-761	Home office, central office, and other off-premises assets. [Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-761, filed 5/30/84.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-743	Property cost area rate. [Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-743, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-743, filed 10/13/82; 81-15-049 (Order 1669), § 388-96-743, filed 7/15/81; 80-06-122 (Order 1510), § 388-96-743, filed 5/30/80, effective 7/1/80; 79-12-085 (Order 1461), § 388-96-743, filed 11/30/79; 78-02-013 (Order 1264), § 388-96-743, filed 1/9/78.] Repealed by 84-24-050 (Order 2172), filed 12/4/84. Statutory Authority: RCW 74.09.120.	388-96-763	Rates for recipients requiring exceptionally heavy care. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-763, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-763, filed 5/26/94, effective 6/26/94; 92-16-013 (Order 3424), § 388-96-763, filed 7/23/92, effective 8/23/92. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-763, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-763, filed 12/21/88. Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-763, filed 10/13/82. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-763, filed 6/1/78. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-763, filed 1/9/78.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-745	Property cost area reimbursement rate. [Statutory Authority: RCW 74.46.800 and 74.46.530. 97-17-040, § 388-96-745, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-745, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-745, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-745, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-745, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-745, filed 7/23/92, effective 8/23/92. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-745, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-745, filed 12/23/87. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-745, filed 4/20/87. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-745, filed 12/4/84.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-764	Activities assistants. [Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-764, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-764, filed 5/30/84.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
		388-96-765	Ancillary care. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-765, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-765, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-765, filed 5/30/84.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-750	Return on investment. [Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-750, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-750, filed 9/16/83; 81-22-080 (Order 1716), § 388-96-750, filed 11/4/81; 80-15-114 (Order 1561), § 388-96-750, filed 10/22/80; 80-06-122 (Order 1510), § 388-96-750, filed 5/30/80, effective 7/1/80; 79-04-061 (Order 1381), § 388-96-750, filed 3/28/79.] Repealed by 84-24-050 (Order 2172), filed 12/4/84. Statutory Authority: RCW 74.09.120.	388-96-768	Minimum wage. [Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-768, filed 9/14/93, effective 10/15/93; 90-09-061 (Order 2970), § 388-96-768, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-768, filed 12/23/87.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-752	Documentation of leased assets. [Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-752, filed 12/4/84.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-769	Adjustments required due to errors or omissions. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-769, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 86-10-055 (Order 2372), § 388-96-769, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120. 82-11-065 (Order 1808), § 388-96-769, filed 5/14/82; 81-22-081 (Order 1712), § 388-96-769, filed 11/4/81; 78-02-013 (Order 1264), § 388-96-769, filed 1/9/78.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
388-96-753	Return on investment—Effect of funding granted under WAC 388-96-774, 388-96-776, and 388-96-777. [Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-753, filed 5/26/94, effective 6/26/94.] Repealed by 95-19-037 (Order 3896), filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18.	388-96-772	Requests for revision of a prospective rate. [Statutory Authority: RCW 74.09.120. 81-22-081 (Order 1712), § 388-96-772, filed 11/4/81; 78-02-013 (Order 1264), § 388-96-772, filed 1/9/78.] Repealed by 83-19-047 (Order 2025), filed 9/16/83. Statutory Authority: RCW 74.09.120.
388-96-754	A contractor's return on investment. [Statutory Authority: RCW 74.46.530. 97-17-040, § 388-96-754, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-754, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-754, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-754, filed 9/14/93, effective 10/15/93; 91-22-025 (Order 3270), § 388-96-754, filed 10/29/91, effective 11/29/91; 90-09-061 (Order 2970), § 388-96-754, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-754, filed 12/21/88. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-754, filed 4/20/87; 86-10-055 (Order 2372), § 388-96-754, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-754, filed 8/19/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-754, filed 12/4/84.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.	388-96-773	Adjustments to prospective rates. [Statutory Authority: RCW 74.09.120 and 74.46.800. 85-13-065 (Order 2245), § 388-96-773, filed 6/18/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-773, filed 9/16/83.] Repealed by 90-09-061 (Order 2970), filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800.
		388-96-774	Add-ons to the prospective rate—Staffing. [Statutory Authority: RCW 74.46.460. 97-17-040, § 388-96-774, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-774, filed 7/16/96, effective 8/16/96; 94-12-043 and 94-14-016 (Order 3737 and 3737A), § 388-96-774, filed 5/26/94 and 6/23/94, effective 6/26/94 and 7/24/94; 93-17-033 (Order 3615), § 388-96-774, filed 8/11/93, effective 9/11/93. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-774, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.09.120 and 74.46.800. 90-09-061 (Order 2970), § 388-96-774, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-774, filed 12/21/88. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-774, filed 12/23/87. Statutory Authority:
388-96-756	Enhancement cost area rate. [Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-756, filed 12/23/87.] Repealed by 93-19-074 (Order 3634), filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800 and 74.09.120.		

- ity: RCW 74.46.800, 87-09-058 (Order 2485), § 388-96-774, filed 4/20/87. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800, 85-17-052 (Order 2270), § 388-96-774, filed 8/19/85.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
- 388-96-775 Public review of rate-setting methods and standards. [Statutory Authority: RCW 74.09.120, 78-02-013 (Order 1264), § 388-96-775, filed 1/9/78.] Repealed by 93-19-074 (Order 3634), filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800 and 74.09.120.
- 388-96-778 Public disclosure of rate-setting methodology. [Statutory Authority: RCW 74.09.120, 78-02-013 (Order 1264), § 388-96-778, filed 1/9/78.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
- 388-96-779 Exceptional therapy care—Designated nursing facilities. [Statutory Authority: RCW 74.46.800, 74.46.508, 00-12-098, § 388-96-779, filed 6/7/00, effective 7/8/00.] Repealed by 04-21-027, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8.
- 388-96-780 Exceptional therapy care—Covered Medicaid residents. [Statutory Authority: RCW 74.46.800, 01-12-037, § 388-96-780, filed 5/29/01, effective 6/29/01. Statutory Authority: RCW 74.46.800, 74.46.508, 00-12-098, § 388-96-780, filed 6/7/00, effective 7/8/00.] Repealed by 04-21-027, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8.
- 388-96-801 Billing period. [Order 1262, § 388-96-801, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
- 388-96-804 Billing procedures. [Statutory Authority: RCW 74.09.120, 82-20-024 and 82-20-036 (Orders 1883 and 1883A), § 388-96-804, filed 9/29/82 and 9/30/82; Order 1262, § 388-96-804, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
- 388-96-807 Charges to patients. [Statutory Authority: RCW 74.09.180 and 74.46.800, 89-01-095 (Order 2742), § 388-96-807, filed 12/21/88. Statutory Authority: RCW 74.09.120, 83-19-047 (Order 2025), § 388-96-807, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-807, filed 10/13/82; Order 1262, § 388-96-807, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
- 388-96-810 Payment. [Statutory Authority: RCW 74.46.800, 96-15-056, § 388-96-810, filed 7/16/96, effective 8/16/96; Order 1262, § 388-96-810, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
- 388-96-813 Suspension of payment. [Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18, 95-19-037 (Order 3896), § 388-96-813, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.09.120, 83-19-047 (Order 2025), § 388-96-813, filed 9/16/83; Order 1262, § 388-96-813, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
- 388-96-816 Termination of payments. [Statutory Authority: RCW 74.09.120, 83-19-047 (Order 2025), § 388-96-816, filed 9/16/83; Order 1262, § 388-96-816, filed 12/30/77.] Repealed by 98-20-023, filed 9/25/98, effective 10/1/98.
- 388-96-900 Definitions. [Order 1169, § 388-96-900, filed 11/10/76.] Repealed by Order 1262, filed 12/30/77.
- 388-96-902 Recoupment of undisputed overpayments. [Statutory Authority: RCW 74.09.120, 82-11-065 (Order 1808), § 388-96-902, filed 5/14/82.] Repealed by 95-19-037 (Order 3896), filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18.

WAC 388-96-010 Definitions. Unless the context indicates otherwise, the following definitions apply in this chapter.

"Accounting" means activities providing information, usually quantitative and often expressed in monetary units, for:

- (1) Decision making;
- (2) Planning;
- (3) Evaluating performance;
- (4) Controlling resources and operations; and

(5) External financial reporting to investors, creditors, regulatory authorities, and the public.

"Administration and management" means activities used to maintain, control, and evaluate the efforts and resources of an organization for the accomplishment of the objectives and policies of that organization.

"Allowable costs" means documented costs that are necessary, ordinary, and related to the care of Medicaid recipients, and are not expressly declared nonallowable by this chapter or chapter 74.46 RCW. Costs are ordinary if they are of the nature and magnitude that prudent and cost conscious management would pay.

"Allowable depreciation costs" means depreciation costs of tangible assets, whether owned or leased by the contractor, meeting the criteria specified in RCW 74.46.330.

"Assignment of contract" means:

(1) A new nursing facility licensee has elected to care for Medicaid residents;

(2) The department finds no good cause to object to continuing the Medicaid contract at the facility; and

(3) The new licensee accepts assignment of the immediately preceding contractor's contract at the facility.

"Capitalized lease" means a lease required to be recorded as an asset and associated liability in accordance with generally accepted accounting principles.

"Cash method of accounting" means a method of accounting in which revenues are recorded when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for those expenditures and assets.

"Change of ownership" means a substitution, elimination, or withdrawal of the individual operator or operating entity contracting with the department to deliver care services to medical care recipients in a nursing facility and ultimately responsible for the daily operational decisions of the nursing facility.

(1) Events which constitute a change of ownership include, but are not limited to, the following:

(a) Changing the form of legal organization of the contractor, e.g., a sole proprietor forms a partnership or corporation;

(b) Transferring ownership of the nursing facility business enterprise to another party, regardless of whether ownership of some or all of the real property and/or personal property assets of the facility are also transferred;

(c) Dissolving of a partnership;

(d) Dissolving the corporation, merging the corporation with another corporation, which is the survivor, or consolidating with one or more other corporations to form a new corporation;

(e) Transferring, whether by a single transaction or multiple transactions within any continuous twenty-four-month period, fifty percent or more of the stock to one or more:

(i) New or former stockholders; or

(ii) Present stockholders each having held less than five percent of the stock before the initial transaction;

(f) Substituting of the individual operator or the operating entity by any other event or combination of events that results in a substitution or substitution of control of the individual operator or the operating entity contracting with the department to deliver care services; or

(g) A nursing facility ceases to operate.

(2) Ownership does not change when the following, without more, occurs:

(a) A party contracts with the contractor to manage the nursing facility enterprise as the contractor's agent, i.e., subject to the contractor's general approval of daily operating and management decisions; or

(b) The real property or personal property assets of the nursing facility change ownership or are leased, or a lease of them is terminated, without a substitution of individual operator or operating entity and without a substitution of control of the operating entity contracting with the department to deliver care services.

"Charity allowance" means a reduction in charges made by the contractor because of the indigence or medical indigence of a patient.

"Component rate allocation(s)" means the initial component rate allocation(s) of the rebased rate for a rebase period effective July 1. If a month and a day, other than July 1, with a year precedes "component rate allocation(s)," it means the initial component rate allocation(s) of the rebased rate of the rebase period has been amended or updated effective the date that precedes it, e.g., October 1, 1999 direct care component rate allocation.

"Contract" means an agreement between the department and a contractor for the delivery of nursing facility services to medical care recipients.

"Cost report" means all schedules of a nursing facility's cost report submitted according to the department's instructions.

"Courtesy allowances" means reductions in charges in the form of an allowance to physicians, clergy, and others, for services received from the contractor. Employee fringe benefits are not considered courtesy allowances.

"Donated asset" means an asset the contractor acquired without making any payment for the asset either in cash, property, or services. An asset is not a donated asset if the contractor:

(1) Made even a nominal payment in acquiring the asset; or

(2) Used donated funds to purchase the asset.

"Equity capital" means total tangible and other assets which are necessary, ordinary, and related to patient care from the most recent provider cost report minus related total long-term debt from the most recent provider cost report plus working capital as defined in this section.

"Fiscal year" means the operating or business year of a contractor. All contractors report on the basis of a twelve-month fiscal year, but provision is made in this chapter for reports covering abbreviated fiscal periods. As determined by context or otherwise, **"fiscal year"** may also refer to a state fiscal year extending from July 1 through June 30 of the following year and comprising the first or second half of a state fiscal biennium.

"Gain on sale" means the actual total sales price of all tangible and intangible nursing facility assets including, but not limited to, land, building, equipment, supplies, goodwill, and beds authorized by certificate of need, minus the net book value of such assets immediately prior to the time of sale.

"Intangible asset" is an asset that lacks physical substance but possesses economic value.

"Interest" means the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user.

"Multiservice facility" means a facility at which two or more types of health or related care are delivered, e.g., a hospital and nursing facility, or a boarding home and nursing facility.

"Nonadministrative wages and benefits" means wages, benefits, and corresponding payroll taxes paid for nonadministrative personnel, not to include administrator, assistant administrator, or administrator-in-training.

"Nonallowable costs" means the same as **"unallowable costs."**

"Nonrestricted funds" means funds which are not restricted to a specific use by the donor, e.g., general operating funds.

"Nursing facility occupancy percentage" is determined by multiplying the number of calendar days for the cost report period by the number of licensed beds for the same cost report period. Then, the nursing facility's actual resident days for the same cost report period is divided by the product. When the nursing facility under chapter 70.38 RCW reinstates or reduces the number of licensed beds, then under WAC 388-96-708 or 388-96-709 the number of licensed beds after reinstatement or reduction will be used. In all determinations that require a nursing facility occupancy percentage, the department will use the greater of either a nursing facility's occupancy percentage or eighty-five percent.

"Per diem (per patient day or per resident day) costs" means total allowable costs for a fiscal period divided by total patient or resident days for the same period.

"Prospective daily payment rate" means the rate assigned by the department to a contractor for providing service to medical care recipients prior to the application of settlement principles.

"Recipient" means a Medicaid recipient.

"Related care" includes:

- (1) The director of nursing services;
- (2) Activities and social services programs;
- (3) Medical and medical records specialists; and
- (4) Consultation provided by:
 - (a) Medical directors; and
 - (b) Pharmacists.

"Relative" includes:

- (1) Spouse;
- (2) Natural parent, child, or sibling;
- (3) Adopted child or adoptive parent;
- (4) Stepparent, stepchild, stepbrother, stepsister;
- (5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law;
- (6) Grandparent or grandchild; and
- (7) Uncle, aunt, nephew, niece, or cousin.

"Start up costs" means the one-time preopening costs incurred from the time preparation begins on a newly constructed or purchased building until the first patient is admitted. Start up costs include:

- (1) Administrative and nursing salaries;
- (2) Utility costs;
- (3) Taxes;
- (4) Insurance;

- (5) Repairs and maintenance; and
- (6) Training costs.

Start up costs do not include expenditures for capital assets.

"Total rate allocation" means the initial rebased rate for a rebase period effective July 1. If a month and a day, other than July 1, with a year precedes "total rate allocation," it means the initial rebased rate of the rebase period has been amended or updated effective the date that precedes it, e.g., October 1, 1999 direct care component rate allocation.

"Unallowable costs" means costs which do not meet every test of an allowable cost.

"Uniform chart of accounts" means a list of account titles identified by code numbers established by the department for contractors to use in reporting costs.

"Vendor number" means a number assigned to each contractor delivering care services to medical care recipients.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-010, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-010, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-010, filed 9/25/98, effective 10/1/98; 97-17-040, § 388-96-010, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-010, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-010, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-010, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-010, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-010, filed 4/17/90, effective 5/18/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-010, filed 12/23/87. Statutory Authority: RCW 74.09.120 and 74.46.800. 85-13-060 (Order 2240), § 388-96-010, filed 6/18/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-010, filed 12/4/84. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-010, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-010, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-010, filed 10/13/82; 81-22-081 (Order 1712), § 388-96-010, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-010, filed 2/25/81. Statutory Authority: RCW 74.09.120. 80-09-083 (Order 1527), § 388-96-010, filed 7/22/80; 79-04-061 (Order 1381), § 388-96-010, filed 3/28/79. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-010, filed 6/1/78; Order 1262, § 388-96-010, filed 12/30/77.]

WAC 388-96-020 Prospective cost-related payment.

The nursing facility Medicaid payment system is the system used by the department to pay for nursing facility services provided to medical care recipients. Payment for nursing facility care shall be determined in accordance with this chapter and chapter 74.46 RCW. The provisions of chapter 74.46 RCW are incorporated by reference in this chapter as if fully set forth.

[Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-020, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.09.120 and 74.46.800. 85-13-065 (Order 2245), § 388-96-020, filed 6/18/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-020, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-020, filed 10/13/82. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-020, filed 6/1/78; Order 1262, § 388-96-020, filed 12/30/77.]

WAC 388-96-026 New contractors. (1) For purposes of administering the payment system, the department shall consider a "new contractor" as one who receives a new vendor number and:

(a) Builds from the ground-up a new facility; and operates the new facility with completely new staff, administration and residents. If the "new contractor" operated a nursing facility immediately before the opening of the new facility, then the "new contractor" must operate the new facility with:

(i) Staff and administration that are substantially to completely different than the previous operation of the "new contractor"; and

(ii) A resident population that is substantially to completely different than the residents residing in the previous nursing facility; or

(b) Currently operates, acquires, or assumes responsibility for operating an existing nursing facility that was not operated under a Medicaid contract immediately prior to the effective date of the new Medicaid contract; or

(c) Purchases or leases a nursing facility that, at the time of the purchase or lease, was operated under a Medicaid contract.

(2) A new contractor shall submit:

(a) At least sixty days before the effective date of the contract or assignment, a statement disclosing the identity of individuals or organizations who:

(i) Have a beneficial ownership interest in the current operating entity or the land, building, or equipment of the facility; or

(ii) Have a beneficial ownership interest in the purchasing or leasing entity.

(b) By March 31st of the following year, a cost report for the period from the effective date of the contract or assignment through December 31st of year the contract or assignment was effective.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(11) and RCW 74.46.800. 98-20-023, § 388-96-026, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-026, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-026, filed 7/23/92, effective 8/23/92. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-026, filed 12/21/88. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-026, filed 9/16/83; Order 1262, § 388-96-026, filed 12/30/77.]

WAC 388-96-107 Requests for extensions. (1) A contractor may request in writing an extension for submitting cost reports. Contractor requests shall:

(a) Be addressed to the manager, residential rates program;

(b) State the circumstances prohibiting compliance with the report due date; and

(c) Be received by the department at least ten days prior to the due date of the report.

(2) The department may grant two extensions of up to thirty days each, only if the circumstances, stated clearly, indicate the due date cannot be met and the following conditions are present:

(a) The circumstances were not foreseeable by the provider; and

(b) The circumstances were not avoidable by advance planning.

[Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-107, filed 12/21/88. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-107, filed 9/16/83; Order 1262, § 388-96-107, filed 12/30/77.]

WAC 388-96-108 Failure to submit final reports. (1)

If a nursing facility's contract is terminated or assigned, and the nursing facility does not submit a final cost report as required by RCW 74.46.040, the nursing facility shall return to the department all payments made to the terminating or assigning contractor relating to the period for which a report has not been received within sixty days after the terminating or assigning contractor receives a written demand from the department.

(2) Effective sixty days after the terminating or assigning contractor receives a written demand for payment, interest will begin to accrue payable to the department on any unpaid balance at the rate of one percent per month.

[Statutory Authority: RCW 74.46.040 and 74.46.050 as amended by 1998 c 322 §§ 3 and 4, 98-20-023, § 388-96-108, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18, 95-19-037 (Order 3896), § 388-96-108, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.09.120, 83-19-047 (Order 2025), § 388-96-108, filed 9/16/83. Statutory Authority: RCW 74.08.090, 82-21-025 (Order 1892), § 388-96-108, filed 10/13/82.]

WAC 388-96-117 Certification requirement. The

contractor as defined in RCW 74.46.020(13) must certify under penalty of perjury that the cost report or an amendment to it is a true, correct, and complete representation of actual costs related to patient care prepared in accordance with applicable instructions provided by the department, chapter 388-96 WAC, and chapter 74.46 RCW. Further, where other costs not related to patient care are shown, they are classified as unallowable.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8, 04-21-027, § 388-96-117, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800, 85-17-052 (Order 2270), § 388-96-117, filed 8/19/85; Order 1262, § 388-96-117, filed 12/30/77.]

WAC 388-96-119 Reports—False information. (1) If

a contractor knowingly or with reason to know files a report containing false information, such action constitutes good cause for termination of its contract with the department.

(2) In accordance with RCW 74.46.531, the department will make adjustments to payment rates because a false report was filed.

(3) Contractors filing false reports may be referred for prosecution under applicable statutes.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 19(11) and 31 and RCW 74.46.800, 98-20-023, § 388-96-119, filed 9/25/98, effective 10/1/98; Order 1262, § 388-96-119, filed 12/30/77.]

WAC 388-96-122 Amendments to reports. (1) For the

purpose of determining allowable costs, the department shall consider an amendment to an annual report only if filed by the provider before the receipt by the provider of the notification scheduling the department's audit. The contractor may file an amendment subsequent to such notification and pursuant to the provisions of RCW 74.46.531 to adjust a payment rate allocation because of an error or omission. When the provider files an amendment, the department shall consider it only if significant errors or omissions are discovered. The department shall deem errors or omissions "significant" when the errors or omissions would mean a net difference of two cents or more per patient day or one thousand dollars or more

in reported costs, whichever is higher, in any component rate allocation. To file an amendment, only those cost report pages where changes appear need to be filed, together with the certification required by WAC 388-96-117.

(2) If an amendment is filed, a contractor shall also submit with the amendment an account of the circumstances relating to and the reasons for the amendment, along with supporting documentation. The department shall refuse to consider an amendment resulting in a more favorable settlement or payment rate allocation to a contractor if the amendment is not the result of circumstances beyond the control of the contractor or the result of good-faith error under the system of cost allocation and accounting in effect during the reporting period in question.

(3) Acceptance or use by the department of an amendment to a cost report shall in no way be construed as a release of applicable civil or criminal liability.

[Statutory Authority: Chapter 74.46 as amended by 1998 c 322 §§ 19(11) and 31 and RCW 74.46.800, 98-20-023, § 388-96-122, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800, 86-10-055 (Order 2372), § 388-96-122, filed 5/7/86, effective 7/1/86; 84-12-039 (Order 2105), § 388-96-122, filed 5/30/84. Statutory Authority: RCW 74.09.120, 82-11-065 (Order 1808), § 388-96-122, filed 5/14/82; 79-03-021 (Order 1370), § 388-96-122, filed 2/21/79; Order 1262, § 388-96-122, filed 12/30/77.]

WAC 388-96-202 Scope of audit or department

audit. (1) The department will review the contractor's record-keeping and accounting practices and, where appropriate, make written recommendations for improvements.

(2) The department's audit will result in a schedule of summarizing adjustments to the contractor's cost report. The schedule will show whether such adjustments eliminate costs reported or include costs not reported. Each adjustment listed will include an explanation for the adjustment, the cost report account, and the dollar amount. In accordance with chapter 74.46 RCW, the department will comply with the purpose of department audits by verifying that:

(a) Supporting records are in agreement with reported data;

(b) Only those assets, liabilities, and revenue and expense items the department has specified as allowable have been included by the contractor in computing the costs of services provided under its contract;

(c) Allowable costs have been accurately determined and are necessary, ordinary, and related to resident care;

(d) Related organizations and beneficial ownerships or interests have been correctly disclosed;

(e) Home office or central office costs have been reported and allocated in accordance with the provisions of this chapter and chapter 74.46 RCW;

(f) Recipient and non-Medicaid resident trust funds have been properly maintained and disbursed;

(g) Facility receivables do not include benefits or payments to which the provider is not entitled; and

(h) The contractor is otherwise in compliance with the provisions of this chapter and chapter 74.46 RCW.

(3) In complying with the purpose of department audits in chapter 74.46 RCW, the department may select any or all schedules of a facility's cost report. The department will audit cost reports, resident trust fund accounts, and facility receivables of each nursing facility participating in the Medicaid payment system as determined necessary by the department.

(4) When determining the contractor's final settlement, the department will apply to reported costs adjustments written under subsection (2), whether used for the purpose of establishing component rate allocations as described in chapter 74.46 RCW or to ascertain contractor compliance with subsection (2).

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-202, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 8 and RCW 74.46.800, 98-20-023, § 388-96-202, filed 9/25/98, effective 10/1/98.]

WAC 388-96-217 Civil fines. (1) When the department finds that a current or former contractor, or any partner, officer, director, owner of five percent or more of the stock of a current or former corporate contractor, or managing agent has failed or refused to comply with any requirement of chapters 74.46 RCW or 388-96 WAC, the department may assess monetary penalties of a civil nature not to exceed one thousand dollars per violation. Every day of noncompliance with any requirement of chapters 74.46 RCW or 388-96 WAC is a separate violation.

(2) The department may fine a contractor or former contractor or any partner, officer, director, owner of five percent or more of the stock of a current or former corporate contractor, or managing agent for the following but is not limited to the following in its fine assessments:

(a) Failure to file a mathematically accurate and complete cost report, including a final cost report, on or prior to the applicable due date established by this chapter or authorized by extension granted in writing by the department; or

(b) Failure to permit an audit authorized by this chapter or to grant access to all records and documents deemed necessary by the department to complete such an audit.

(3) The department shall send notice of a fine assessed under subsection (2) of this section by certified mail return receipt requested to the current contractor, administrator, or former contractor informing the addressee of the following:

(a) The fine shall become effective the date of receipt of the notice by the addressee; and

(b) If within two weeks of the date of receipt of the notice by the addressee, an acceptable cost report is received by the department; an audit is allowed; or access to documentation is allowed, as applicable, the department may waive the fine.

(4)(a) The department may fine a current or former contractor, or any partner, officer, director, owner of a current or former corporate contractor, or managing agent for failure to comply with RCW 74.46.630.

(b) The department shall send notice of a fine assessed under (a) of this subsection by certified mail, to the current contractor, administrator, or former contractor informing the addressee that the fine shall become effective upon receipt of notice by the addressee.

[Statutory Authority: RCW 74.46.050, 74.46.431, 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8, 04-21-027, § 388-96-217, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800, 94-12-043 (Order 3737), § 388-96-217, filed 5/26/94, effective 6/26/94; 87-09-058 (Order 2485), § 388-96-217, filed 4/20/87.]

WAC 388-96-218 Proposed, preliminary, and final settlements. (1) For each component rate, the department shall calculate a proposed, preliminary or final settlement at (2007 Ed.)

the lower of prospective payment rate or audited allowable costs, except as otherwise provided in this chapter [and chapter 74.46 RCW].

(2) As part of the cost report, the proposed settlement report is due in accordance with RCW 74.46.040. In the proposed preliminary settlement report, a contractor shall compare the contractor's payment rates during a cost report period, weighted by the number of resident days reported for the same cost report period to the contractor's allowable costs for the cost report period. [In accordance with RCW 74.46.-100, 74.46.155 and 74.46.165] the contractor shall take into account all authorized shifting, retained savings, and upper limits to rates on a cost center basis.

(a) The department will:

(i) Review the proposed preliminary settlement report for accuracy; and

(ii) Accept or reject the proposal of the contractor. If accepted, the proposed preliminary settlement report shall become the preliminary settlement report. If rejected, the department shall issue, by component payment rate allocation, a preliminary settlement report fully substantiating disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

(b) When the department receives the proposed preliminary settlement report:

(i) By the cost report due date specified in RCW 74.46.040, it will issue the preliminary settlement report within one hundred twenty days of the cost report due date; or

(ii) After the cost report due date specified in RCW 74.46.040, it will issue the preliminary settlement report within one hundred twenty days of the date the cost report was received.

(c) In its discretion, the department may designate a date later than the dates specified in subsection (2)(b)(i) and (ii) of this section to issue preliminary settlements.

(d) A contractor shall have twenty-eight days after receipt of a preliminary settlement report to contest such report under WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight day period, the department shall not review or adjust a preliminary settlement report. Any administrative review of a preliminary settlement shall be limited to calculation of the settlement, to the application of settlement principles and rules, or both, and shall not encompass rate or audit issues.

(3) The department shall issue a final settlement report to the contractor after the completion of the department audit process, including exhaustion or termination of any administrative review and appeal of audit findings or determinations requested by the contractor, but not including judicial review as may be available to and commenced by the contractor.

(a) The department shall prepare a final settlement by component payment rate allocation and shall fully substantiate disallowed costs, refunds, underpayments, or adjustments to the cost report and financial statements, reports, and schedules submitted by the contractor. The department shall take into account all authorized shifting, savings, and upper limits to rates on a component payment rate allocation basis. For the final settlement report, the department shall compare:

(i) The payment rates it paid the contractor for the facility in question during the report period, weighted by the num-

ber of allowable resident days reported for the period each rate was in effect to the contractor's;

- (ii) Audited allowable costs for the reporting period; or
- (iii) Reported costs for the nonaudited reporting period.

(b) A contractor shall have twenty-eight days after the receipt of a final settlement report to contest such report pursuant to WAC 388-96-901 and 388-96-904. Upon expiration of the twenty-eight day period, the department shall not review a final settlement report. Any administrative review of a final settlement shall be limited to calculation of the settlement, the application of settlement principles and rules, or both, and shall not encompass rate or audit issues.

(c) The department shall reopen a final settlement if it is necessary to make adjustments based upon findings resulting from a department audit performed pursuant to RCW 74.46-100. The department may also reopen a final settlement to recover an industrial insurance dividend or premium discount under RCW 51.16.035 in proportion to a contractor's Medicaid recipient days.

(4)(a) In computing a preliminary or final settlement, a contractor must comply with the requirements of RCW 74.46.165 (2), (3), and (4) for retaining or refunding to the department payments made in excess of the adjusted costs of providing services corresponding to each component rate allocation.

(b) The facility shall refund all amounts due the department within sixty days after the date of decision or termination plus interest on any unpaid balance after sixty days will accrue at one percent per month. Repayment will be without prejudice to obtain review of the settlement determination pursuant to WAC 388-96-901 and 388-96-904. After an administrative hearing and/or judicial review, if the payment obligation is reduced, then the department will rescind the difference between the accrued interest on the payment obligation and the interest that would have accrued on the reduced payment obligation from the date interest began to accrue on the original payment obligation.

(5) In determining whether a facility has forfeited unused rate funds in its direct care, therapy care and support services component rates under authority of RCW 74.46.165, the following rules shall apply:

(a) Federal or state survey officials shall determine when a facility is not in substantial compliance or is providing substandard care, according to federal and state nursing facility survey regulations;

(b) Correspondence from state or federal survey officials notifying a facility of its compliance status shall be used to determine the beginning and ending dates of any period(s) of noncompliance; and

(c) Forfeiture shall occur if the facility was out of substantial compliance more than ninety days during the settlement period. The ninety-day period need not be continuous if the number of days of noncompliance exceed ninety days during the settlement period regardless of the length of the settlement period. Also, forfeiture shall occur if the nursing facility was determined to have provided substandard quality of care at any time during the settlement period.

(6)(a) For calendar year 1998, the department will calculate two settlements covering the following periods:

- (i) January 1, 1998 through September 30, 1998; and
- (ii) October 1, 1998 through December 31, 1998.

(b) The department will use Medicaid rates weighted by total patient days (i.e., Medicaid and non-Medicaid days) to divide 1998 costs between the two settlement periods identified in subsection (6)(a) of this section.

(c) The department will net the two settlements for 1998 to determine a nursing facility's 1998 settlement.

[Statutory Authority: RCW 74.46.155, 74.46.165, 74.46.431, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-218, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-218, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-218, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 9 and 10 and RCW 74.46.800. 98-20-023, § 388-96-218, filed 9/25/98, effective 10/1/98.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-96-310 Interest on other excess payments.

(1) Any contractor obtaining benefits or payments under the medical assistance program to which such contractor is not entitled or in an amount to which such contractor is not entitled, shall be liable for such benefits or payments received and for interest on the amount of benefits or payments from the date of receipt until repayment is made to the department at the rate of one percent per month, unless the contractor establishes the overpayment was the result of errors made by the department.

(2) Interest charged by the department or interest expense incurred by the contractor, from whatever source, in making refund to the department shall not be reimbursable by the department as an allowable cost. The contractor may, by payment of a disputed settlement in whole or in part, stop accrual of interest on the amount paid. Such payment will be without prejudice to obtain review of a settlement determination.

[Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-310, filed 9/16/83.]

WAC 388-96-366 Facility records and handling of resident moneys. (1) A nursing facility may not require residents to deposit personal funds with the facility. A facility may hold a resident's personal funds only if the resident or resident's guardian provides written authorization.

(2) Once a nursing facility accepts the written authorization of the resident or resident's guardian, the facility shall hold, safeguard, and account for such personal funds under an established system in accordance with this chapter. The nursing facility shall establish and maintain as a service to the residents a bookkeeping system, incorporated in the business records and adequate for audit, for all resident moneys received by the facility.

(3) The nursing facility shall maintain the resident's or guardian's written authorization in the resident's file. The facility shall deposit any resident's personal funds in excess of fifty dollars in an interest-bearing resident personal fund account or accounts, separate from any of the facility's operating accounts, and credit all interest earned on an account to the account. With respect to any other personal funds, the facility shall keep such funds in a noninterest-bearing account or petty cash fund maintained for residents.

(4) The facility shall give the resident at least a quarterly reporting of all financial transactions involving personal funds held for the resident by the facility. The facility shall send the representative payee, the guardian, or other designated agents of the resident a copy of the quarterly accounting report.

(5) The nursing facility shall further maintain a written record of all personal property deposited with the facility for safekeeping by or for the resident. The facility shall issue or obtain written receipts upon taking possession or disposing of such property and retain copies and/or originals of such receipts. The facility shall maintain records adequate for audit.

(6) The facility shall purchase a surety bond, or otherwise provide assurances or security satisfactory to the department, to assure the security of all personal funds of residents deposited with the facility.

[Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120. 90-20-075 (Order 3070), § 388-96-366, filed 9/28/90, effective 10/1/90. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-366, filed 4/20/87; Order 1168, § 388-96-366, filed 11/3/76; Order 1114 § 388-96-366, filed 4/21/76.]

WAC 388-96-369 The nursing facility shall maintain a subsidiary ledger with an account for each resident for whom the facility holds money. (1) The facility shall assure a full and complete separate accounting of each resident's personal funds. Each account record and related supporting information and documentation shall:

- (a) Be maintained at the facility;
- (b) Be kept current;
- (c) Be balanced each month; and
- (d) Show in writing and in detail, with supporting verification, all moneys received on behalf of the individual resident and the disposition of all moneys so received.

(2) Each account shall be reasonably accessible to the resident or the resident's guardian or legal representative and shall be available for audit and inspection by a department representative. Each account shall be maintained for a minimum of four years. A Medicaid provider shall notify each Title XIX Medicaid recipient or guardian and the home and community services office of the department that serves the area when the amount in the account of any Title XIX Medicaid recipient reaches two hundred dollars less than the applicable dollar resource limit for supplemental security income (SSI) eligibility set forth in Title XVI of the Social Security Act.

(3) When notice is given under subsection (2) of this section, the facility shall notify the recipient or guardian that if the amount in the account, in addition to the value of the recipient's other nonexempt resources, reaches the dollar resource limit determined under Title XVI, the recipient may lose eligibility for SSI medical assistance or benefits under Title XVI.

(4) After the recipient's admission to the facility, accumulation toward the Title XVI limit is permitted only from the clothing and personal incidentals allowance and other income that the department specifically designates as exempt income.

(5) No resident funds may be overdrawn (show a debit balance). If a resident wants to spend an amount greater than

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the facility is holding for the resident, the home may provide money from its own funds and collect the debt by installments from that portion of the resident's allowance remaining at the end of each month. No interest may be charged to residents for such loans.

(6) The facility may not impose a charge against the personal funds of a Medicare or Medicaid recipient for any item or service for which payment is made under the Title XVIII Medicare program or the Title XIX Medicaid program. In order to ensure that Medicaid recipients are not charged for services provided under the Title XIX program, any charge for medical services otherwise properly made to a recipient's personal funds shall be supported by a written denial from the department.

(a) Mobility aids including walkers, wheelchairs, or crutches requested for the exclusive use by a Medicaid recipient shall have a written denial from the department of social and health services before a recipient's personal funds may be charged.

(b) Requests for medically necessary services and supplies not funded under the provisions of chapter 388-96 WAC or chapter 388-86 WAC (reimbursement rate or coupon system) shall have a written denial from the department before a Medicaid recipient's personal funds may be charged.

(c) A written denial from the department is not required when the pharmacist verifies that a drug is not covered by the program, e.g., items on the FDA list of ineffective or possible effective drugs, nonformulary over-the-counter (OTC) medications. The pharmacist's notation to this effect is sufficient.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-369, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-369, filed 5/29/01, effective 6/29/01. Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120. 90-20-075 (Order 3070), § 388-96-369, filed 9/28/90, effective 10/1/90. Statutory Authority: RCW 74.42.620 and 74.46.800. 85-17-070 (Order 2275), § 388-96-369, filed 8/21/85. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-369, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-369, filed 10/13/82; Order 1168, § 388-96-369, filed 11/3/76; Order 1114, § 388-96-369, filed 4/21/76.]

WAC 388-96-372 The nursing facility may maintain a petty cash fund originating from resident personal funds of an amount reasonable and necessary for the size of the facility and the needs of the residents. (1) This petty cash fund shall be an imprest fund limited to one thousand dollars unless the facility demonstrates good cause for the department to grant a higher limit. All moneys over and above the petty cash limit shall be deposited intact in an interest bearing account or accounts maintained for resident personal funds, separate and apart from any other bank account of the facility or other facilities. All interest earned on an account containing resident personal funds shall be credited to such account.

(2) Cash deposits of recipient allowances must be made intact to the resident personal fund account within one week from the time that payment is received from the department, Social Security Administration, or other payer.

(3) Any related bankbooks, bank statements, checkbook, check register, and all voided and cancelled checks, shall be made available for audit and inspection by a department rep-

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representative, and shall be maintained by the home for not less than four years.

(4) No service charges for such checking account shall be paid by residents or deducted from resident personal funds.

(5) The resident personal fund account or accounts per bank shall be reconciled monthly to the resident personal funds per resident ledgers.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8, 04-21-027, § 388-96-372, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120. 90-20-075 (Order 3070), § 388-96-372, filed 9/28/90, effective 10/1/90. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-372, filed 9/16/83; Order 1114, § 388-96-372, filed 4/21/76.]

WAC 388-96-375 Resident personal funds control/disbursement. Personal funds shall be held and used for the benefit of the resident and are not to be turned over to anyone other than the resident or the resident's guardian without the written consent of the resident, the resident's designated agent as appointed by power of attorney, or appropriate department of social and health services personnel as designated by the CSO administrator.

(1) When money is received, a receipt shall be filled out in duplicate:

(a) One copy shall be given to the person making payment or deposit; and

(b) The other copy shall be retained in the receipt book for easy reference.

(2) Checks received by residents shall be endorsed by the resident. Schedule I-A(6e) of the agreement states in part: "Each patient receiving a check or state warrant is responsible for endorsement by his own signature. Only when the patient is incapable of signing his name may the Provider assume the responsibility of securing the patient's mark "X" followed by the name of the patient and the signature of two witnesses."

(3) If both a facility operating account and a resident personal fund account are at the same bank, the resident portion of checks which include care payments can be deposited directly to the resident account by including a resident account deposit slip for the correct amount with the checks and the operating account deposit slip.

(4) The resident's ledger sheet shall be credited with the allowance received. This shall be referenced with the receipt number and shall be supported by a copy of the deposit slip (one copy for all deposits made).

[Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120. 90-20-075 (Order 3070), § 388-96-375, filed 9/28/90, effective 10/1/90. Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-375, filed 10/13/82; Order 1168, § 388-96-375, filed 11/3/76; Order 1114, § 388-96-375, filed 4/21/76.]

WAC 388-96-378 Resident personal funds availability. Funds held for any resident shall be available for the resident's personal and incidental needs when requested by the resident or one of the individuals designated in WAC 388-96-375.

[Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120. 90-20-075 (Order 3070), § 388-96-378, filed 9/28/90, effective 10/1/90; Order 1114, § 388-96-378, filed 4/21/76.]

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WAC 388-96-381 Procedure for refunding resident personal funds. (1) When a resident is discharged or transferred, the balance of the resident's personal funds shall be returned to the individual designated in WAC 388-96-375 within one week and a receipt obtained. In some cases it may be advisable to mail the refund to the resident's new residence.

[Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120. 90-20-075 (Order 3070), § 388-96-381, filed 9/28/90, effective 10/1/90; Order 1114, § 388-96-381, filed 4/21/76.]

WAC 388-96-384 Liquidation or transfer of resident personal funds. (1) Upon the death of a resident, the facility shall promptly convey the resident's personal funds held by the facility with a final accounting of such funds to the department or to the individual or probate jurisdiction administering the resident's estate.

(a) If the deceased resident was a recipient of long-term care services paid for in whole or in part by the state of Washington then the personal funds held by the facility and the final accounting shall be sent to the state of Washington, department of social and health services, office of financial recovery (or successor office).

(b) The personal funds of the deceased resident and final accounting must be conveyed to the individual or probate jurisdiction administering the resident's estate or to the state of Washington, department of social and health services, office of financial recovery (or successor office) no later than the thirtieth day after the date of the resident's death.

(i) When the personal funds of the deceased resident are to be paid to the state of Washington, those funds shall be paid by the facility with a check, money order, certified check or cashier's check made payable to the secretary, department of social and health services, and mailed to the Office of Financial Recovery, Estate Recovery Unit, P.O. Box 9501, Olympia, Washington 98507-9501, or such address as may be directed by the department in the future.

(ii) The check, money order, certified check or cashier's check or the statement accompanying the payment shall contain the name and social security number of the deceased individual from whose personal funds account the monies are being paid.

(c) The department of social and health services shall establish a release procedure for use of funds necessary for burial expenses.

(2) In situations where the resident leaves the nursing home without authorization and the resident's whereabouts is unknown:

(a) The nursing facility shall make a reasonable attempt to locate the missing resident. This includes contacting:

- (i) Friends,
- (ii) Relatives,
- (iii) Police,
- (iv) The guardian, and

(v) The home and community services office in the area.

(b) If the resident cannot be located after ninety days, the nursing facility shall notify the department of revenue of the existence of "abandoned property," outlined in chapter 63.29 RCW. The nursing facility shall deliver to the department of revenue the balance of the resident's personal funds within twenty days following such notification.

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(3) Prior to the sale or other transfer of ownership of the nursing facility business, the facility operator shall:

(a) Provide each resident or resident representative with a written accounting of any personal funds held by the facility;

(b) Provide the new operator with a written accounting of all resident funds being transferred; and

(c) Obtain a written receipt for those funds from the new operator.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-384, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-384, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-384, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800, 74.42.620 and 74.09.120. 90-20-075 (Order 3070), § 388-96-384, filed 9/28/90, effective 10/1/90. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-384, filed 12/23/87. Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-384, filed 10/13/82; Order 1168, § 388-96-384, filed 11/3/76; Order 1114, § 388-96-384, filed 4/21/76.]

WAC 388-96-502 Indirect and overhead costs. Subject to the provisions of this chapter and chapter 74.46 RCW, when a contractor provides goods or services that are not reimbursable, any indirect or overhead costs associated with their provision must be allocated to such goods or services on a reasonable basis approved by the department and must not be reported as allowable costs.

[Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-502, filed 9/25/98, effective 10/1/98. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-502, filed 12/23/87. Statutory Authority: RCW 74.46.800. 86-10-055 (Order 2372), § 388-96-502, filed 5/7/86, effective 7/1/86; 84-12-039 (Order 2105), § 388-96-502, filed 5/30/84.]

WAC 388-96-505 Offset of miscellaneous revenues.

(1) The contractor shall reduce allowable costs whenever the item, service, or activity covered by such costs generates revenue or financial benefits (e.g., purchase discounts, refunds of allowable costs or rebates) other than through the contractor's normal billing for care services; except, the department shall not deduct from the allowable costs of a nonprofit facility unrestricted grants, gifts, and endowments, and interest therefrom.

(2) The contractor shall reduce allowable costs for hold-bed revenue in the support services, operations and property rate components only. In the support services rate component, the amount of reduction shall be determined by dividing a facility's allowable housekeeping costs by total adjusted patient days and multiplying the result by total hold-room days. In the operations rate component, the amount of the reduction shall be determined by dividing a facility's allowable operation costs by total adjusted patient days and multiplying the result by total hold-room days. In the property rate component, the amount of reduction shall be determined by dividing allowable property costs by the total adjusted patient days and multiplying the result by total hold-room days.

(3) Where goods or services are sold, the amount of the reduction shall be the actual cost relating to the item, service, or activity. In the absence of adequate documentation of cost, it shall be the full amount of the revenue received. Where financial benefits such as purchase discounts, refunds of allowable costs or rebates are received, the amount of the reduction shall be the amount of the discount or rebate.

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Financial benefits such as purchase discounts, refunds of allowable costs and rebates, including industrial insurance rebates, shall be offset against allowable costs in the year the contractor actually receives the benefits.

(4) Only allowable costs shall be recovered under this section. Costs allocable to activities or services not included in nursing facility services, e.g., costs of vending machines and services specified in chapter 388-86 WAC not included in nursing facility services, are nonallowable costs.

[Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-505, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.200 and 74.46.800. 97-17-040, § 388-96-505, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-505, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-505, filed 7/23/92, effective 8/23/92. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-505, filed 12/23/87. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-505, filed 12/4/84; 82-21-025 (Order 1892), § 388-96-505, filed 10/13/82. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-505, filed 2/25/81. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-505, filed 6/1/78; Order 1262, § 388-96-505, filed 12/30/77.]

WAC 388-96-525 Education and training. (1) Necessary and ordinary expenses of on-the-job training and in-service training required for employee orientation and certification training directly related to the performance of duties assigned will be allowable costs. Cost of training for which the nursing facility is reimbursed outside the payment rate is an unallowable cost.

(2) Necessary and ordinary expenses of recreational and social activity training conducted by the contractor for volunteers will be allowable costs. Expenses of training programs for other nonemployees will not be allowable costs.

(3) Expenses for travel, lodging, and meals associated with education and training in the states of Idaho, Oregon, and Washington and the province of British Columbia are allowable if the expenses meet the requirements of this chapter.

(4) Except travel, lodging, and meal expenses, education and training expenses at sites outside of the states of Idaho, Oregon, and Washington and the province of British Columbia are allowable costs if the expenses meet the requirements of this chapter.

(5) Costs designated by this section as allowable shall be subject to any applicable cost center limit established by this chapter.

[Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-525, filed 9/25/98, effective 10/1/98; 94-12-043 (Order 3737), § 388-96-525, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-525, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-525, filed 5/30/84. Statutory Authority: RCW 74.09.120. 81-22-081 (Order 1712), § 388-96-525, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-525, filed 2/25/81. Statutory Authority: RCW 74.09.120. 80-06-122 (Order 1510), § 388-96-525, filed 5/30/80, effective 7/1/80; Order 1262, § 388-96-525, filed 12/30/77.]

WAC 388-96-530 What will be allowable compensation for owners, relatives, licensed administrator, assistant administrator, and/or administrator-in-training? Subject to any applicable cost center limit established by chapter 74.46 RCW, total allowable compensation shall be:

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(1) As provided in the employment contract, including benefits, whether such contract is written, verbal, or inferred from the acts of the parties; or

(2) In the absence of a contract, gross salary or wages excluding payroll taxes and benefits made available to all employees, e.g., health insurance.

[Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-530, filed 9/25/98, effective 10/1/98.]

WAC 388-96-532 Does the contractor have to maintain time records? (1) The contractor shall maintain time records that are adequate for audit for owners, relatives, the licensed administrator, assistant administrator, and/or administrator-in-training. The contractor shall include in such records verification of the actual hours of service performed for the nursing home and shall document compensated time was spent in provision of necessary services actually performed.

(2) If the contractor has no or inadequate time records, the undocumented cost of compensation shall be unallowable.

[Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-532, filed 9/25/98, effective 10/1/98.]

WAC 388-96-534 Joint cost allocation disclosure (JCAD). (1) The contractor shall disclose to the department:

(a) The nature and purpose of all costs representing allocations of joint facility costs; and

(b) The methodology of the allocation utilized.

(2) The contractor shall demonstrate in such disclosure:

(a) The services involved are necessary and nonduplicative; and

(b) Costs are allocated in accordance with benefits received from the resources represented by those costs.

(3) The contractor shall make such disclosure not later than September 30th for the following year; except, a new contractor shall submit the first year's disclosure together with the submissions required by WAC 388-96-026. Within this section, the meaning of the:

(a) "Effective date" is the date the department will recognize allocation per an approved JCAD; and

(b) "Implementation date" is the date the facility will begin or began incurring joint facility costs.

(4) The department shall determine the acceptability of the JCAD methodology not later than December 31 of each year for all JCADs received by September 30th.

(a) The effective date of an acceptable JCAD that was received by September 30th is January 1st.

(b) The effective date of an acceptable JCAD that was received after September 30th shall be ninety days from the date the JCAD was received by the department.

(5) The contractor shall submit to the department for approval an amendment or revision to an approved JCAD methodology at least thirty days prior to the implementation date of the amendment or revision. For amendments or revisions received less than thirty days before the implementation date, the effective date of approval will be thirty days from the date the JCAD is received by the department.

(6) When a contractor, who is not currently incurring joint facility costs, begins to incur joint facility costs during the calendar year, the contractor shall provide the information

required in subsections (1) and (2) of this section at least ninety days prior to the implementation date. If the JCAD is not received ninety days before the implementation date, the effective date of the approval will be ninety days from the date the JCAD is received by the department.

(7) Joint facility costs not disclosed, allocated, and reported in conformity with this section are nonallowable costs. Joint facility costs incurred before the effective dates of subsections (4), (5), and (6) of this section are unallowable. Costs disclosed, allocated, and reported in conformity with a department-approved JCAD methodology must undergo review and be determined allowable costs for the purposes of rate setting and audit.

[Statutory Authority: RCW 74.46.270. 97-17-040, § 388-96-534, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-534, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-534, filed 5/26/94, effective 6/26/94. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-534, filed 12/23/87. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-534, filed 9/16/83; 80-09-083 (Order 1527), § 388-96-534, filed 7/22/80.]

WAC 388-96-535 Management agreements, management fees, and central office services. (1) The contractor shall disclose to the department the nature and purpose of the management agreement, including an organizational chart showing the relationship between the contractor, management company and all related organizations. The department may request additional information or clarification.

(2) Acceptance of a management agreement may not be construed as a determination that all management fees or costs are allowable in whole or in part. Management fees or costs not disclosed or approved in conformity with chapter 74.46 RCW and this section are unallowable. When necessary for the health and safety of medical care recipients, the department may waive the sixty-day or thirty-day advance notice requirement of RCW 74.46.280 in writing.

(3) Management fees are allowable only for necessary, nonduplicative services that are of the nature and magnitude that prudent and cost-conscious management would pay. Costs of services, facilities, supplies and employees furnished by the management company are subject to RCW 74.46.220.

(4) Allowable fees for all general management services of any kind referenced in this section, including corporate or business entity management and management fees not allocated to specific services, are subject to any applicable cost center limit established in chapter 74.46 RCW.

(5) Central office costs, owner's compensation, and other fees or compensation, including joint facility costs, for general administrative and management services, including management expense not allocated to specific services, shall be subject to any cost center limit established by chapter 74.46 RCW.

(6) Necessary travel and housing expenses of nonresident staff working at a contractor's nursing facility shall be considered allowable costs if the visit does not exceed three weeks.

(7) Bonuses paid to employees at a contractor's nursing facility or management company shall be considered compensation.

[Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-535, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-535, filed 9/14/93, effective 10/15/93. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-535, filed 12/23/87. Statutory Authority: RCW 74.46.800. 86-10-055 (Order 2372), § 388-96-535, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-535, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-535, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-535, filed 2/25/81. Statutory Authority: RCW 74.09.120. 80-09-083 (Order 1527), § 388-96-535, filed 7/22/80; 79-03-020 (Order 1371), § 388-96-535, filed 2/21/79; Order 1262, § 388-96-535, filed 12/30/77.]

WAC 388-96-536 Does the department limit the allowable compensation for an owner or relative of an owner? (1) The department shall limit total compensation of an owner or relative of an owner to ordinary compensation for necessary services actually performed.

(a) Compensation is ordinary if it is the amount usually paid for comparable services in a comparable facility to an unrelated employee, and does not exceed any applicable limit set out in chapter 74.46 RCW.

(b) A service is necessary if it is related to patient care and would have had to be performed by another person if the owner or relative had not done it.

(2) If the service provided would require licensed staff, e.g., RN, then the same license standard must be met when performed by an owner, relative or other administrative personnel.

[Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-536, filed 9/25/98, effective 10/1/98.]

WAC 388-96-540 Will the department allow the cost of an administrator-in-training? (1) The department shall not allow costs of an administrator-in-training for the purpose of setting the operations component prospective payment rate allocation.

(2) The department shall pay the costs of an approved administrator-in-training program by an add-on to the current prospective payment rate, unless the operations cost center is at or above the median cost limit for the facility's peer group reduced or increased under chapter 74.46 RCW.

(3) To obtain a rate add-on, the contractor shall submit a request for an add-on to its current prospective rate together with necessary documentation which shall include:

(a) A copy of the department of licensing approval of the administrator-in-training program, and

(b) A schedule indicating the commencement date, expected termination date, salary or wage, hours, and costs of benefits. The contractor shall notify the department, at least thirty days in advance, of the actual termination date of the administrator-in-training program. Upon termination of the program, the department shall reduce the current prospective rate by an amount corresponding to the rate add-on.

(4) If the contractor does not use the administrator-in-training funds for the purpose for which they were granted, the department shall immediately recoup the misspent or unused funds.

[Statutory Authority: RCW 74.46.800. 98-20-023, § 388-96-540, filed 9/25/98, effective 10/1/98.]

WAC 388-96-542 Home office or central office. (1) The department shall audit the home office or central office

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whenever a nursing facility receiving such services is audited.

(2)(a) Assets used in the provision of services by or to a nursing facility, but not located on the premises of the nursing facility, shall not be included in net invested funds or in the calculation of property payment for the nursing facility.

(b) The nursing facility may allocate depreciation, interest expense, and operating lease expense for the home office, central office, and other off-premises assets to the cost of the services provided to or by the nursing facility on a reasonable statistical basis approved by the department.

(c) The allocated costs of (b) of this subsection may be included in the cost of services in such cost centers where such services and related costs are appropriately reported.

(3) Home office or central office costs must be allocated and reported in conformity with the department-approved JCAD methodology as required by WAC 388-96-534.

(4) Home office or central office costs are subject to the limitation specified in RCW 74.46.410.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(11), RCW 74.46.270 and 74.46.800. 98-20-023, § 388-96-542, filed 9/25/98, effective 10/1/98.]

WAC 388-96-553 Capitalization. The following costs shall be capitalized:

(1) Expenditures for depreciable assets with historical cost in excess of seven hundred fifty dollars per unit and a useful life of more than one year from the date of purchase;

(2) Expenditures and costs for depreciable assets with historical cost of seven hundred fifty dollars or less per unit if either:

(a) The depreciable asset was acquired in a group purchase where the total cost exceeded seven hundred fifty dollars; or

(b) The depreciable asset was part of the initial equipment or stock of the nursing home; and

(3) Expenditures for any change, including repairs with a cost in excess of seven hundred fifty dollars that increases the useful life of the depreciable asset by two years or more.

[Statutory Authority: RCW 74.46.310, [74.46.]320 and [74.46.]330. 97-17-040, § 388-96-553, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-553, filed 9/16/83; 83-05-007 (Order 1944), § 388-96-553, filed 2/4/83; 82-11-065 (Order 1808), § 388-96-553, filed 5/14/82. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-553, filed 2/25/81; Order 1262, § 388-96-553, filed 12/30/77.]

WAC 388-96-554 Expensing. The following costs shall be expensed:

(1) Expenditures for depreciable assets with historical cost of seven hundred fifty dollars or less per unit or a useful life of one year or less from the date of purchase.

(2) Subsection (1) of this section shall not apply if:

(a) The depreciable asset was acquired in a group purchase where the total cost exceeded seven hundred fifty dollars; or

(b) The depreciable asset was part of the initial equipment or stock of the nursing home.

(3) Expenditures for and costs of building and other real property items, components and improvements, whether for leased or owner-operated facilities, of seven hundred and fifty dollars or less.

(4) Expenditures for and costs of repairs necessary to maintain the useful life of equipment, including furniture and furnishings, and real property items, components or improvements which do not increase the useful life of the asset by two years or more. If a repair is to the interior or exterior of the structure, the term "asset" shall refer to the structure.

(5) Remaining undepreciated cost of equipment, including furniture or furnishings or real property items, components, or improvements which are retired and not replaced, provided such cost shall be offset by any proceeds or compensations received for such assets, and such cost shall be expensed only if the contractor has made a reasonable effort to recover at least the outstanding book value of such assets. If a retired asset is replaced, WAC 388-96-572(3) shall apply and the replacement or renewal shall be capitalized if required by WAC 388-96-553.

[Statutory Authority: RCW 74.46.310, [74.46.]320 and [74.46.]330. 97-17-040, § 388-96-554, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-554, filed 9/16/83; 83-05-007 (Order 1944), § 388-96-554, filed 2/4/83.]

WAC 388-96-559 Cost basis of land and depreciation base. (1) For all partial or whole rate periods after December 31, 1984 unless otherwise provided or limited by this chapter or by this section, chapter 388-96 WAC or chapter 74.46 RCW, the total depreciation base of depreciable assets and the cost basis of land shall be the lowest of:

- (a) The contractor's appraisal, if any;
- (b) The department's appraisal obtained through the department of general administration of the state of Washington, if any; or
- (c) The historical purchase cost of the contractor, or lessor if the assets are leased by the contractor, in acquiring ownership of the asset in an arm's-length transaction, and preparing the asset for use, less goodwill, and less accumulated depreciation, if applicable, incurred during periods the assets have been used in or as a facility by any and all contractors. Such accumulated depreciation is to be measured in accordance with WAC 388-96-561, 388-96-565, chapter 388-96 WAC, and chapter 74.46 RCW. Where the straight-line or sum-of-the-years digits method of depreciation is used the contractor:

- (i) May deduct salvage values from historical costs for each cloth based item, e.g., mattresses, linen, and draperies; and
- (ii) Shall deduct salvage values from historical costs of at least:
 - (A) Five percent of the historical value for each noncloth item included in moveable equipment; and
 - (B) Twenty-five percent of the historical value for each vehicle.

(2) Unless otherwise provided or limited by this chapter or by chapter 74.46 RCW, the department shall, in determining the total depreciation base of a depreciable real or personal asset owned or leased by the contractor, deduct depreciation relating to all periods subsequent to the more recent of:

- (a) The date such asset was first used in the medical care program; or
- (b) The most recent date such asset was acquired in an arm's-length purchase transaction which the department is

required to recognize for Medicaid cost reimbursement purposes.

No depreciation shall be deducted for periods such asset was not used in the medical care program or was not used to provide nursing care.

(3) The department may have the fair market value of the asset at the time of purchase established by appraisal through the department of general administration of the state of Washington if:

- (a) The department challenges the historical cost of an asset; or
- (b) The contractor cannot or will not provide the historical cost of a leased asset and the department is unable to determine such historical cost from its own records or from any other source.

The contractor may allocate or reallocate values among land, building, improvements, and equipment in accordance with the department's appraisal.

If an appraisal is conducted, the depreciation base of the asset and cost basis of land will not exceed the fair market value of the asset. An appraisal conducted by or through the department of general administration shall be final unless the appraisal is shown to be arbitrary and capricious.

(4) If the land and depreciable assets of a newly constructed nursing facility were never used in or as a nursing facility before being purchased from the builder, the cost basis and the depreciation base shall be the lesser of:

- (a) Documented actual cost of the builder; or
- (b) The approved amount of the certificate of need issued to the builder.

When the builder is unable or unwilling to document its costs, the cost basis and the depreciation base shall be the approved amount of the certificate of need.

(5) For leased assets, the department may examine documentation in its files or otherwise obtainable from any source to determine:

- (a) The lessor's purchase acquisition date; or
- (b) The lessor's historical cost at the time of the last arm's-length purchase transaction.

If the department is unable to determine the lessor's acquisition date by review of its records or other records, the department, in determining fair market value as of such date, may use the construction date of the facility, as found in the state fire marshal's records or other records, as the lessor's purchase acquisition date of leased assets.

(6) For all rate periods past or future, where depreciable assets or land are acquired from a related organization, the contractor's depreciation base and land cost basis shall not exceed the base and basis the related organization had or would have had under a contract with the department.

(7) If a contractor cannot or will not provide the lessor's purchase acquisition cost of assets leased by the contractor and the department is unable to determine historical purchase cost from another source, the appraised asset value of land, building, or equipment, determined by or through the department of general administration shall be adjusted, if necessary, by the department using the *Marshall and Swift Valuation Guide* to reflect the value at the lessor's acquisition date. If an appraisal has been prepared for leased assets and the assets subsequently sell in the first arm's-length transaction since January 1, 1980, under subsection (9) of this section, the

Marshall and Swift Valuation Guide will be used to adjust, if necessary, the asset value determined by the appraisal to the sale date. If the assets are located in a city for which the *Marshall and Swift Valuation Guide* publishes a specific index, or if the assets are located in a county containing that city, the city-specific index shall be used to adjust the appraised value of the asset. If the assets are located in a city or county for which a specific index is not calculated, the *Western District Index* calculated by Marshall and Swift shall be used.

(8) For new or replacement building construction or for substantial building additions requiring the acquisition of land and which commenced to operate on or after July 1, 1997, the department shall determine allowable land costs of the additional land acquired for the new or replacement construction or for substantial building additions to be the lesser of:

(a) The contractor's or lessor's actual cost per square foot; or

(b) The square foot land value as established by an appraisal that meets the latest publication of the *Uniform Standards of Professional Appraisal Practice (USPAP)* and the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (FIRREA). The department shall obtain a USPAP appraisal that meets FIRREA first from:

(i) An arms'-length lender that has accepted the ordered appraisal; or

(ii) If the department is unable to obtain from the arms'-length lender a lender-approved appraisal meeting USPAP and FIRREA standards or if the contractor or lessor is unable or unwilling to provide or cause to be provided a lender-approved appraisal meeting USPAP and FIRREA standards, then:

(A) The department shall order such an appraisal; and

(B) The contractor shall immediately reimburse the department for the costs incurred in obtaining the USPAP and FIRREA appraisal.

(9) Except as provided for in subsection (8) of this section, for all rates effective on or after January 1, 1985, if depreciable assets or land are acquired by purchase which were used in the medical care program on or after January 1, 1980, the depreciation base or cost basis of such assets shall not exceed the net book value existing at the time of such acquisition or which would have existed had the assets continued in use under the previous Medicaid contract with the department; except that depreciation shall not be accumulated for periods during which such assets were not used in the medical care program or were not in use in or as a nursing care facility.

(10)(a) Subsection (9) of this section shall not apply to the most recent arm's-length purchase acquisition if it occurs ten years or more after the previous arm's-length transfer of ownership nor shall subsection (9) of this section apply to the first arm's-length purchase acquisition of assets occurring on or after January 1, 1980, for facilities participating in the Medicaid program before January 1, 1980. The depreciation base or cost basis for such acquisitions shall not exceed the lesser of the fair market value as of the date of purchase of the assets determined by an appraisal conducted by or through the department of general administration or the owner's acquisition cost of each asset, land, building, or equipment. An appraisal conducted by or through the department of gen-

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eral administration shall be final unless the appraisal is shown to be arbitrary and capricious. Should a contractor request a revaluation of an asset, the contractor must document ten years have passed since the most recent arm's-length transfer of ownership. As mandated by Section 2314 of the Deficit Reduction Act of 1984 (P.L. 98-369) and state statutory amendments, and under RCW 74.46.840, for all partial or whole rate periods after July 17, 1984, this subsection is inoperative for any transfer of ownership of any asset, including land and all depreciable or nondepreciable assets, occurring on or after July 18, 1984, leaving subsection (9) of this section to apply without exception to acquisitions occurring on or after July 18, 1984, except as provided in subsections (10)(b) and (11) of this section.

(b) For all rates after July 17, 1984, subsection (8)(a) shall apply, however, to transfers of ownership of assets:

(i) Occurring before January 1, 1985, if the costs of such assets have never been reimbursed under Medicaid cost reimbursement on an owner-operated basis or as a related party lease; or

(ii) Under written and enforceable purchase and sale agreements dated before July 18, 1984, which are documented and submitted to the department before January 1, 1988.

(c) For purposes of Medicaid cost reimbursement under this chapter, an otherwise enforceable agreement to purchase a nursing home dated before July 18, 1984, shall be considered enforceable even though the agreement contains:

(i) No legal description of the real property involved; or

(ii) An inaccurate legal description, notwithstanding the statute of frauds or any other provision of law.

(11)(a) In the case of land or depreciable assets leased by the same contractor since January 1, 1980, in an arm's-length lease, and purchased by the lessee/contractor, the lessee/contractor shall have the option to have the:

(i) Provisions of subsection (10) of this section apply to the purchase; or

(ii) Component rate allocations for property and financing allowance calculated under the provisions of chapter 74.46 RCW. Component rate allocations will be based upon provisions of the lease in existence on the date of the purchase, but only if the purchase date meets the criteria of RCW 74.46.360 (6)(c)(ii)(A) through (D).

(b) The lessee/contractor may select the option in subsection (11)(a)(ii) of this section only when the purchase date meets one of the following criteria. The purchase date is:

(i) After the lessor has declared bankruptcy or has defaulted in any loan or mortgage held against the leased property;

(ii) Within one year of the lease expiration or renewal date contained in the lease;

(iii) After a rate setting for the facility in which the reimbursement rate set, under this chapter and under chapter 74.46 RCW, no longer is equal to or greater than the actual cost of the lease; or

(iv) Within one year of any purchase option in existence on January 1, 1988.

(12) For purposes of establishing the property and financing allowance component rate allocations, the value of leased equipment, if unknown by the contractor, may be estimated by the department using previous department of gen-

eral administration appraisals as a data base. The estimated value may be adjusted using the *Marshall and Swift Valuation Guide* to reflect the value of the asset at the lessor's purchase acquisition date.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-559, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-559, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.360. 97-17-040, § 388-96-559, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-559, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-559, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-559, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.46.800. 88-16-079 (Order 2660), § 388-96-559, filed 8/2/88; 86-10-055 (Order 2372), § 388-96-559, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800. 85-17-052 (Order 2270), § 388-96-559, filed 8/19/85. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-559, filed 12/4/84; 81-22-081 (Order 1712), § 388-96-559, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-559, filed 2/25/81; Order 1262, § 388-96-559, filed 12/30/77.]

WAC 388-96-561 Cost basis of land and depreciation base—Donated or inherited assets. (1) The cost basis or depreciation base of land or depreciable assets, either donated[,] or received through testate or intestate distribution, will be the lesser of:

(a) Fair market value at the date of donation or death, less goodwill, provided the estimated salvage value shall be deducted from fair market value where the straight-line or sum-of-the-years digits method of depreciation is used; or

(b) The historical cost of the owner last contracting with the department, if any.

(2) When the donation or distribution is between related organizations, the base shall be the lesser of:

(a) Fair market value, less goodwill and, where appropriate, salvage value; or

(b) The depreciation base or cost basis the related organization had or would have had for the asset under a contract with the department.

(3) Notwithstanding the provisions of subsections (1) and (2) of this section, for all rates after July 17, 1984, neither the depreciation base of depreciable assets nor the cost basis of land shall increase for reimbursement purposes if the asset is donated or acquired through testate or intestate distribution on or after July 18, 1984, the enactment date of the Deficit Reduction Act of 1984.

[Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800. 90-09-061 (Order 2970), § 388-96-561, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-561, filed 12/4/84; 83-19-047 (Order 2025), § 388-96-561, filed 9/16/83. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-561, filed 2/25/81; Order 1262, § 388-96-561, filed 12/30/77.]

WAC 388-96-565 Lives. (1) Except for new buildings replacement buildings, major remodels and major repair projects as defined in subsection (5) of this section, to compute allowable depreciation, the contractor must use lives reflecting the estimated actual useful life of the assets (e.g., land improvements, buildings, including major remodels and major repair projects, equipment, leasehold improvements, etc.). However the lives used must not be shorter than guidelines lives in the most current edition of *Estimated Useful*

Lives of Depreciable Hospital Assets published by American Hospital Publishing, Inc.

(2) To compute allowable depreciation for major remodels and major repair projects as defined in subsection (5) of this section that began operating:

(a) Before July 1, 1997, the contractor must use the shortest lives in the most recently published lives for construction classes as defined and described in the *Marshall Valuation Service* published by the Marshall Swift Publication Company; or

(b) After July 1, 1997, the contractor must use the shortest lives of the guideline lives in the most current edition of *Estimated Useful Lives of Depreciable Hospital Assets* published by American Hospital Publishing, Inc.

(3) To compute allowable depreciation for new buildings and replacement buildings as defined in subsection (5) of this section that:

(a) Began operating before July 1, 1997, the contractor must use the construction classes as defined and described in *Marshall Valuation Service* published by the Marshall Swift Publication Company; provided that, thirty years is the shortest life that may be used;

(b) Began operating on or after July 1, 1997, the contractor must use the most current edition of *Estimated Useful Lives of Depreciable Hospital Assets* published by American Hospital Publishing, Inc.; provided that, thirty years is shortest life that may be used; and

(c) Received certificate of need approval or certificate of need exemptions under chapter 70.38 RCW on or after July 1, 1999, the contractor must use the most current edition of *Estimated Useful Lives of Depreciable Assets* published by American Hospital Publishing, Inc.; provided that, forty years is the shortest life that may be used.

(4) To compute allowable depreciation, the contractor must:

(a) Measure lives from the most recent of either the date on which the assets were first used in the medical care program or the last date of purchase of the asset through an arm's-length acquisition; and

(b) Extend lives to reflect periods, if any, during which assets were not used in a nursing facility or as a nursing facility.

(5) New buildings, replacement buildings, major remodels, and major repair projects are those projects that meet or exceed the expenditure minimum established by the department of health pursuant to chapter 70.38 RCW.

(6) Contractors shall depreciate building improvements other than major remodels and major repairs defined in subsection (5) of this section over the remaining useful life of the building, as modified by the improvement, but not less than fifteen years.

(7) Improvements to leased property which are the responsibility of the contractor under the terms of the lease shall be depreciated over the useful life of the improvement in accordance with American Hospital Association guidelines.

(8) A contractor may change the estimate of an asset's useful life to a longer life for purposes of depreciation.

(9) For new or replacement building construction or for major renovations receiving certificate of need approval or exemption under chapter 70.38 RCW on or after July 1, 1999,

the department will depreciate fixed equipment the same number of years as the life of the building to which it is affixed.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-565, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.310, [74.46.]320 and [74.46.]330, 97-17-040, § 388-96-565, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800, 94-12-043 (Order 3737), § 388-96-565, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.180 and 74.46.800, 89-01-095 (Order 2742), § 388-96-565, filed 12/21/88. Statutory Authority: RCW 74.46.800, 87-09-058 (Order 2485), § 388-96-565, filed 4/20/87; 86-10-055 (Order 2372), § 388-96-565, filed 5/7/86, effective 7/1/86. Statutory Authority: RCW 74.09.120, 83-19-047 (Order 2025), § 388-96-565, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-565, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800, 81-06-024 (Order 1613), § 388-96-565, filed 2/25/81; Order 1262, § 388-96-565, filed 12/30/77.]

WAC 388-96-572 Handling of gains and losses upon retirement of depreciable assets—Other periods. (1) This section shall apply in the place of WAC 388-96-571 effective January 1, 1981, for purposes of settlement for settlement periods subsequent to that date, and for purposes of setting rates for rate periods beginning July 1, 1982, and subsequently.

(2) A gain or loss on the retirement of an asset shall be the difference between the remaining undepreciated base and any proceeds received for, or to compensate for loss of, the asset.

(3) If the retired asset is replaced, the gain or loss shall be applied against or added to the cost of the replacement asset, provided that a loss will only be so applied if the contractor has made a reasonable effort to recover at least the outstanding book value of the asset.

(4) If the retired asset is not replaced, any gain shall be offset against property expense for the period during which it is retired and any loss shall be expensed subject to the provisions of WAC 388-96-554.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-572, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120, 93-12-051 (Order 3555), § 388-96-572, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.09.120, 83-19-047 (Order 2025), § 388-96-572, filed 9/16/83. Statutory Authority: RCW 74.09.120 and 74.46.800, 81-06-024 (Order 1613), § 388-96-572, filed 2/25/81.]

WAC 388-96-580 Operating leases of office equipment. (1) Rental costs of office equipment under arm's-length operating leases shall be allowable to the extent such costs are necessary, ordinary, and related to patient care.

(2) The department shall pay office equipment rental costs in the operations component rate allocation. Office equipment may include items typically used in administrative or clerical functions such as telephones, copy machines, desks and chairs, calculators and adding machines, file cabinets, typewriters, and computers.

(3) The department shall not pay for depreciation of leased office equipment.

[Statutory Authority: RCW 74.46.800, 98-20-023, § 388-96-580, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 74.09.120, 93-19-074 (Order 3634), § 388-96-580, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.09.120, 74.46.840 and 74.46.800, 85-17-052 (Order 2270), § 388-96-580, filed 8/19/85. Statutory Authority: RCW 74.09.120, 84-24-050 (Order 2172), § 388-96-580, filed 12/4/84. Statutory Authority: RCW 74.46.800, 84-12-039 (Order 2105), § 388-96-580, filed 5/30/84.]

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WAC 388-96-585 Unallowable costs. (1) The department shall not allow costs if not documented, necessary, ordinary, and related to the provision of care services to authorized patients. Unallowable costs listed in subsection (2) of this section represent a partial summary of such costs, in addition to those unallowable under chapter 74.46 RCW and this chapter.

(2) The department shall include, but not limit, unallowable costs to the following:

(a) Costs in excess of limits or violating principles set forth in this chapter;

(b) Costs resulting from transactions or the application of accounting methods circumventing principles set forth in this chapter;

(c) Bad debts. Beginning July 1, 1983, the department shall allow bad debts of Title XIX recipients only if:

(i) The debt is related to covered services;

(ii) It arises from the recipient's required contribution toward the cost of care;

(iii) The provider can establish reasonable collection efforts were made;

(iv) The debt was actually uncollectible when claimed as worthless; and

(v) Sound business judgment established there was no likelihood of recovery at any time in the future.

Reasonable collection efforts shall consist of at least three documented attempts by the contractor to obtain payment demonstrating that the effort devoted to collecting the bad debts of Title XIX recipients is the same devoted by the contractor to collect the bad debts of non-Title XIX recipients;

(d) Any portion of trade association dues attributable to legal and consultant fees and costs in connection with lawsuits or other legal action against the department shall be unallowable;

(e) Legal and consultant fees in connection with a fair hearing against the department relating to those issues where:

(i) A final administrative decision is rendered in favor of the department or where otherwise the determination of the department stands at the termination of administrative review; or

(ii) In connection with a fair hearing, a final administrative decision has not been rendered; or

(iii) In connection with a fair hearing, related costs are not reported as unallowable and identified by fair hearing docket number in the period they are incurred if no final administrative decision has been rendered at the end of the report period; or

(iv) In connection with a fair hearing, related costs are not reported as allowable, identified by docket number, and prorated by the number of issues decided favorably to a contractor in the period a final administrative decision is rendered;

(f) All interest costs not specifically allowed in this chapter or chapter 74.46 RCW; and

(g) Increased costs resulting from a series of transactions between the same parties and involving the same assets, e.g., sale and lease back, successive sales or leases of a single facility or piece of equipment.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-585, filed 11/30/99, effective 12/31/99. Statu-

tory Authority: RCW 74.46.800. 98-20-023, § 388-96-585, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.190, [74.46.]460 and [74.46.]800. 97-17-040, § 388-96-585, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-585, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-585, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-585, filed 5/26/94, effective 6/26/94; 93-17-033 (Order 3615), § 388-96-585, filed 8/11/93, effective 9/11/93. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-585, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.09.120. 91-22-025 (Order 3270), § 388-96-585, filed 10/29/91, effective 11/29/91. Statutory Authority: RCW 74.09.120 and 74.46.800. 90-09-061 (Order 2970), § 388-96-585, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.46.800. 89-17-030 (Order 2847), § 388-96-585, filed 8/8/89, effective 9/8/89. Statutory Authority: RCW 74.09.180 and 74.46.800. 89-01-095 (Order 2742), § 388-96-585, filed 12/21/88. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-585, filed 4/20/87; 86-10-055 (Order 2372), § 388-96-585, filed 5/7/86, effective 7/1/86; 84-12-039 (Order 2105), § 388-96-585, filed 5/30/84. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-585, filed 9/16/83; 82-21-025 (Order 1892), § 388-96-585, filed 10/13/82; 82-11-065 (Order 1808), § 388-96-585, filed 5/14/82; 81-22-081 (Order 1712), § 388-96-585, filed 11/4/81. Statutory Authority: RCW 74.09.120 and 74.46.800. 81-06-024 (Order 1613), § 388-96-585, filed 2/25/81. Statutory Authority: RCW 74.09.120. 79-04-102 (Order 1387), § 388-96-585, filed 4/4/79. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-585, filed 6/1/78; Order 1262, § 388-96-585, filed 12/30/77.]

WAC 388-96-704 Prospective payment rates. The department, as provided in chapter 74.46 RCW and this chapter, shall determine, adjust, or update prospective Medicaid payment rates for nursing facility services provided to medical care recipients. Each rate, subject to the principles of this chapter and chapter 74.46 RCW, represents a nursing facility's maximum compensation for one resident day of care provided a medical care recipient determined by the department to both require and be eligible to receive nursing facility care.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322. 98-20-023, § 388-96-704, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-704, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-704, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-704, filed 10/13/82. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-704, filed 6/1/78. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-704, filed 1/9/78.]

WAC 388-96-705 Payment for services after settlement. When payment for services is first made following preliminary or final settlement for the period during which the services were provided, payment will be at the most recent available settlement rate.

[Statutory Authority: RCW 74.09.120. 81-22-081 (Order 1712), § 388-96-705, filed 11/4/81.]

WAC 388-96-708 Reinstatement of beds previously removed from service under chapter 70.38 RCW—Effect on prospective payment rate. (1) After removing beds from service (banked) under the provisions of chapter 70.38 RCW, the contractor may bring back into service beds that were previously banked.

(2) When the contractor returns to service beds banked under the provisions of chapter 70.38 RCW, the department will recalculate the contractor's prospective Medicaid payment rate allocations using the greater of actual days from the

cost report period on which the rate is based or days calculated by multiplying the new number of licensed beds times the appropriate minimum occupancy pursuant to chapter 74.46 RCW times the number of calendar days in the cost report period on which the rate being recalculated is based.

(3) The effective date of the recalculated prospective rate for beds returned to service shall be the first of the month:

(a) In which the banked beds returned to service when the beds are returned to service on the first of the month; or

(b) Following the month in which the banked beds returned to service when the beds are returned to service after the first of the month.

(4) The recalculated prospective payment rate shall comply with all the provisions of rate setting contained in chapter 74.46 RCW or in this chapter, including all lids and maximums unless otherwise specified in this section.

(5) The recalculated prospective Medicaid payment rate shall be subject to adjustment if required by RCW 74.46.421.

(6) After the department recalculates the contractor's prospective Medicaid component rate allocations using the increased number of licensed beds, the department will use the increased number of licensed beds in all post unbanking rate settings, until under chapter 74.46 RCW and/or this chapter, the post unbanking number of licensed beds changes.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-708, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-708, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-708, filed 11/30/99, effective 12/31/99. Statutory Authority: 1998 c 322 § 19(11). 98-20-023, § 388-96-708, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-708, filed 7/16/96, effective 8/16/96.]

WAC 388-96-709 Prospective rate revisions—Reduction in licensed beds. (1) The department will recalculate a contractor's prospective Medicaid payment rate when the contractor reduces the number of its licensed beds and:

(a) Provides a copy of the new bed license and documentation of the number of beds sold, exchanged or otherwise placed out of service, along with the name of the contractor that received the beds, if any; and

(b) Requests a rate revision.

(2) For facilities other than essential community providers which bank beds under chapter 70.38 RCW, after May 25, 2001, Medicaid rates shall be revised upward, in accordance with department rules, in direct care, therapy care, support services, and variable return components only, by using the facility's decreased licensed bed capacity to recalculate minimum occupancy for rate setting. No rate upward revision shall be made to operations, property, or financing allowance.

(3) The requested revised prospective Medicaid payment rate will be effective the first of the month:

(a) The new license is effective when the new license is effective the first day of the month; or

(b) Following the month the new license is effective when the new license is effective after the first day of the month it is issued.

(4) The department will recalculate a nursing facility's prospective Medicaid payment rate allocations using the

greater of actual days from the cost report period on which the rate is based or days calculated by multiplying the new number of licensed beds times the appropriate minimum occupancy pursuant to chapter 74.46 RCW times the number of calendar days in the cost report period on which the rate being recalculated is based.

(5) The revised prospective Medicaid payment rate will comply with all the provisions of rate setting contained in chapter 74.46 RCW and in this chapter, including all lids and maximums, unless otherwise specified in this section.

(6) After the department recalculates the contractor's prospective Medicaid component rate allocations using the decreased number of licensed beds, the department will use the decreased number of licensed beds in all post banking rate settings, until under chapter 74.46 RCW and/or this chapter, the post banking number of licensed beds changes.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8, 04-21-027, § 388-96-709, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800, 01-12-037, § 388-96-709, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-709, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(11) and RCW 74.46.800, 98-20-023, § 388-96-709, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.510, 97-17-040, § 388-96-709, filed 8/14/97, effective 9/14/97. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18, 95-19-037 (Order 3896), § 388-96-709, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800, 94-12-043 (Order 3737), § 388-96-709, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120, 93-12-051 (Order 3555), § 388-96-709, filed 5/26/93, effective 6/26/93.]

WAC 388-96-710 Prospective payment rate for new contractors. (1) The department will establish an initial prospective Medicaid payment rate for a new contractor as defined under WAC 388-96-026 within sixty days following the new contractor's application and approval for a license to operate the facility under chapter 18.51 RCW. The rate will take effect as of the effective date of the contract, except as provided in this section, and will comply with all the provisions of rate setting contained in chapter 74.46 RCW and in this chapter, including all lids and maximums set forth.

(2) Except for quarterly updates per RCW 74.46.501 (7)(c), the rate established for a new contractor as defined in WAC 388-96-026 (1)(a) or (b) will remain in effect for the nursing facility until the rate can be reset effective July 1 using the first cost report for that facility under the new contractor's operation containing at least six months' data from the prior calendar year, regardless of whether reported costs for facilities operated by other contractors for the prior calendar year in question will be used to cost rebase their July 1 rates. The new contractor's rate thereafter will be cost rebased only as provided in this chapter and chapter 74.46 RCW.

(3) To set the initial prospective Medicaid payment rate for a new contractor as defined in WAC 388-96-026 (1)(a) and (b), the department will:

(a) Determine whether the new contractor nursing facility belongs to the metropolitan statistical area (MSA) peer group or the non-MSA peer group using the latest information received from the office of management and budget or the appropriate federal agency;

(b) Select all nursing facilities from the department's records of all the current Medicaid nursing facilities in the

new contractor's peer group with the same bed capacity plus or minus ten beds. If the selection does not result in at least seven facilities, then the department will increase the bed capacity by plus or minus five bed increments until a sample of at least seven nursing facilities is obtained;

(c) Based on the information for the nursing facilities selected under subsection (3)(b) of this section and available to the department on the day the new contractor began participating in the Medicaid payment rate system at the facility, rank from the highest to the lowest the component rate allocation in direct care, therapy care, support services, and operations cost centers and based on this ranking:

(i) Determine the middle of the ranking and then identify the rate immediately above the median for each cost center identified in subsection (3)(c) of this section. The rate immediately above the median will be known as the "selected rate" for each cost center;

(ii) Set the new contractor's nursing facility component rate allocation for therapy care, support services, and operations at the "selected rate";

(iii) Set the direct care rate using data from the direct care "selected" rate facility identified in (c) of this subsection as follows:

(A) The cost per case mix unit will be the rate base allowable case mixed direct care cost per patient day for the direct care "selected" rate facility, whether or not that facility is held harmless under WAC 388-96-728 and 388-96-729, divided by the facility average case mix index per WAC 388-96-741;

(B) The cost per case mix unit determined under (c)(iii)(A) of this subsection will be multiplied by the Medicaid average case mix index per WAC 388-96-740. The product will be the new contractor's direct care rate under case mix; and

(C) The department will not apply RCW 74.46.506 (5)(k) to any direct care rate established under subsection (5)(e) or (f) of this section. When the department establishes a new contractor's direct care rate under subsection (5)(e) or (f) of this section, the new contractor is not eligible to be paid by a "hold harmless" rate as determined under RCW 74.46.506 (5)(k);

(iv) Set the property rate in accordance with the provisions of this chapter and chapter 74.46 RCW; and

(v) Set the financing allowance and variable return component rate allocations in accordance with the provisions of this chapter and chapter 74.46 RCW. In computing the variable return component rate allocation, the department will use for direct care, therapy care, support services and operations rate allocations those set pursuant to subsection (3)(c)(i), (ii) and (iii) of this section.

(d) Any subsequent revisions to the rate component allocations of the sample members will not impact a "selected rate" component allocation of the initial prospective rate established for the new contractor under this subsection.

(4) For the WAC 388-96-026 (1)(a) or (b) new contractor, the department will establish rate component allocations for:

(a) Direct care, therapy care, support services and operations based on the "selected rates" as determined under subsection (3)(c) of this section that are in effect on the date the new contractor began participating in the program;

(b) Property in accordance with the provisions of this chapter and chapter 74.46 RCW using for the new contractor as defined under:

(i) WAC 388-96-026 (1)(a), information from the certificate of need; or

(ii) WAC 388-96-026 (1)(b), information provided by the new contractor within ten days of the date the department requests the information in writing. If the contractor as defined under WAC 388-96-026 (1)(b), has not provided the requested information within ten days of the date requested, then the property rate will be zero. The property rate will remain zero until the information is received;

(c) Variable return in accordance with the provisions of this chapter and chapter 74.46 RCW using the "selected rates" established under subsection (3)(c) of this section that are in effect on the date the new contractor began participating in the program; and

(d) Financing allowance using for the new contractor as defined under:

(i) WAC 388-96-026 (1)(a), information from the certificate of need; or

(ii) WAC 388-96-026 (1)(b), information provided by the new contractor within ten days of the date the department requests the information in writing. If the contractor as defined under WAC 388-96-026 (1)(b), has not provided the requested information within ten days of the date requested, then the net book value of allowable assets will be zero. The financing allowance rate component allocation will remain zero until the information is received.

(5) The initial prospective payment rate for a new contractor as defined under WAC 388-96-026 (1)(a) or (b) will be established under subsections (3) and (4) of this section. If the WAC 388-96-026 (1)(a) or (b) contractor's initial rate is set:

(a) Between July 1, 2000 and June 30, 2001, the department will set the new contractor's rates for:

(i) July 1, 2001 using the July 1, 2001 rates for direct care, therapy care, support services, and operations of the sample facilities used to set the initial rate under subsections (3) and (4) of this section.

(A) Property and financing allowance component rates will remain the same as set for the initial rate.

(B) Variable return component rate using the rates determined under subsection (5)(a)(i) of this section;

(ii) July 1, 2002 rate using 2001 cost report data; and

(iii) All July 1 rates following July 1, 2002 in accordance with this chapter and chapter 74.46 RCW;

(b) Between July 1, 2001, and June 30, 2002, the department will set the new contractor's rates for:

(i) July 1, 2002 using July 1, 2002 rates for direct care, therapy care, support services, and operation of the sample facilities used to set the initial rate under subsections (3) and (4) of this section.

(A) Property and financing allowance component rates will remain the same as set for the initial rate.

(B) Variable return component rate using the rates determined under subsection (5)(b)(i) of this section;

(ii) July 1, 2003 rate by rebasing using 2002 cost report data in accordance with this chapter and chapter 74.46 RCW; and

(iii) All July 1 rates following July 1, 2003 in accordance with this chapter and chapter 74.46 RCW; or

(c) Between July 1, 2002, and June 30, 2003, the department will set the contractor's rates for:

(i) July 1, 2003 using July 1, 2003 rates for direct care, therapy care, support services, and operation of the sample facilities used to set the initial rate under subsection (3) and (4) of this section.

(A) Property and financing allowance component rates will remain the same as set for the initial rate.

(B) Variable return component rate using the rates determined under subsection (5)(c)(i) of this section;

(ii) July 1, 2004 by rebasing using 2003 cost report data; and

(iii) All July 1 rates following July 1, 2004 in accordance with this chapter and chapter 74.46 RCW.

(6) For the WAC 388-96-026 (1)(c) new contractor, the initial prospective payment rate will be the last prospective payment rate the department paid to the Medicaid contractor operating the nursing facility immediately prior to the effective date of the new Medicaid contract or assignment. If the WAC 388-96-026 (1)(c) contractor's initial rate is set:

(a) Between October 1, 1998 and June 30, 1999, the department will not rebase the contractor's rate for:

(i) July 1, 1999; and

(ii) July 1, 2000;

(b) Between July 1, 1999 and June 30, 2000, the department will for:

(i) July 1, 2000 not rebase the new contractor's rate;

(ii) July 1, 2001 rebase the new contractor's rate using twelve months of cost report data derived from the old contractor's and the new contractor's 1999 cost reports; and

(iii) July 1, 2002 not rebase the new contractor's rate; and

(iv) July 1, 2003 not rebase the new contractor's rate;

(c) Between July 1, 2000 and June 30, 2001, the department will for:

(i) July 1, 2001 rebase the new contractor's rate using the old contractor's 1999 twelve month cost report;

(ii) July 1, 2002 not rebase the new contractor's rate;

(iii) July 1, 2003 not rebase the new contractor's rate; or

(d) Between July 1, 2001 and June 30, 2002, the department will for:

(i) July 1, 2002 not rebase the new contractor's rate;

(ii) July 1, 2003 not rebase the new contractor's rate; and

(iii) July 1, 2004 rebase the new contractor's rate using the new contractor's 2002 cost report containing at least six month's data.

(7) A prospective payment rate set for all new contractors will be subject to adjustments for economic trends and conditions as authorized and provided in this chapter and in chapter 74.46 RCW.

(8) For a WAC 388-96-026 (1)(a), (b) or (c) new contractor, the Medicaid case mix index and facility average case mix index will be determined in accordance with this chapter and chapter 74.46 RCW.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-710, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-710, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(11) and RCW 74.46.800. 98-20-023, § 388-96-710, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-710, filed 9/12/95, effective

10/13/95. Statutory Authority: RCW 74.46.800. 94-12-043 (Order 3737), § 388-96-710, filed 5/26/94, effective 6/26/94; 93-17-033 (Order 3615), § 388-96-710, filed 8/11/93, effective 9/11/93. Statutory Authority: RCW 74.46.800, 74.46.450 and 74.09.120. 93-12-051 (Order 3555), § 388-96-710, filed 5/26/93, effective 6/26/93. Statutory Authority: RCW 74.46.800. 92-16-013 (Order 3424), § 388-96-710, filed 7/23/92, effective 8/23/92. Statutory Authority: 1987 c 476. 88-01-126 (Order 2573), § 388-96-710, filed 12/23/87. Statutory Authority: RCW 74.46.800. 87-09-058 (Order 2485), § 388-96-710, filed 4/20/87. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-710, filed 9/16/83; 78-02-013 (Order 1264), § 388-96-710, filed 1/9/78.]

WAC 388-96-713 Rate determination. (1) Each nursing facility's Medicaid payment rate for services provided to medical care recipients will be determined, adjusted and updated prospectively as provided in this chapter and in chapter 74.46 RCW. The department will calculate any limit, lid, and/or median only when it rebases each nursing facility's July 1 Medicaid payment rate in accordance with chapter 74.46 RCW and this chapter.

(2) If the contractor participated in the program for less than six months of the prior calendar year, its rates will be determined by procedures set forth in WAC 388-96-710.

(3) Contractors submitting correct and complete cost reports by March 31st, shall be notified of their rates by July 1st, unless circumstances beyond the control of the department interfere.

(4) In setting rates, the department will use the greater of actual days from the cost report period on which the rate is based or days calculated at minimum occupancy pursuant to chapter 74.46 RCW.

(5) Adjusted cost report data from 1999 shall be used for July 1, 2001 through June 30, 2005 direct care, therapy care, support services, and operations component rate allocations.

[Statutory Authority: RCW 74.46.431, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-713, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-713, filed 5/29/01, effective 6/29/01; 98-20-023, § 388-96-713, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-713, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-713, filed 9/14/93, effective 10/15/93; 90-09-061 (Order 2970), § 388-96-713, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.120. 83-19-047 (Order 2025), § 388-96-713, filed 9/16/83; 81-15-049 (Order 1669), § 388-96-713, filed 7/15/81; 80-06-122 (Order 1510), § 388-96-713, filed 5/30/80, effective 7/1/80; 78-02-013 (Order 1264), § 388-96-713, filed 1/9/78.]

WAC 388-96-718 Public process for determination of rates. (1) The purpose of this section is to describe the manner in which the department will comply with the federal Balanced Budget Act of 1997, Section 4711 (a)(1), codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For all material changes to the methodology for determining nursing facility Medicaid payment rates occurring after October 1, 1997, and requiring a Title XIX state plan amendment to be submitted to and approved by the Health Care Financing Administration under applicable federal laws, the department shall follow the following public process:

(a) The proposed estimated initial payment rates, the proposed new methodologies for determining the payment rates, and the underlying justifications shall be published. Publication shall be:

(i) In the Washington State Register; or

(ii) In the Seattle Times and Spokane Spokesman Review newspapers.

(b) The department shall maintain and update as needed a mailing list of all individuals and organizations wishing to receive notice of changes to the nursing facility Medicaid payment rate methodology, and all materials submitted for publication shall be sent postage prepaid by regular mail to such individuals and organizations. Individuals and organizations wishing to receive notice shall notify the department in writing.

(c) Nursing facility contractors, their associations, nursing facility Medicaid beneficiaries, representatives of contractors or beneficiaries, and other concerned members of the public shall be given a reasonable opportunity to review and comment on the proposed estimated rates, methodologies and justifications. The period allowed for review and comment shall not be less than fourteen calendar days after the date of the Washington State Register containing the published material or the date the published material has appeared in both the Seattle Times and the Spokane Spokesman Review.

(d) If, after receiving and considering all comments, the department decides to move ahead with any change to its nursing facility Medicaid payment rate methodology, it shall adopt needed further changes in response to comments, if any, and shall publish the final estimated initial rates, final rate determination methodologies and justifications. Publication shall be:

(i) In the Washington State Register; or

(ii) In the Seattle Times and Spokane Spokesman Review newspapers.

(e) Unless an earlier effective date is required by state or federal law, implementation of final changes in methodologies and commencement of the new rates shall not occur until final publication has occurred in the Register or in both designated newspapers. The department shall not be authorized to delay implementation of, or to alter, ignore or violate requirements of, state or federal laws in response to public process comments.

(f) Publication of proposed estimated initial payment rates and final estimated initial payment rates shall be deemed complete once the department has published:

(i) The statewide average proposed estimated initial payment rate weighted by adjusted Medicaid resident days for all Medicaid facilities from the most recent cost report year, including the change from the existing statewide average payment rate weighted by adjusted Medicaid resident days for all Medicaid facilities from the most recent cost report year; and

(ii) The statewide average final estimated initial payment rate weighted by adjusted Medicaid resident days for all Medicaid facilities from the most recent cost report year, including the change from the existing statewide average payment rate weighted by adjusted Medicaid resident days for all Medicaid facilities from the most recent cost report year.

(3) Nothing in this section shall be construed to prevent the department from commencing or completing the public process authorized by this section even though the proposed changes to the methodology for determining nursing facility Medicaid payment rates are awaiting federal approval, or are the subject of pending legislative, gubernatorial or rule-making.

ing action and are yet to be finalized in statute and/or regulation.

(4)(a) Neither a contractor nor any other interested person or organization shall challenge, in any administrative appeals or exception procedure established in rule by the department under the provisions of chapter 74.46 RCW, the adequacy or validity of the public process followed by the department in proposing or implementing a change to the payment rate methodology, regardless of whether the challenge is brought to obtain a ruling on the merits or simply to make a record for subsequent judicial or other review. Such challenges shall be pursued only in courts of proper jurisdiction as may be provided by law.

(b) Any challenge to the public process followed by the department that is brought in the course of an administrative appeals or exception procedure shall be dismissed by the department or presiding officer, with prejudice to further administrative review and record-making, but without prejudice to judicial or other review as may be provided by law.

(5) The public process required and authorized by this section shall not apply to any change in the payment rate methodology that does not require a Title XIX state plan amendment under applicable federal laws, including but not limited to:

(a) Prospective or retrospective changes to nursing facility payment rates or to methodologies for establishing such rates ordered by a court or administrative tribunal, after exhaustion of all appeals by either party as may be authorized by law, or the expiration of time to appeal; or

(b) Changes to nursing facility payment rates for one or more facilities resulting from the application of authorized payment rate methodologies, principles or adjustments, including but not limited to: Partial or phased-in termination or implementation of rate methodologies; scheduled cost rebasing; quarterly or other updates to reflect changes in case mix or other private or public source data used to establish rates; adjustments for inflation or economic trends and conditions; rate funding for capital improvements or new requirements imposed by the department; changes to resident-specific or exceptional care rates; and changes to correct errors or omissions by the contractor or the department.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-718, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800, 74.09.500 and 74.08.090. 98-19-062, § 388-96-718, filed 9/16/98, effective 10/17/98.]

WAC 388-96-723 Comparison of the statewide weighted average payment rate for all nursing facilities with the weighted average payment rate identified in the Biennial Appropriations Act. (1) On a quarterly basis, the department will compare the statewide weighted average payment rate for all nursing facilities with the weighted average payment rate identified in the Biennial Appropriations Act.

(2) To determine the statewide weighted average payment rate, the department will use total billed Medicaid days incurred in the calendar year immediately preceding the current fiscal year for the purpose of weighting the July 1 nursing facilities' rates that have been adjusted, or updated pursuant to chapter 74.46 RCW and this chapter.

[Title 388 WAC—p. 486]

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-723, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-723, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-723, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-723, filed 9/25/98, effective 10/1/98.]

WAC 388-96-724 Advance notice—Nursing facility component rate reduction taken under RCW 74.46.421.

(1) The department will notify the nursing facility at least twenty-eight calendar days in advance of the effective date of a reduction taken under RCW 74.46.421.

(2) A rate reduction taken under RCW 74.46.421 will be effective the first day of the month following the twenty-eight calendar day advance notice.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-724, filed 10/13/04, effective 11/13/04. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-724, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-724, filed 9/25/98, effective 10/1/98.]

WAC 388-96-725 RCW 74.46.421 rate reduction—A nursing facility's rates. (1) The department will not reverse any rate reductions taken in accordance with RCW 74.46.-421.

(2) If after a reduction a nursing facility is eligible to receive an increase in a component rate for some unrelated change (e.g., a change in the Medicaid case mix index causes the direct care rate to increase), the department will apply the increase to the rate reduced by application of RCW 74.46.-421.

(3) Reductions made under RCW 74.46.421 are cumulative. The department will reduce the component rates for all nursing facilities without reversing any previous reductions.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-725, filed 10/13/04, effective 11/13/04. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-725, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-725, filed 9/25/98, effective 10/1/98.]

WAC 388-96-726 RCW 74.46.421 nursing facility component rates below the statewide weighted average payment rate identified in the Biennial Appropriations Act. (1) Even if an individual nursing facility's component rates are below the statewide weighted average payment rate identified in the Biennial Appropriations Act, the department will reduce the nursing facility's rates as required under RCW 74.46.421.

(2) The department will not exempt any nursing facility from a component rates reduction required by RCW 74.46.-421 for any circumstance, e.g., billed Medicaid days, under-spending of the biennial appropriation for nursing facility rates, etc.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-726, filed 10/13/04, effective 11/13/04. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-726, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.421 and 74.46.800. 98-20-023, § 388-96-726, filed 9/25/98, effective 10/1/98.]

(2007 Ed.)

WAC 388-96-730 Methodology for reducing a nursing facility's Medicaid payment rate in order to reduce the statewide weighted average nursing facility Medicaid payment rate to equal or be less than the weighted average payment rate identified in the Biennial Appropriations Act. (1) The department will determine a percentage reduction factor (PRF) that, when applied to all nursing facilities' rates will result in a statewide weighted average payment rate that is equal to or less than the weighted average payment rate identified in the Biennial Appropriations Act.

(2) By applying various percentages to the rates for all nursing facilities, the department will identify a percentage that reduces the statewide weighted average payment rate equal to or less than the weighted average payment rate identified in the Biennial Appropriations Act.

(3) The percentage identified in subsection (2) of this section will be the PRF. To reduce the statewide average payment rate to less than or equal to the weighted average payment rate identified in the Biennial Appropriations Act, the department will apply the PRF equally to all rate component allocations of each nursing facility's rate.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-730, filed 10/13/04, effective 11/13/04. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-730, filed 11/30/99, effective 12/31/99.]

WAC 388-96-731 Nursing facilities' rate reductions pursuant to RCW 74.46.421. Under RCW 74.46.421, the department will reduce the rate for each nursing facility when the statewide weighted average payment rate for all nursing facilities exceeds or is likely to exceed the weighted average payment rate identified in the Biennial Appropriations Act.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-731, filed 10/13/04, effective 11/13/04. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-731, filed 11/30/99, effective 12/31/99.]

WAC 388-96-738 What default case mix group and weight must the department use for case mix grouping when there is no minimum data set resident assessment for a nursing facility resident? (1) When a resident:

(a) Dies before the facility completes the resident's initial assessment, the department must assign the assessment to the special care case mix group - SSB. The department must use the case mix weight assigned to the special care case mix group - SSB;

(b) Is discharged to an acute care facility before the nursing facility completes the resident's initial assessment, the department must assign the assessment to the special care case mix group - SSB. The department must use the case mix weight assigned to the special care case mix group - SSB; or

(c) Is discharged for a reason other than those noted above before the facility completes the resident's initial assessment, the department must assign the assessment to the case mix group BC1 with a case mix weight of 1.000.

(2) If the resident assessment is untimely as defined in RCW 74.46.501 and as defined by federal regulations, then the department must assign the case to the default case mix group of BC1 which has a case mix weight of 1.000.

(2007 Ed.)

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-738, filed 9/25/98, effective 10/1/98.]

WAC 388-96-739 How will the department determine which resident assessments are Medicaid resident assessments? The department must identify a Medicaid resident assessment through the review of the minimum data set (MDS) payer source code. If the nursing facility codes the payer source as "Medicaid per diem," regardless of whether any other payer source codes are checked, then the department will count the case as a Medicaid resident assessment.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-739, filed 9/25/98, effective 10/1/98.]

WAC 388-96-740 Medicaid case mix index—When a facility does not meet the ninety percent minimum data set (MDS) threshold as identified in RCW 74.46.501. (1) When the department certifies a nursing facility as Medicaid, which was not previously certified as Medicaid in or after the quarter that will serve as the basis for the facility's Medicaid case mix index, then the department will use the industry average Medicaid case mix index for the quarter specified in RCW 74.46.501 (7)(c) as the facility's Medicaid average case mix index.

(2) If the nursing facility does not meet the ninety percent MDS threshold for any other reason, then the department will use one as the Medicaid case mix index.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-740, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-740, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-740, filed 9/25/98, effective 10/1/98.]

WAC 388-96-741 When the nursing facility does not have facility average case mix indexes for the four quarters specified in RCW 74.46.501 (7)(b) for determining the cost per case mix unit, what will the department use to determine the nursing facility's cost per case mix unit? If the nursing facility:

(1) Is newly Medicaid certified after the four quarters specified in RCW 74.46.501 (7)(b), then the department must use the industry average case mix index for those four quarters as the facility's average case mix index.

(2) Existed during at least one of the four quarters and met the ninety percent threshold for at least one of the four quarters specified in RCW 74.46.501 (7)(b), then the department must use the facility's average case mix index for the quarter(s) that the facility met the ninety percent threshold.

(3) Existed during at least one of the four quarters and did not meet the ninety percent threshold for any of the four quarters, then the department must use the industry average case mix index as the facility's average case mix index.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-741, filed 9/25/98, effective 10/1/98.]

WAC 388-96-742 Licensed beds to compute the ninety percent minimum data set (MDS) threshold rather than a nursing facility's quarterly average census. The

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department will use the number of licensed beds to compute the ninety percent threshold of MDS data when:

- (1) The reported census as a result of errors exceeds the number of current licensed beds; or
- (2) There is a significant discrepancy between the reported census and the number of current licensed beds. A significant discrepancy exists when the census is fifty percent or less of the number of licensed beds.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-742, filed 10/13/04, effective 11/13/04. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 §§ 22, 24 and 25 and RCW 74.46.800. 98-20-023, § 388-96-742, filed 9/25/98, effective 10/1/98.]

WAC 388-96-744 How will the department set the therapy care rate and determine the median cost limit per unit of therapy? (1) For a nursing facility that does not report units of therapy for the applicable cost report year, the department will set its nursing facility therapy care rate at \$0.00 until units of therapy are submitted.

(2) After the nursing facility reports its units of therapy, the department will pay the nursing facility a rate beginning the effective date of the rate year, e.g., July 1.

(3) In a rebase year the nursing facility's units of therapy must be reported in the cost report used to rebase the rate. If reported later than the cost report due date, the department shall exclude the nursing facility's therapy costs from the array of costs use to set the median cost limit per unit of therapy.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 26 and RCW 74.46.800. 98-20-023, § 388-96-744, filed 9/25/98, effective 10/1/98.]

WAC 388-96-746 How much therapy consultant expense for each therapy type will the department allow to be added to the total allowable one-on-one therapy expense? (1) The department will multiply the actual patient days when greater than eighty-five percent or patient days at eighty-five percent occupancy by both:

- (a) A nursing facility's adjusted therapy consulting costs per patient day; and
- (b) The median adjusted therapy consulting cost plus ten percent.

The lesser of (a) or (b) of this subsection will be reasonable therapy consulting costs that the department shall add to the total allowable one-on-one therapy expense used to calculate the therapy care rate.

(2) To determine the median adjusted therapy consulting cost per type of therapy, the department shall:

- (a) Divide Medicaid nursing facilities in the state into two peer groups:
 - (i) Those facilities located within a metropolitan statistical area; and
 - (ii) Those not located in a metropolitan statistical area. Metropolitan statistical areas and nonmetropolitan statistical areas shall be as determined by the United States Office of Management and Budget or other applicable federal office.

(b) Array the facilities in each peer group from highest to lowest based on their therapy consulting cost per patient day for each type of therapy.

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(c) Determine the median total cost for therapy consulting per patient day costs by MSA and non-MSA peer group and add ten percent to that median cost.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 26 and RCW 74.46.800. 98-20-023, § 388-96-746, filed 9/25/98, effective 10/1/98.]

WAC 388-96-747 Constructed, remodeled or expanded facilities. (1) When a facility is constructed, remodeled, or expanded after obtaining a certificate of need or exemption from the requirements for certificate of need for the replacement of existing nursing home beds pursuant to RCW 70.38.115 (13)(a), the department shall determine actual and allocated allowable land cost and building construction cost. Payment for such allowable costs, determined pursuant to the provisions of this chapter, shall not exceed the maximums set forth in this subsection and in subsections (2) and (7) of this section. The department shall determine construction class and types through examination of building plans submitted to the department and/or on-site inspections. The department shall use definitions and criteria contained in the Marshall and Swift Valuation Service published by the Marshall and Swift Publication Company. Buildings of excellent quality construction shall be considered to be of good quality, without adjustment, for the purpose of applying these maximums.

(2) Construction costs shall be final labor, material, and service costs to the owner or owners and shall include:

- (a) Architect's fees;
- (b) Engineers' fees (including plans, plan check and building permit, and survey to establish building lines and grades);
- (c) Interest on building funds during period of construction and processing fee or service charge;
- (d) Sales tax on labor and materials;
- (e) Site preparation (including excavation for foundation and backfill);
- (f) Utilities from structure to lot line;
- (g) Contractors' overhead and profit (including job supervision, workmen's compensation, fire and liability insurance, unemployment insurance, etc.);
- (h) Allocations of costs which increase the net book value of the project for purposes of Medicaid payment;
- (i) Other items included by the Marshall and Swift Valuation Service when deriving the calculator method costs.

(3) The department shall allow such construction costs, at the lower of actual costs or the maximums derived from the sum of the basic construction cost limit plus the common use area limit which corresponds to the type, class and number of total nursing home beds for the new construction, remodel or expansion. The maximum limits shall be calculated using the most current cost criteria contained in the *Marshall and Swift Valuation Service* and shall be adjusted forward to the mid-point date between award of the construction contract and completion of construction.

(4) When some or all of a nursing facility's common-use areas are situated in a basement, the department shall exclude some or all of the per-bed allowance for common-use areas to derive the construction cost lid for the facility. The amount excluded will be equal to the ratio of basement common-use areas to all common-use areas in the facility times the com-

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mon-use area limits determined in accordance with subsection (3) of this section. In lieu of the excluded amount, the department shall add an amount calculated using the calculator method guidelines for basements in nursing homes published in the *Marshall and Swift Valuation Service*.

(5) Subject to provisions regarding allowable land contained in this chapter, allowable costs for land shall be the lesser of:

(a) Actual cost per square foot, including allocations;

(b) The average per square foot land value of the ten nearest urban or rural nursing facilities at the time of purchase of the land in question. The average land value sample shall reflect either all urban or all rural facilities depending upon the classification of urban or rural for the facility in question. The values used to derive the average shall be the assessed land values which have been calculated for the purpose of county tax assessments; or

(c) Land value for new or replacement building construction or substantial building additions requiring the acquisition of land that commenced to operate on or after July 1, 1997, determined in accordance with RCW 74.46.360 (2) and (3).

(6) If allowable costs for construction or land are determined to be less than actual costs pursuant to subsections (1) and (7) of this section, the department may increase the amount if the owner or contractor is able to show unusual or unique circumstances having substantially impacted the costs of construction or land. Actual costs shall be allowed to the extent they resulted from such circumstances up to a maximum of ten percent above levels determined under subsections (3), (4), and (5) of this section for construction or land. An adjustment under this subsection shall be granted only if requested by the contractor. The contractor shall submit documentation of the unusual circumstances and an analysis of its financial impact with the request.

(7) If a capitalized addition or retirement of an asset will result in an increased licensed bed capacity during the calendar year following the capitalized addition or replacement, the department shall use the facility's anticipated resident occupancy level subsequent to the increase in licensed bed capacity as long as the occupancy for the increased number of beds is at or above eighty-five percent. Subject to the provisions of this chapter and chapter 74.46 RCW, in no case shall the department use less than eighty-five percent occupancy of the facility's increased licensed bed capacity. If a capitalized addition, replacement, or retirement results in a decreased licensed bed capacity, WAC 388-96-709 will apply.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(12) and RCW 74.46.800. 98-20-023, § 388-96-747, filed 9/25/98, effective 10/1/98.]

WAC 388-96-748 Financing allowance component rate allocation. (1) Beginning July 1, 1999, for each Medicaid nursing facility, the department will establish a financing allowance component rate allocation. The financing allowance component rate allocation will be rebased annually, effective July 1st, in accordance with this chapter and chapter 74.46 RCW.

(2) The department will determine the financing allowance component rate allocation by:

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(a) Multiplying the net invested funds of each nursing facility by the applicable factor identified in subsection (3) of this section; and

(b) Dividing the sum of the products by the greater of:

(i) A nursing facility's total resident days from the most recent cost report period; or

(ii) Resident days calculated on eighty-five percent facility occupancy.

(3)(a) The multiplication factor required by subsection (2) (a) of this section is determined by the acquisition date of the tangible fixed asset(s). For each nursing facility, the department will multiply the net invested funds for assets acquired:

(i) Before May 17, 1999 by a factor of .10; and/or

(ii) On or after May 17, 1999 by a factor of .085.

(b) The department will apply the factor of .10 to the net invested funds pertaining to new construction or major renovations:

(i) That received certificate of need approval before May 17, 1999;

(ii) That received an exemption from certificate of need requirements under chapter 70.38 RCW before May 17, 1999; or

(iii) for which the nursing facility submitted working drawings to the department of health for construction review before May 17, 1999.

(c) For a new contractor as defined under WAC 388-96-026 (1)(c), assets acquired from the former contractor will retain their initial acquisition dates when determining the new contractor's financing allowance under this section.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-748, filed 11/30/99, effective 12/31/99.]

WAC 388-96-749 Variable return—Quartiles and percentages. (1) When the department rebases each nursing facility's July 1 Medicaid payment rate in accordance with chapter 74.46 RCW and this chapter, it applies RCW 74.46.-433 to set the variable return (VR) quartiles and assigns the designated percentage to the quartile.

(2) Following a July 1 rebasing of all component rates, the department will not adjust the quartiles or the percentages assigned to them for any reason, including but not limited to reversal of cost report adjustments by administrative review conferences, fair hearings, and/or judicial reviews until the next July 1 rebasing of all component rates.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-749, filed 10/13/04, effective 11/13/04.]

WAC 388-96-757 Payment for veterans' homes. Payment rates to nursing facilities operated by the state of Washington, department of veterans' affairs shall be determined in accordance with chapter 74.46 RCW and this chapter as for all other facilities.

[Statutory Authority: RCW 74.09.120 and 74.46.800. 98-20-023, § 388-96-757, filed 9/25/98, effective 10/1/98; 93-19-074 (Order 3634), § 388-96-757, filed 9/14/93, effective 10/15/93.]

WAC 388-96-760 Upper limits to the payment rate. The average payment rate for the cost report year shall not exceed the contractor's average customary charges to the gen-

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eral public for the services covered by the payment rate for the same time period. The department will pay public facilities rendering such services free of charge or at a nominal charge according to the methods and standards set out in this chapter. The contractor shall provide as part of the annual cost report a statement of the average charges for the cost report year for services covered by the payment rate and supporting computations and documentation. The contractor shall immediately inform the department if its payment rate does exceed customary charges for comparable services. If necessary, the department will adjust the payment rate in accordance with RCW 74.46.531.

[Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322, RCW 74.46.800 and 74.09.120. 98-20-023, § 388-96-760, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 74.09.120. 91-12-026 (Order 3185), § 388-96-760, filed 5/31/91, effective 7/1/91. Statutory Authority: RCW 74.09.120. 84-24-050 (Order 2172), § 388-96-760, filed 12/4/84; 83-19-047 (Order 2025), § 388-96-760, filed 9/16/83; 81-22-081 (Order 1712), § 388-96-760, filed 11/4/81. Statutory Authority: RCW 74.08.090 and 74.09.120. 78-06-080 (Order 1300), § 388-96-760, filed 6/1/78. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-760, filed 1/9/78.]

WAC 388-96-762 Allowable land. (1) Beginning January 1, 1985, land associated with a nursing facility which is eligible for inclusion in net invested funds shall not exceed two acres for facilities located in a Metropolitan Statistical Area (MSA), as defined and determined by the United States Office of Management and Budget or other applicable federal office, and three acres for nursing facilities located outside such an area.

(2) The department may grant an exception to these limits if a contractor presents documentation deemed adequate by the department establishing a larger area of land is directly related to patient care. Requests for exceptions and any exceptions granted must be in writing.

(3) Requests for exceptions may be granted in the following cases:

(a) The area occupied by the nursing home building exceeds the allowable land area specified in subsection (1) of this section;

(b) The land is used directly in the provision of patient care;

(c) The land is maintained;

(d) The land is not subdivided or eligible for subdivision;

(e) The land is zoned for nursing home or similar use; and

(f) Other reasons exist which are deemed sufficient by the department.

[Statutory Authority: RCW 74.46.800. 96-15-056, § 388-96-762, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 74.09.120. 93-19-074 (Order 3634), § 388-96-762, filed 9/14/93, effective 10/15/93. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-762, filed 5/30/84.]

WAC 388-96-766 Notification. (1) The department will notify each contractor in writing of its prospective Medicaid payment rate allocation. Unless otherwise specified at the time it is issued, the Medicaid payment rate allocation and/or component rate allocation(s) will be effective from the first day of the month in which it (they) is (are) issued. When the department amends a Medicaid payment rate allocation and/or component rate allocation(s) as the result of an appeal

in accordance with WAC 388-96-904, the amended rate will have the same effective date as the appealed rate.

(2) If a total Medicaid component payment rate allocation and/or rate allocation(s) is (are) adjusted, updated or amended after the calendar year in which the adjustment or update was effective, then the department will account for any amounts owed through the settlement process.

(3)(a) The department shall deem the contractor to have received the department's notice five calendar days after the date of the notification letter, unless proof of the date of receipt of the department's notification letter exists, in which case the actual date of receipt shall be used. Proof of date of receipt of department's notification must be from an independent source that has no stake in the outcome.

(b) When the department has sent notice by certified letter, the department shall deem the contractor to have received the department's notice five calendar days after the date the U.S. Post Office first attempts to deliver the certified letter containing the notice of the department's action(s).

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-766, filed 10/13/04, effective 11/13/04. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-766, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.09.120. 78-02-013 (Order 1264), § 388-96-766, filed 1/9/78.]

WAC 388-96-767 Appraisal values. If a contractor is unwilling or unable to provide and document the lessor's historical cost of leased assets, the department shall arrange for an appraisal of such assets to be conducted by the state of Washington department of general administration. If such an appraisal is conducted, it shall be the basis for all property and financing allowance component rate allocations, except that: If documentation subsequently becomes available to the department establishing the lessor's historical cost is less than the appraisal value, the historical cost shall be the basis for all property and financing allowance component rate allocations.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207. 99-24-084, § 388-96-767, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 74.46.800. 84-12-039 (Order 2105), § 388-96-767, filed 5/30/84.]

WAC 388-96-771 Receivership. (1) If the nursing home is providing care to recipients of state medical assistance, the receiver shall:

(a) Become the Medicaid contractor for the duration of the receivership period;

(b) Assume all reporting responsibilities for new contractors;

(c) Assume all other responsibilities for new contractors set forth in this chapter; and

(d) Be responsible for the refund of Medicaid rate payments in excess of costs during the period of receivership.

(2) In establishing the prospective rate during receivership the department shall consider:

(a) Compensation, if any, ordered by the court for the receiver. Such compensation may already be available to the receiver through the rate as follows:

(i) Financing allowance and variable return component rate allocations, or

(ii) The administrator's salary in the case of facilities where the receiver is also the administrator.

If these existing sources of compensation are less than what was ordered by the court, additional costs may be allowed in the rate up to the compensation amount ordered by the court.

(b) Start up costs and costs of repairs, replacements, and additional staff needed for patient health, security, and welfare. To the extent such costs can be covered through the financing allowance and the variable return component rate allocations, no additional monies will be added to the rate;

(c) Any other allowable costs as set forth in this chapter.

(3)(a) Upon order of the court, the department shall provide emergency or transitional financial assistance to a receiver not to exceed thirty thousand dollars.

(b) The department shall recover any emergency or transitional expenditure made by the department on behalf of a nursing home not certified to participate in the Medicaid Title XIX program from revenue generated by the facility which is not obligated to the operation of the facility.

(c) In order to help recover an emergency or transitional expenditure, regardless of whether the facility is certified to participate in the Medicaid Title XIX program or not, the department may:

(i) File an action against the former licensee or owner at the time the expenditure is made to recover such expenditure; or

(ii) File a lien on the facility or on the proceeds of the sale of the facility.

(4) If recommendations on receiver's compensation are solicited from the department by the court, the department shall consider the following:

(a) The range of compensation for nursing home managers;

(b) Experience and training of the receiver;

(c) The size, location, and current condition of the facility;

(d) Any additional factors deemed appropriate by the department.

(5) When the receivership terminates, the department may revise the nursing home's Medicaid reimbursement. The Medicaid reimbursement rate for:

(a) The former owner or licensee shall be what it was before receivership, unless the former owner or licensee requests prospective rate revisions from the department as set forth in this chapter; and

(b) Licensed replacement operators shall be determined consistent with rules governing prospective reimbursement rates for new contractors as set forth in this chapter.

[Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-771, filed 11/30/99, effective 12/31/99. Statutory Authority: RCW 79.09.120 [74.09.120] and 74.46.800, 90-09-061 (Order 2970), § 388-96-771, filed 4/17/90, effective 5/18/90. Statutory Authority: RCW 74.09.120, 88-06-085 (Order 2602), § 388-96-771, filed 3/2/88.]

WAC 388-96-776 Add-ons to the property and financing allowance payment rate—Capital improvements. (1) For new or replacement building construction or major renovation projects begun after July 1, 2001, the contractor must have a certificate of capital authorization (CCA)

issued pursuant to WAC 388-96-783 and chapter 74.46 RCW.

(2)(a) Beginning July 1, 2001, the department shall grant an add-on to a prospective payment rate for capitalized improvements done under RCW 74.46.431(12) for all new or replacement building construction or major renovation projects; provided, the department granted the contractor a certificate of capital authorization (CCA) pursuant to WAC 388-96-783 for the fiscal year in which the contractor will complete the project and the net rate effect is ten cents per patient day or greater.

(b) Rate add-on requests filed with the department or approved by the certificate of need unit of the department of health for projects commencing before July 1, 2001 and finishing after July 1, 2001, are not subject to CCA requirements set forth in this chapter and chapter 74.46 RCW.

(3) The department may grant a rate add-on to a payment rate for capital improvements not requiring a CON and a CCA per subsections (1) and (2) of this section. However, the capital improvement must have a net rate effect of ten cents per patient day or greater.

(4) Rate add-ons for all construction and renovation projects granted pursuant to subsection (1) or (2) of this section shall be limited to the total legislative authorization for capital construction and renovation projects for the fiscal year (FY) of the biennium in which the construction or renovation project will be completed. Rate add-ons are subject to the provisions of RCW 74.46.421.

(5) When physical plant improvements made under subsection (1) or (2) of this section are completed in phases, the department shall:

(a) Grant a rate add-on in accordance with subsection (6) of this section for any addition, replacement or improvement when each phase is completed and certified for occupancy for the purpose for which it was intended;

(b) Limit the rate add-on to the actual cost of the depreciable tangible assets meeting the criteria of RCW 74.46.330;

(c) Add-on construction fees as defined in WAC 388-96-747 and other capitalized allowable fees and costs for the completed phase of the project; and

(d) Make the effective date for the rate add-on for the completed phase the quarterly rate change immediately following the completion and certification for occupancy of the phase. When the date of the written request for a phase add-on rate falls after the first quarter immediately following the completion and certification for occupancy of the phase, the department will issue the rate add-on retroactive to the first of the quarter in which the department received a complete written request.

(6) When the construction class of any portion of a newly constructed building will improve as the result of any addition, replacement or improvement occurring in a later, but not yet completed and fully utilized phase of the project, the most appropriate construction class, as applicable to that completed and fully utilized phase, will be assigned for purposes of calculating the rate add-on. The department shall not revise the rate add-on retroactively after completion of the portion of the project that provides the improved construction class. Rather, the department shall calculate a new rate add-on when the improved construction class phase is completed and fully utilized and the rate add-on will be effective in

accordance with subsection (7) of this section using the date the class was improved.

(7) The contractor requesting a rate add-on under subsection (1), (2) or (3) of this section shall submit a written request to the department separate from all other requests and inquiries of the department, e.g., WAC 388-96-904 (1) and (5). A complete written request shall include the following:

(a) A copy of documentation requiring completion of the addition or replacements to maintain licensure or certification for adjustments requested under subsection (1) of this section;

(b) A copy of the new bed license, whether the number of licensed beds increases or decreases, if applicable;

(c) All documentation, e.g., copies of paid invoices showing actual final cost of assets and/or service, e.g., labor purchased as part of the capitalized addition or replacements;

(d) Certification showing the completion date of the capitalized additions or replacements and the date the assets were placed in service per RCW 74.46.360;

(e) A properly completed depreciation schedule for the capitalized additions or replacement as provided in this chapter; and

(f) When the rate increase is requested pursuant to subsection (3) of this section, a written justification for granting the rate increase.

(8) For rate add-on requests for projects not completed in phases that are approved pursuant to subsection (7) of this section and the written request is received:

(a) Within sixty calendar days following the completion and certification of occupancy of the new or replacement construction, major renovation, or the acquisition and installation (if applicable) of a capital improvement made under subsection (3) of this section, the effective date of the rate add-on will be the first of the month following the month in which the project was completed and certified for occupancy or acquired and installed; or

(b) More than sixty days following the completion and certification for occupancy of the new or replacement construction, major renovation project, or the acquisition and installation (if applicable) of a capital improvement made under subsection (3) of this section, the effective date of the rate add-on will be the first of the month following the month in which the written request was received.

(9) If the initial written request is incomplete, the department will notify the contractor of the documentation and information required. The contractor shall submit the requested information within fifteen calendar days from the date the contractor receives the notice to provide the information. If the contractor fails to complete the add-on request by providing all the requested documentation and information within the fifteen calendar days from the date of receipt of notification, the department shall deny the request for failure to complete.

(10) If, after the denial for failure to complete, the contractor submits another written request for a rate add-on for the same project the date of receipt for the purpose of applying subsection (8) of this section will depend upon whether the subsequent request for the same project is complete, i.e., the department does not have to request additional documentation and information in order to make a determination. If a subsequent request for funding of the same project is:

(a) Complete, then the date of the first request may be used when applying subsection (8) of this section; or

(b) Incomplete, then the date of the subsequent request must be used when applying subsection (8) of this section even though the physical plant improvements may be completed and fully utilized prior to that date.

(11) The department shall respond, in writing, not later than sixty calendar days after receipt of a complete request.

(12) If the contractor does not use the funds for the purpose for which they were granted, the department immediately shall have the right to recoup the misspent or unused funds.

(13) When any physical plant improvements made under subsection (1) or (2) of this section result in a change in licensed beds, any rate add-on granted will be subject to the provisions regarding the number of licensed beds, patient days, occupancy, etc., included in this chapter and chapter 74.46 RCW.

(14) Effective July 1, 2002, except for essential community providers, the Medicaid share of nursing facility new construction or refurbishing projects shall be based upon a minimum facility occupancy of ninety percent for the operations, property, and financing allowance component rate allocations. For essential community providers, the Medicaid share of nursing facility new construction or refurbishing project will be based upon a minimum facility occupancy of eighty-five percent for operations, property, and financing allowance component rate allocations.

(15) When a capitalized addition or replacement results in an increased licensed bed capacity during the calendar year following the capitalized addition or replacement:

(a) The department shall determine a nursing facility's prospective Medicaid:

(i) Property payment rate allocation by dividing the property costs using the greater of actual days from the cost report period on which the rate being recalculated is based or days calculated by multiplying the new number of licensed beds times ninety percent times the number of calendar days in the cost report period on which the rate being recalculated is based. For essential community providers, the department shall use eighty-five percent to calculate days to compare with actual days; and

(ii) Financing allowance payment rate allocation by multiplying the net invested funds by the applicable factor in WAC 388-96-748(3) and dividing by the greater of the facility's actual days from the cost report period on which the rate being recalculated is based or on days calculated by multiplying the new number of licensed beds times ninety percent occupancy times the calendar days in the cost report period on which the rate being recalculated is based. For essential community providers, the department shall use eighty-five percent occupancy to calculate days to compare to actual days.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8, 04-21-027, § 388-96-776, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800, 01-12-037, § 388-96-776, filed 5/29/01, effective 6/29/01. Statutory Authority: Chapter 74.46 RCW, 1999 c 376 § 3 amending c 309 § 207, 99-24-084, § 388-96-776, filed 11/30/99, effective 12/31/99. Statutory Authority: Chapter 74.46 RCW as amended by 1998 c 322 § 19(12) and RCW 74.46.800, 98-20-023, § 388-96-776, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.465, 97-17-040, § 388-96-776, filed 8/14/97,

effective 9/14/97. Statutory Authority: RCW 74.46.800, 96-15-056, § 388-96-776, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18, 95-19-037 (Order 3896), § 388-96-776, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800, 94-12-043 (Order 3737), § 388-96-776, filed 5/26/94, effective 6/26/94.]

WAC 388-96-777 Add-ons to the prospective rate—Initiated by the department. (1) The department shall initiate all rate add-ons granted under this section. Contractors may not request and be approved a rate add-on under this section.

(2) Rate add-ons the department grants under the authority of this section shall be for costs to implement:

(a) Program changes that the director of residential care services, aging and adult services administration determines a rate add-on is necessary to accomplish the purpose of the change and announces same in a written directive to the chief of the office of rates management; or

(b) Changes in either the state or federal statutes or regulations or directives that the director of management services, aging and adult services administration determines requires a rate add-on to implement and directs in writing the chief of the office of rates management to implement.

(3) Changes made under this section are subject to review under WAC 388-96-901 and 388-96-904; provided, the issue is not whether a rate add-on should have been granted.

(4) If the contractor does not use the funds for the purpose for which they were granted, the department shall immediately recoup the misspent or unused funds.

[Statutory Authority: RCW 74.46.800, 01-12-037, § 388-96-777, filed 5/29/01, effective 6/29/01; 94-12-043 (Order 3737), § 388-96-777, filed 5/26/94, effective 6/26/94.]

WAC 388-96-781 Exceptional direct care component rate allocation—Covered Medicaid residents. A nursing facility (NF) may receive an increase in its direct care component rate allocation for providing exceptional care to a Medicaid resident who:

(1) Receives specialized services to meet chronic complex medical conditions and neurodevelopment needs of medically fragile children; and

(2) Resides in a NF where all residents are under age twenty-one with at least fifty percent of the residents entering the facility before the age of fourteen.

[Statutory Authority: RCW 74.46.800, 74.46.508, 00-12-098, § 388-96-781, filed 6/7/00, effective 7/8/00.]

WAC 388-96-782 Exceptional therapy care and exceptional direct care—Payment. For WAC 388-96-781 residents, the department will pay the resident's total rate in effect on December 31, 1999, inflated by the industry weighted average economic trends and conditions adjustment factor.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8, 04-21-027, § 388-96-782, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800, 74.46.508, 00-12-098, § 388-96-782, filed 6/7/00, effective 7/8/00.]

WAC 388-96-783 Certificate of capital authorization (CCA). (1)(a) A certificate of capital authorization (CCA) is a certification from the department for an allocation from the

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biennial capital financing authorization for a nursing facility's new or replacement building construction, or major renovation project, receiving a certificate of need (CON) or a CON exemption from the department of health under chapter 70.38 RCW and chapter 246-310 WAC after July 1, 2001.

(b) Issuance of a CCA as required by this regulation and by chapter 74.46 RCW is necessary before:

(i) Any depreciation resulting from the capitalized addition is included in a facility's property component rate allocation, including both determinations under RCW 74.46.435 and property rate add-ons done pursuant to WAC 388-96-776; and/or

(ii) Any net invested funds associated with the capitalized addition are included in the calculation of the facility's financing allowance rate allocation, including both determinations under RCW 74.46.437 and financing allowance rate add-ons done pursuant to WAC 388-96-776.

(2) To apply for a CCA, a contractor must submit a written application to the nursing home rates section of the office of rates management (ORM) within the department. The application must be entirely separate from, and not included with, any other request or communication. The application must include:

(a) A description of the proposed new or replacement construction or major renovation;

(b) A copy of the CON approval, or the determination of CON exception issued by the department of health for the construction or renovation;

(c) The amount of money for which the CCA is being requested; this will presumably be the same amount as included in the CON approval or exception, but may be different where good cause is shown;

(d) The name of the general contractor who will build the construction or renovation; and

(e) The anticipated starting and completion dates of the construction or renovation.

(3) Completed applications for CCAs will be reviewed in the order received. An application will be deemed completed as of the date when all required information has been received by ORM. Within ninety days of the receipt of an application, ORM will either reject it as incomplete, or act upon it. If more than one CCA application is received on the same date, priority will first be given to an application from an essential community provider and then to an application in relation to the facility which has gone the longest from its last major renovation or building project.

(4) ORM will accept applications and issue CCAs for each state fiscal year for which the legislature has enacted authorization in the biennial appropriations act as provided by RCW 74.46.807, subject to the limits of such authorization. CCAs for a fiscal year will be issued until the remaining capital authorization for that year is insufficient to cover any more applications made for that year. An application denied because that year's authorization has been depleted may be resubmitted for a later year, and will be given priority for the remaining amounts of capital authorization in the later year, after CCAs already issued for that year. The state fiscal year runs from July 1 of one calendar year to June 30 of the following calendar year, and is designated by the second calendar year. For example, state fiscal year 2004 (SFY04) runs from July 1, 2003 through June 30, 2004.

(5)(a) When a CCA has been issued, the contractor must act to complete the construction or renovation in a timely manner, consistent with the estimates included in the application. The construction or renovation must be completed and ready for occupancy no later than the last day of the state fiscal year for which the CCA is issued. "Ready for occupancy" means that all federal, state, and local permits for occupancy of the buildings by residents have been issued.

(b) The contractor must send the department ORM a copy of each progress report submitted to the certificate of need section of the department of health under WAC 246-310-590, or a regulation adopted as a successor thereto, at the same time the progress report is filed with the department of health.

(c) Based upon the application for the CCA and the progress reports filed with the department of health by the contractor, ORM will set deadlines for progress of the project toward completion. ORM may withdraw a CCA if its holder does not comply with those deadlines in a good faith manner. A contractor that fails to meet a progress deadline due to its own action or inaction shall be considered not to have acted in a good faith manner.

(d) If a CCA is withdrawn by ORM, or if the construction or renovation is not ready for occupancy by the last day of the fiscal year for which the CCA was issued, the value of the construction or renovation will not be included in the facility's property component or financing allowance rate allocations, as provided in subsection (1)(b) of this section. To include the value of the construction or renovation in the facility's property component or financing allowance rate allocations, the contractor must seek and obtain another CCA.

(6)(a) Although they are related, the CON and CCA processes are separate. When a CON requires amendment under department of health requirements, the contractor must notify ORM. The previously issued CCA will stay in effect. When the amended CON is issued in an amount greater than the original CON, the contractor must submit a new CCA application to ORM covering only the difference between the original and amended CONs. This supplemental CCA application may reference the original CCA application to the greatest extent possible, to expedite its filing and review.

(b) The department of health allows the dollar amount of a CON to be exceeded by the greater of twelve percent or fifty thousand dollars without requiring an amendment to the CON. This excess is not automatically reflected in the corresponding CCA. Any increase in the amount requires an application for a new CCA.

(c) ORM will review the new CCA application based on the estimated date of occupancy and the authorization remaining for the relevant state fiscal year. If there is insufficient authorization remaining in that fiscal year to fund the project, ORM will deny the application in whole or in part.

(d) If a contractor's application for a CCA is denied pursuant to subsection (c) above, the contractor may resubmit it for a later state fiscal year and the application will be given priority as described in subsection (4) of this section.

(7) If ORM withdraws a CCA previously issued, the amount of that authorization shall be restored to the total capital authorization available for the state fiscal year against which the CCA was issued.

(8) An application for a CCA may be considered on an emergency basis. If the application is approved and a sufficient amount of authorization remains for the relevant fiscal year, the CCA may be issued without regard to the priority of the application. Only an application made in relation to a major renovation project may be considered on an emergency basis, and then only if it must be completed as soon as possible to:

(a) Retain a facility's license or certification provided the net rate effect is ten cents per patient day or greater;

(b) Protect the health or safety of the facility's residents; or

(c) Avoid closure if the facility is an essential community provider.

[Statutory Authority: RCW 74.46.807, 74.46.431, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-783, filed 10/13/04, effective 11/13/04.]

WAC 388-96-802 May the nursing facility (NF) contractor bill the department for a Medicaid resident's day of death, discharge, or transfer from the NF? No, the NF contractor may bill the department for the first day of a Medicaid resident's stay but not the last day.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-802, filed 5/29/01, effective 6/29/01.]

WAC 388-96-803 When a nursing facility (NF) contractor becomes aware of a change in the Medicaid resident's income and/or resources, must he or she report it? Yes, within seventy-two hours of becoming aware of a change in the Medicaid resident's income and/or resources, the NF contractor will report the change in writing to the home and community services office serving the area in which the NF is located. When reporting the change, the NF contractor will include copies of any available documentation of the change in the Medicaid resident's income and/or resources.

[Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-803, filed 5/29/01, effective 6/29/01.]

WAC 388-96-901 Disputes. (1) If a contractor wishes to contest the way in which the department applied a statute or department rule to the contractor's circumstances, the contractor shall pursue the administrative review process prescribed in WAC 388-96-904.

(a) Adverse actions taken under the authority of this chapter or chapter 74.46 RCW subject to administrative review under WAC 388-96-904 include but are not limited to:

- (i) Determining a nursing facility payment rate;
- (ii) Calculating a nursing facility settlement;
- (iii) Imposing a civil fine on the nursing facility;
- (iv) Suspending payment to a nursing facility; or
- (v) Refusing to contract with a nursing facility.

(b) Adverse actions taken under the authority of this chapter or chapter 74.46 RCW not subject to administrative review under WAC 388-96-904 include but are not limited to:

(i) Actions taken under the authority of RCW 74.46.421 and sections of this chapter implementing RCW 74.46.421;

(ii) Case mix accuracy review of minimum data set (MDS) nursing facility resident assessments, which shall be limited to separate administrative review under the provisions of WAC 388-96-905;

(iii) Quarterly rate updates to reflect changes in a facility's resident case mix including contractor errors made in the MDSs used to update the facility's resident case mix;

(iv) Exceptional direct care program codified at WAC 388-96-781; and

(v) Actions taken under WAC 388-96-218 (2)(c).

(2) The administrative review process prescribed in WAC 388-96-904 shall not be used to contest or review unrelated or ancillary department actions, whether review is sought to obtain a ruling on the merits of a claim or to make a record for subsequent judicial review or other purpose. If an issue is raised that is not subject to review under WAC 388-96-904, the presiding officer shall dismiss such issue with prejudice to further review under the provisions of WAC 388-96-904, but without prejudice to other administrative or judicial review as may be provided by law. Unrelated or ancillary actions not eligible for administrative review under WAC 388-96-904 include but are not limited to:

(a) Challenges to the adequacy or validity of the public process followed by department in proposing or making a change to the nursing facility Medicaid payment rate methodology, as required by 42 U.S.C. 1396a (a)(13)(A) and WAC 388-96-718;

(b) Challenges to the nursing facility Medicaid payment system that are based in whole or in part on federal laws, regulations, or policies;

(c) Challenges to a contractor's rate that are based in whole or in part on federal laws, regulations, or policies;

(d) Challenges to the legal validity of a statute or regulation; and

(e) Actions of the department affecting a Medicaid beneficiary or provider that were not commenced by the office of rates management, aging and disability services administration, for example, entitlement to or payment for durable medical equipment or other services.

(3) If a contractor wishes to challenge the legal validity of a statute or regulation relating to the nursing facility Medicaid payment system, or wishes to bring a challenge based in whole or in part on federal law, it must bring such action de novo in a court of proper jurisdiction as may be provided by law.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8. 04-21-027, § 388-96-901, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.800. 01-12-037, § 388-96-901, filed 5/29/01, effective 6/29/01. Statutory Authority: RCW 74.46.800, 74.46.508. 00-12-098, § 388-96-901, filed 6/7/00, effective 7/8/00. Statutory Authority: RCW 74.46.780 as amended by 1998 c 322 § 41. 98-20-023, § 388-96-901, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18. 95-19-037 (Order 3896), § 388-96-901, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800 and 74.09.120. 91-12-026 (Order 3185), § 388-96-901, filed 5/31/91, effective 7/1/91. Statutory Authority: RCW 74.09.120. 82-21-025 (Order 1892), § 388-96-901, filed 10/13/82; Order 1262, § 388-96-901, filed 12/30/77.]

WAC 388-96-904 Administrative review—Adjudicative proceeding. (1) Contractors seeking to appeal or take exception to an action or determination of the department, under authority of this chapter or chapter 74.46 RCW, relat-

ing to the contractor's payment rate, audit or settlement, or otherwise affecting the level of payment to the contractor, or seeking to appeal or take exception to any other adverse action taken under authority of this chapter or chapter 74.46 RCW eligible for administrative review under this section, shall request an administrative review conference in writing within twenty-eight calendar days after receiving notice of the department's action or determination. The department shall deem the contractor to have received the department's notice five calendar days after the date of the notification letter, unless proof of the date of receipt of the department's notification letter exists, in which case the actual date of receipt shall be used to determine timeliness of the contractor's request for an administrative review conference. The contractor's request for administrative review shall:

(a) Be signed by the contractor or by a partner, officer, or authorized employee of the contractor;

(b) State the particular issues raised; and

(c) Include all necessary supporting documentation or other information.

(2) After receiving a request for administrative review conference that meets the criteria in subsection (1) of this section, the department shall schedule an administrative review conference. The conference may be conducted by telephone.

(3) At least fourteen calendar days prior to the scheduled date of the administrative review conference, the contractor must supply any additional or supporting documentation or information upon which the contractor intends to rely in presenting its case. In addition, the department may request at any time prior to issuing a determination any documentation or information needed to decide the issues raised, and the contractor must comply with such a request within fourteen calendar days after it is received. The department may extend this period up to fourteen additional calendar days for good cause shown if the contractor requests an extension in writing received by the department before expiration of the initial fourteen-day period. The department shall dismiss issues that cannot be decided or resolved due to a contractor's failure to provide requested documentation or information within the required period.

(4) The department shall, within sixty calendar days after conclusion of the conference, render a determination in writing addressing the issues raised. If the department is waiting for additional documentation or information promised by or requested from the contractor pursuant to subsection (3) of this section, the sixty-day period shall not commence until the department's receipt of such documentation or information or until expiration of the time allowed to provide it. The determination letter shall include a notice of dismissal of all issues which cannot be decided due to a contractor's failure to provide documentation or information promised or requested.

(5) A contractor seeking further review of a determination issued pursuant to subsection (4) of this section shall apply for an adjudicative proceeding, in writing, signed by one of the individuals authorized by subsection (1) of this section, within twenty-eight calendar days after receiving the department's administrative review conference determination letter. A review judge or other presiding officer employed by the department's board of appeals shall conduct the adjudicative proceeding.

The department shall deem the contractor to have received the department's determination five calendar days after the date of the administrative review determination letter, unless proof of the date of receipt of the letter exists, in which case the actual date of receipt shall be used to determine timeliness of the contractor's application for an adjudicative proceeding. The contractor shall attach to its application for an adjudicative proceeding the department's administrative review conference determination letter. A contractor's application for an adjudicative proceeding shall be addressed to the department's board of appeals.

(6) Except as authorized by subsection (7) of this section, the scope of an adjudicative proceeding shall be limited to the issues specifically raised by the contractor at the administrative review conference and addressed on the merits in the department's administrative review conference determination letter. The contractor shall be deemed to have waived all issues or claims that could have been raised by the contractor relating to the challenged determination or action, but which were not pursued at the conference and not addressed in the department's administrative review conference determination letter. In its request for an adjudicative proceeding or as soon as practicable, the contractor must specify its issues.

(7) If the contractor wishes to have further review of any issue not addressed on its merits, but instead dismissed in the department's administrative review conference determination letter, for failure to supply needed, promised, or requested additional information or documentation, or because the department has concluded the request was untimely or otherwise procedurally defective, the issue shall be considered by the presiding officer for the purpose of upholding the department's dismissal, reinstating the issue and remanding for further agency staff action, or reinstating the issue and rendering a decision on the merits.

(8) An adjudicative proceeding shall be conducted in accordance with this chapter, chapter 388-02 WAC and chapter 34.05 RCW. In the event of a conflict between hearing requirements in chapter 74.46 RCW and chapter 388-96 WAC specific to the nursing facility Medicaid payment system and general hearing requirements in chapter 34.05 RCW and chapter 388-02 WAC, the specific requirements of chapter 74.46 RCW and chapter 388-96 WAC shall prevail. The presiding officer assigned by the department's board of appeals to conduct an adjudicative proceeding and who conducts the proceeding shall render the final agency decision.

(9) At the time an adjudicative proceeding is being scheduled for a future time and date certain, or at any appropriate stage of the prehearing process, the presiding officer shall have authority, upon the motion of either party or the presiding officer's own motion, to compel either party to identify specific issues remaining to be litigated.

(10) If the presiding officer determines there is no material issue(s) of fact to be resolved in a case, the presiding officer shall have authority, upon the motion of either party or the presiding officer's own motion, to decide the issue(s) presented without convening or conducting an in-person evidentiary hearing. In such a case, the decision may be reached on documentation admitted to the record, party admissions, written or oral stipulation(s) of facts, and written or oral argument.

(11) The board of appeals shall issue an order dismissing an adjudicative proceeding requested under subsection (5) of this section, unless within two hundred seventy calendar days after the board of appeals receives the application for an adjudicative proceeding:

(a) All issues have been resolved by a written settlement agreement between the contractor and the department signed by both and filed with the board of appeals; or

(b) An adjudicative proceeding has been held for all issues not resolved and the evidentiary record, including all rebuttal evidence and post-hearing or other briefing, is closed.

This time limit may be extended one time thirty additional calendar days for good cause shown upon the motion of either party made prior to the expiration of the initial two hundred seventy day period. It shall be the responsibility of the contractor to request that hearings be scheduled and ensure that settlement agreements are signed and filed with the board of appeals in order to comply with the time limit set forth in this subsection.

(12) Any party dissatisfied with a decision or an order of dismissal of the board of appeals may file a petition for reconsideration within ten calendar days after the decision or order of dismissal is served on such party. The petition shall state the specific grounds upon which relief is sought. The time for seeking reconsideration may be extended by the presiding officer for good cause upon motion of either party. The presiding officer shall rule on a petition for reconsideration and may seek additional argument, briefing, testimony, or other evidence if deemed necessary. Filing a petition for reconsideration shall not be a requisite for seeking judicial review; however, if a petition is filed by either party, the agency decision shall not be deemed final until a ruling is made by the presiding officer.

(13) A contractor dissatisfied with a decision or an order of dismissal of the board of appeals may file a petition for judicial review pursuant to RCW 34.05.570(3) or other applicable authority.

[Statutory Authority: RCW 74.46.431 (11) and (12), 74.46.800, chapter 74.46 RCW, 2004 c 276 § 913, 2001 1st sp.s. c 8, 04-21-027, § 388-96-904, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.46.780 as amended by 1998 c 322 § 41, 98-20-023, § 388-96-904, filed 9/25/98, effective 10/1/98. Statutory Authority: RCW 74.46.800, 96-15-056, § 388-96-904, filed 7/16/96, effective 8/16/96. Statutory Authority: RCW 74.46.800 and 1995 1st sp.s. c 18, 95-19-037 (Order 3896), § 388-96-904, filed 9/12/95, effective 10/13/95. Statutory Authority: RCW 74.46.800, 94-12-043 (Order 3737), § 388-96-904, filed 5/26/94, effective 6/26/94. Statutory Authority: RCW 74.46.800 and 74.09.120, 91-12-026 (Order 3185), § 388-96-904, filed 5/31/91, effective 7/1/91. Statutory Authority: RCW 34.05.220 (1)(a) and 74.09.120, 90-04-071 (Order 3003), § 388-96-904, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.09.180 and 74.46.800, 89-01-095 (Order 2742), § 388-96-904, filed 12/21/88. Statutory Authority: 1987 c 476, 88-01-126 (Order 2573), § 388-96-904, filed 12/23/87. Statutory Authority: RCW 34.04.020, 84-05-040 (Order 2076), § 388-96-904, filed 2/17/84. Statutory Authority: RCW 74.09.120, 82-21-025 (Order 1892), § 388-96-904, filed 10/13/82; Order 1262, § 388-96-904, filed 12/30/77.]

WAC 388-96-905 Case mix accuracy review of MDS nursing facility resident assessments. (1) The department shall perform periodic nursing facility on-site accuracy reviews of minimum data set (MDS) assessments of nursing facility residents, for the purpose of verifying the accuracy of facility case mix data used to establish and update Medicaid

payment rates, and for other purposes the department may deem appropriate.

(2) Contractors, their representatives, and authorized nursing facility personnel may ask questions and raise concerns with the quality assurance nurse (QAN) or other designated department representative at the time a case mix accuracy review is conducted. Contractors, their representatives and authorized nursing facility personnel should attempt to resolve any differences and provide additional documentation, information or clarification prior to the case mix accuracy review exit conference.

(3) Upon completing a case mix accuracy review, the QAN shall hold an exit conference to inform the facility of the QAN's observations and preliminary findings. MDS inaccuracies, if any, will be identified and the findings that substantiate these inaccuracies shall be described.

(4) Within five working days after the case mix accuracy review exit conference is held, the nursing facility district manager (DM) for the facility's district shall send the case mix accuracy review decision letter to the nursing facility administrator at the facility address. The case mix accuracy review decision letter shall be sent certified mail, return receipt requested, shall describe in detail the QAN's findings, and shall identify the:

- (a) Resident assessments that were reviewed;
- (b) RUG-III or other applicable case mix grouping that was determined for the resident assessments reviewed;
- (c) Changes in assigned classification, if any, that were made for residents whose assessments were reviewed;
- (d) Right of the contractor to appeal any disagreement with the case mix accuracy review decision to the department's case mix accuracy review administrator or his or her delegate:

- (i) Where to send an appeal request; and
- (ii) The time limit for requesting an appeal.

(5) If the contractor intends to appeal the DM's case mix accuracy review decision letter, the appeal request must be in writing and mailed to the department's case mix accuracy administrator within ten calendar days after receipt of the case mix accuracy review decision letter. The appeal request letter shall:

- (a) Be signed by the contractor or by a partner, officer, or authorized employee of the contractor;
- (b) State the particular issue(s) raised, including any explanation or basis for disagreeing with the department's findings or actions.

(6) Prior to the informal administrative hearing, the case mix accuracy review administrator shall have no involvement in the case mix accuracy review decision.

(7) Upon receiving a timely appeal request, the administrator shall review any documentation and information submitted with the request, and contact the contractor by telephone to schedule an informal administrative hearing. The purpose of this informal hearing is to give the contractor one opportunity to present information which might warrant modification or deletion of resident-specific accuracy findings resulting from the case mix accuracy review. The scope of the informal administrative hearing shall be limited to clinical issues of resident need and assessment. Nonclinical issues beyond the scope of appeal include, but are not limited to:

- (a) Any remedies or negative actions imposed by the department to rectify practices or inaccuracies;
- (b) Alleged inconsistencies in the accuracy review process;
- (c) Challenges to the authority or adequacy of the case mix accuracy review process; and
- (d) Payment rate issues or other adverse actions subject to review under WAC 388-96-904.

(8) On or before the informal hearing date, the contractor must submit all necessary supporting documentation or other information to the case mix accuracy review administrator. The administrator may request additional information or documentation from the contractor at any time before issuing the final, informal hearing decision. The contractor shall provide all information or documentation within the time limits established by this section, or by the administrator. In the event that the contractor fails to submit the required documentation for a claim or issue within the specified time limits, the accuracy review administrator shall dismiss the claim or issue with prejudice.

(9) The informal case mix accuracy review administrative hearing shall be conducted in person, unless both the contractor and the department agree that it can be conducted by telephone.

(10) Within ten days after the informal administrative hearing or within ten days after receipt of any additional information or documentation requested, whichever is later, the case mix accuracy review administrator shall send the appeal decision in writing to the nursing facility administrator at the facility address. The appeal decision letter shall be sent regular mail and shall:

- (a) Be the final agency decision of the department;
- (b) Be based on the independent judgment of the case mix accuracy review administrator who conducted the informal administrative hearing and reviewed all information and documentation; and
- (c) Recite the right of the contractor to seek judicial review under the state's Administrative Procedure Act (chapter 34.05 RCW).

(11) A contractor dissatisfied with the final agency decision issued by the case mix accuracy review administrator may file a petition for judicial review pursuant to RCW 34.05.570(3) or other applicable authority.

[Statutory Authority: RCW 74.46.780 as amended by 1998 c 322 § 41 and RCW 74.46.800. 98-20-023, § 388-96-905, filed 9/25/98, effective 10/1/98.]

Chapter 388-97 WAC NURSING HOMES

WAC

SUBCHAPTER I RESIDENT RIGHTS, CARE AND RELATED SERVICES

Definitions

388-97-005	Definitions.
	Admission, Transfer and Discharge
388-97-012	Nursing facility care.
388-97-017	Discrimination prohibited.
388-97-027	Nursing facility admission and payment requirements.
388-97-032	Discharge planning.
388-97-037	Utilization review.
388-97-042	Individual transfer and discharge rights and procedures.

- 388-97-043 Transfer and discharge appeals for residents in Medi-care or Medicaid certified facilities.
388-97-047 Discharge or leave of a nursing facility resident.

Resident Rights

WAC sections 388-97-055, 388-97-060, and 388-97-065 implement the federal Patient Self-Determination Act and clarify requirements under chapter 11.94 RCW, Power of attorney; chapter 7.70 RCW, Actions for injuries resulting from health care; and chapter 70.122 RCW, Natural Death Act; chapter 11.88 RCW, Guardianship-appointment, qualification, removal of guardians and limited guardians; chapter 11.92 RCW, Guardianship-powers and duties of guardian or limited guardian.

- 388-97-051 Resident rights.
388-97-052 Free choice.
388-97-053 Statutes implemented in resident decision making, informed consent and advance directives.
388-97-055 Resident decision making.
388-97-060 Informed consent.
388-97-065 Advance directives.
388-97-07005 Notice of rights and services.
388-97-07010 Notification of changes.
388-97-07015 Protection of resident funds.
388-97-07020 Privacy and confidentiality.
388-97-07025 Work.
388-97-07030 Self-administration of drugs.
388-97-07035 Grievance rights.
388-97-07040 Examination of survey results.
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**DISPOSITION OF SECTIONS FORMERLY
 CODIFIED IN THIS CHAPTER**

388-97-010 License—Application. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-010, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-015 License—Qualification. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-015, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-020 Nursing home fees. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-020, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-022 Medical eligibility for nursing facility care. [Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-022, filed 2/24/00, effective 3/26/00.] Repealed by 00-22-018, filed 10/20/00, effective 10/31/00. Statutory Authority: RCW 74.39A.040, 74.42.056.

388-97-025 License capacity. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-025, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-030 Change of ownership. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-030, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-035 Change in administrator or director of nursing services. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-035, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-040 Name of nursing home. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-040, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-045 License relinquishment upon closure. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-045, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-050 License denial, modification, nonrenewal, revocation. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-050, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-070 Resident rights. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-070, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-080 Quality of life. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-080, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-095 Dementia care unit. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-095, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-100 Discharge planning. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-100, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-105 Relocation due to decertification, license revocation closure, evacuation. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), §

388-97-105, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-145 Early identification of persons with active tuberculosis. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-145, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-150 Surveillance and management of tuberculosis. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-150, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-200 Criminal history disclosure and background inquiries. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-200, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-210 Respite services. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-210, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-215 Adult day or night care. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-215, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-225 Nursing facility care. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-225, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-230 Discrimination prohibited. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-230, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-235 Medical eligibility for nursing facility care. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-235, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-240 Nursing facility admission. [Statutory Authority: 1995 c 18, RCW 18.51.070, 74.42.620 and 74.42.056. 95-24-019 (Order 3922), § 388-97-240, filed 11/22/95, effective 12/23/95. Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-240, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-245 Pre-admission screening. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-245, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-250 Identification screening for current residents. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-250, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-255 Pre-admission screening and annual resident review (PASARR). [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-255, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-265 Utilization review. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-265, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-270 Individual transfer and discharge rights, procedures, appeals. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-270, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

388-97-275	Resident assessment instrument. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-275, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-280	Discharge or leave of a nursing facility resident. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-280, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-300	Fire standards and approval. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-300, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-305	Other standards. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-305, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-320	Space and equipment. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-320, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-380	Maintenance and repair. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-380, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-390	General. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-390, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-395	Design requirements. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-395, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-435	Resident care unit. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-435, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-440	Resident rooms. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-440, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-445	Resident room equipment. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-445, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-450	Resident toilet and bathing facilities. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-450, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.
388-97-475	Electrical. [Statutory Authority: RCW 18.51.070 and 74.42.620. 94-19-041 (Order 3782), § 388-97-475, filed 9/15/94, effective 10/16/94.] Repealed by 00-06-028, filed 2/24/00, effective 3/26/00. Statutory Authority: RCW 18.51.070 and 74.42.620.

SUBCHAPTER I RESIDENT RIGHTS, CARE AND RELATED SERVICES

Definitions

WAC 388-97-005 Definitions. "Abandonment" means action or inaction by an individual or entity with a duty of care for a vulnerable adult that leaves the vulnerable individual without the means or ability to obtain necessary food, clothing, shelter, or health care.

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"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Further clarification of the definition of abuse, and examples of types of behavior that constitute abuse are described in RCW 74.34.020(2).

"Administrative hearing" is a formal hearing proceeding before a state administrative law judge that gives a licensee an opportunity to be heard in disputes about licensing actions, including the imposition of remedies, taken by the department.

"Administrative law judge (ALJ)" means an impartial decision-maker who presides over an administrative hearing. ALJs are employed by the office of administrative hearings (OAH), which is a separate state agency. ALJs are not DSHS employees or DSHS representatives.

"Administrator" means a nursing home administrator, licensed under chapter 18.52 RCW, must be in active administrative charge of the nursing home, as that term is defined in the board of nursing home administrator's regulations.

"Advanced registered nurse practitioner (ARNP)" means a registered nurse currently licensed in Washington under RCW 18.79.050 or successor laws.

"Applicant" means an individual, partnership, corporation, or other legal entity seeking a license to operate a nursing home.

"ASHRAE" means the American Society of Heating, Refrigerating, and Air Conditioning Engineers, Inc.

"Attending physician" means the doctor responsible for a particular individual's total medical care.

"Berm" means a bank of earth piled against a wall.

"Chemical restraint" means a psychopharmacologic drug that is used for discipline or convenience and not required to treat the resident's medical symptoms.

"Civil fine" is a civil monetary penalty assessed against a nursing home as authorized by chapters 18.51 and 74.42 RCW. There are two types of civil fines, "per day" and "per instance."

(1) "Per day fine" means a fine imposed for each day that a nursing home is out of compliance with a specific requirement. Per day fines are assessed in accordance with WAC 388-97-660(1); and

(2) "Per instance fine" means a fine imposed for the occurrence of a deficiency.

"Condition on a license" means that the department has imposed certain requirements on a license and the licensee cannot operate the nursing home unless the requirements are observed.

"Deficiency" is a nursing home's failed practice, action or inaction that violates any or all of the following:

(1) Requirements of chapters 18.51 or 74.42 RCW, or the requirements of this chapter; and

(2) In the case of a Medicare and Medicaid contractor, participation requirements under Title XVIII and XIX of the Social Security Act and federal Medicare and Medicaid regulations.

"Deficiency citation" or "cited deficiency" means written documentation by the department that describes a nursing home's deficiency(ies); the requirement that the deficiency(ies) violates; and the reasons for the determination of noncompliance.

"Deficient facility practice" or **"failed facility practice"** means the nursing home action(s), error(s), or lack of action(s) that provide the basis for the deficiency.

"Dementia care" means a therapeutic modality or modalities designed specifically for the care of persons with dementia.

"Denial of payment for new admissions" is an action imposed on a nursing home (facility) by the department that prohibits payment for new Medicaid admissions to the nursing home after a specified date. Nursing homes certified to provide Medicare and Medicaid services may also be subjected to a denial of payment for new admissions by the federal Centers for Medicare and Medicaid Services.

"Department" means the state department of social and health services (DSHS).

"Department on-site monitoring" means an optional remedy of on-site visits to a nursing home by department staff according to department guidelines for the purpose of monitoring resident care or services or both.

"Dietitian" means a qualified dietitian. A qualified dietitian is one who is registered by the American Dietetic Association or certified by the state of Washington.

"Disclosure statement" means a signed statement by an individual in accordance with the requirements under RCW 43.43.834. The statement should include a disclosure of whether or not the individual has been convicted of certain crimes or has been found by any court, state licensing board, disciplinary board, or protection proceeding to have neglected, sexually abused, financially exploited, or physically abused any minor or adult individual.

"Drug" means a substance:

(1) Recognized as a drug in the official *United States Pharmacopoeia*, *Official Homeopathic Pharmacopoeia of the United States*, *Official National Formulary*, or any supplement to any of them; or

(2) Intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.

"Drug facility" means a room or area designed and equipped for drug storage and the preparation of drugs for administration.

"Emergency closure" is an order by the department to immediately close a nursing home.

"Emergency transfer" is an order by the department to immediately transfer residents from a nursing home to safe settings.

"Entity" means any type of firm, partnership, corporation, company, association, or joint stock association.

"Financial exploitation" means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any individual for his or her profit or advantage.

"Habilitative services" means the planned interventions and procedures which constitute a continuing and comprehensive effort to teach an individual previously undeveloped skills.

"Highest practicable physical, mental, and psychosocial well-being" means that the nursing home must provide each resident with the necessary individualized care and services to assist the resident to achieve or maintain the highest possible health, functional and independence level in accordance with the resident's comprehensive assessment and plan

of care. Care and services provided by the nursing home must be consistent with all requirements in this chapter, chapter 74.42 and 18.51 RCW, and the resident's informed choices. For Medicaid and Medicare residents, care and services must also be consistent with Title XVIII and XIX of the Social Security Act and federal Medicare and Medicaid regulations.

"Informal department review" is a dispute resolution process that provides an opportunity for the licensee or administrator to informally present information to a department representative about disputed, cited deficiencies. Refer to WAC 388-97-620.

"Inspection" or **"survey"** means the process by which department staff evaluate the nursing home licensee's compliance with applicable statutes and regulations.

"Intermediate care facility for the mentally retarded (ICF/MR)" means an institution certified under chapter 42 C.F.R., Part 483, Subpart I, and licensed under chapter 18.51 RCW.

"License revocation" is an action taken by the department to cancel a nursing home license in accordance with RCW 18.51.060 and WAC 388-97-570.

"License suspension" is an action taken by the department to temporarily revoke a nursing home license in accordance with RCW 18.51.060 and this chapter.

"Licensee" means an individual, partnership, corporation, or other legal entity licensed to operate a nursing home.

"Licensed practical nurse" means an individual licensed under chapter 18.79 RCW;

"Mandated reporter" as used in this chapter means any employee of a nursing home, any health care provider subject to chapter 18.130 RCW, the Uniform Disciplinary Act, and any licensee of a nursing home. Under RCW 74.34.020, mandated reporters also include any employee of the department of social and health services, law enforcement officers, social workers, professional school personnel, individual providers, employees and licensees of boarding home, adult family homes, soldiers' homes, residential habilitation centers, or any other facility licensed by the department, employees of social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agencies, county coroners or medical examiners, or Christian Science practitioners.

"Misappropriation of resident property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money.

"NFPA" means National Fire Protection Association, Inc.

"Neglect":

(1) For a nursing home licensed under chapter 18.51 RCW, neglect means that an individual or entity with a duty of care for nursing home residents has:

(a) By a pattern of conduct or inaction, failed to provide goods and services to maintain physical or mental health or to avoid or prevent physical or mental harm or pain to a resident; or

(b) By an act or omission, demonstrated a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the resident's health, welfare, or safety.

(2) For a skilled nursing facility or nursing facility, neglect also means a failure to provide a resident with the

goods and services necessary to avoid physical harm, mental anguish, or mental illness.

"Noncompliance" means a state of being out of compliance with state and/or federal requirements for nursing homes/facilities.

"Nursing assistant" means a nursing assistant as defined under RCW 18.88A.020 or successor laws.

"Nursing facility (NF)" or **"Medicaid-certified nursing facility"** means a nursing home that has been certified to provide nursing services to Medicaid recipients under Section 1919(a) of the Federal Social Security Act.

"Nursing home" means any facility licensed to operate under chapter 18.51 RCW.

"Officer" means an individual serving as an officer of a corporation.

"Owner of five percent or more of the assets of a nursing home" means:

(1) In the case of a sole proprietorship, the owner, or if owned as community property, the owner and the owner's spouse;

(2) In the case of a corporation, the owner of at least five percent of the capital stock of a corporation; or

(3) In the case of other types of business entities, the owner of a beneficial interest in at least five percent of the capital assets of an entity.

"Partner" means an individual in a partnership owning or operating a nursing home.

"Person" means any individual, firm, partnership, corporation, company, association or joint stock association.

"Pharmacist" means an individual licensed by the Washington state board of pharmacy under chapter 18.64 RCW.

"Pharmacy" means a place licensed under chapter 18.64 RCW where the practice of pharmacy is conducted.

"Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily, and which restricts freedom of movement or access to the resident's body.

"Physician's assistant (PA)" means a physician's assistant as defined under chapter 18.57A or 18.71A RCW or successor laws.

"Plan of correction" is a nursing home's written response to cited deficiencies that explains how it will correct the deficiencies and how it will prevent their reoccurrence.

"Reasonable accommodation" and **"reasonably accommodate"** has the meaning given in federal and state anti-discrimination laws and regulations. For the purpose of this chapter:

(1) Reasonable accommodation means that the nursing home must:

(a) Not impose admission criteria that excludes individuals unless the criteria is necessary for the provision of nursing home services;

(b) Make reasonable modification to its policies, practices or procedures if the modifications are necessary to accommodate the needs of the resident;

(c) Provide additional aids and services to the resident.

(2) Reasonable accommodations are not required if:

(a) The resident or individual applying for admission presents a significant risk to the health or safety of others that cannot be eliminated by the reasonable accommodation;

(b) The reasonable accommodations would fundamentally alter the nature of the services provided by the nursing home; or

(c) The reasonable accommodations would cause an undue burden, meaning a significant financial or administrative burden.

"Receivership" is established by a court action and results in the removal of a nursing home's current licensee and the appointment of a substitute licensee to temporarily operate the nursing home.

"Recurring deficiency" means a deficiency that was cited by the department, corrected by the nursing home, and then cited again within fifteen months of the initial deficiency citation.

"Registered nurse" means an individual licensed under chapter 18.79 RCW or successor laws.

"Rehabilitative services" means the planned interventions and procedures which constitute a continuing and comprehensive effort to restore an individual to the individual's former functional and environmental status, or alternatively, to maintain or maximize remaining function.

"Resident" generally means an individual residing in a nursing home, and if applicable, the surrogate decision maker. The term resident excludes outpatients and individuals receiving adult day or night care, or respite care.

"Resident care unit" means a functionally separate unit including resident rooms, toilets, bathing facilities, and basic service facilities.

"Respiratory isolation" is a technique or techniques instituted to prevent the transmission of pathogenic organisms by means of droplets and droplet nuclei coughed, sneezed, or breathed into the environment.

"Siphon jet clinic service sink" means a plumbing fixture of adequate size and proper design for waste disposal with siphon jet or similar action sufficient to flush solid matter of at least two and one-eighth inches in diameter.

"Skilled nursing facility (SNF)" or **"Medicare-certified skilled nursing facility"** means a nursing home that has been certified to provide nursing services to Medicare recipients under Section 1819(a) of the Federal Social Security Act.

"Social/therapeutic leave" means leave which is for the resident's social, emotional, or psychological well-being; it does not include medical leave.

"Staff work station" means a location at which nursing and other staff perform charting and related activities throughout the day.

"Stop placement" or **"stop placement order"** is an action taken by the department prohibiting nursing home admissions, readmissions, and transfers of patients into the nursing home from the outside.

"Substantial compliance" means the nursing home has no deficiencies higher than severity level 1 as described in WAC 388-97-640, or for Medicaid certified facility, no deficiencies higher than a scope and severity "C."

"Surrogate decision maker" means a resident representative or representatives as outlined in WAC 388-97-055, and as authorized by RCW 7.70.065.

"Survey" means the same as **"inspection"** as defined in this section.

"Temporary manager" means an individual or entity appointed by the department to oversee the operation of the nursing home to ensure the health and safety of its residents, pending correction of deficiencies or closure of the facility.

"Termination" means an action taken by:

(1) The department, or the nursing home, to cancel a nursing home's Medicaid certification and contract; or

(2) The Department of Health and Human Services Centers for Medicare and Medicaid Services, or the nursing home, to cancel a nursing home's provider agreement to provide services to Medicaid or Medicare recipients, or both.

"Toilet room" means a room containing at least one toilet fixture.

"Uncorrected deficiency" is a deficiency that has been cited by the department and that is not corrected by the licensee by the time the department does a revisit.

"Violation" means the same as **"deficiency"** as defined in this section.

"Volunteer" means an individual who is a regularly scheduled individual not receiving payment for services and having unsupervised access to a nursing home resident.

"Whistle blower" means a resident, employee of a nursing home, or any person licensed under Title 18 RCW, who in good faith reports alleged abandonment, abuse, financial exploitation, or neglect to the department, the department of health or to a law enforcement agency.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-005, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-005, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-005, filed 9/15/94, effective 10/16/94.]

Admission, Transfer and Discharge

WAC 388-97-012 Nursing facility care. The nursing facility must provide items, care, and services in accordance with this chapter and with federal regulations under 42 C.F.R. § 483.1 through 483.206, or successor laws, and other applicable federal requirements.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-012, filed 2/24/00, effective 3/26/00.]

WAC 388-97-017 Discrimination prohibited. (1) A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services covered under the state Medicaid plan for all individuals regardless of source of payment.

(2) A nursing facility must not require or request:

(a) Residents or potential residents to waive their rights to Medicare or Medicaid;

(b) Oral or written assurance that residents or potential residents are not eligible for, or will not apply for Medicare or Medicaid benefits; and

(c) A third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

[Title 388 WAC—p. 504]

(3) A nursing facility must inform, in writing, a prospective resident, and where applicable, the resident's representative, before or at the time of admission, that a third party may not be required or requested to personally guarantee payment to the nursing home, as specified in subsection (2)(c) of this section.

(4) A nursing facility must readmit a resident, who has been hospitalized or on therapeutic leave, immediately to the first available bed in a semiprivate room if the resident:

(a) Requires the services provided by the facility; and

(b) Is eligible for Medicaid nursing facility services.

(5) A nursing facility must not:

(a) Deny or delay admission or readmission of an individual to the facility because of the individual's status as a Medicaid recipient;

(b) Transfer a resident, except from a single room to another room within the facility, because of the resident's status as a Medicaid recipient;

(c) Discharge a resident from a facility because of the resident's status as a Medicaid recipient; or

(d) Charge Medicaid recipients any amounts in excess of the Medicaid rate from the date of eligibility, except for any supplementation that may be permitted by department regulation.

(6) A nursing facility must maintain only one list of names of individuals seeking admission to the facility, which is ordered by the date of request for admission, and must:

(a) Offer admission to individuals in the order they appear on the list, except as provided in subsection (7), as long as the facility can meet the needs of the individual with available staff or through the provision of reasonable accommodations required by state or federal laws;

(b) Retain the list of individuals seeking admission for one year from the month admission was requested; and

(c) Offer admission to the portions of the facility certified under Medicare and Medicaid without discrimination against persons eligible for Medicaid, except as provided in subsection (7).

(7) A nursing facility is permitted to give preferential admission to individuals who seek admission from a boarding home, licensed under chapter 18.20 RCW, or from independent retirement housing, if:

(a) The nursing facility is owned by the same entity that owns the boarding home or independent housing; and

(b) They are located within the same proximate geographic area; and

(c) The purpose of the preferential admission is to allow continued provision of culturally or faith-based services, or services provided by a continuing care retirement community as defined in RCW 74.38.025.

(8) A nursing facility must develop and implement written policies and procedures to ensure nondiscrimination in accordance with this section and RCW 74.42.055.

[Statutory Authority: RCW 18.51.070, 74.42.620, and 2004 c 34. 04-20-055, § 388-97-017, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-017, filed 2/24/00, effective 3/26/00.]

WAC 388-97-027 Nursing facility admission and payment requirements. Refer to WAC 388-71-0700 (3) through (5).

(2007 Ed.)

[Statutory Authority: RCW 74.39A.040, 74.42.056. 00-22-018, § 388-97-027, filed 10/20/00, effective 10/31/00. Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-027, filed 2/24/00, effective 3/26/00.]

WAC 388-97-032 Discharge planning. (1) A resident has the right to attain or maintain the highest practicable physical, mental, and psychosocial well-being, and to reside in the most independent setting. Therefore, the nursing home must:

(a) Utilize a formal resident discharge planning system with identical policies and practices for all residents regardless of source of payment;

(b) Inform the resident or resident's representative in writing of the nursing home's discharge planning system when the resident is admitted or as soon as practical after the resident's admission, including:

(i) Specific resources available to assist the resident in locating a lesser care setting;

(ii) The name of the nursing home's discharge coordinator(s);

(iii) In the case of a Medicaid certified nursing facility, the address and telephone number for the department's local home and community services office; and

(iv) In the case of a resident identified through pre-admission screening and resident review (PASRR) as having a developmental disability or mental illness, the address and telephone number for the division of developmental disabilities or the mental health PASRR contractor.

(2) The nursing home must prepare a detailed, written transfer or discharge plan for each resident determined to have potential for transfer or discharge within the next three months. The nursing home must:

(a) Develop and implement the plan with the active participation of the resident and, where appropriate, the resident's representative;

(b) In the case of a Medicaid resident, coordinate the plan with the department's home and community services staff;

(c) In the case of a resident identified through PASRR as having a developmental disability or mental illness, coordinate the plan with the division of developmental disabilities or the mental health PASRR contractor;

(d) Ensure the plan is an integral part of the resident's comprehensive plan of care and, as such, includes measurable objectives and timetables for completion;

(e) Incorporate in the plan relevant factors to include, but not be limited to the:

(i) Resident's preferences;

(ii) Support system;

(iii) Assessments and plan of care; and

(iv) Availability of appropriate resources to match the resident's preferences and needs.

(f) Identify in the plan specific options for more independent placement; and

(g) Provide in the plan for the resident's continuity of care, and to reduce potential transfer trauma, including, but not limited to, pretransfer visit to the new location whenever possible.

(3) For a resident whose transfer or discharge is not anticipated in the next three months, the nursing home must:

(a) Document the specific reasons transfer or discharge is not anticipated in that time frame;

(b) Review the resident's potential for transfer or discharge at the time of the quarterly comprehensive plan of care review. If the reasons documented under subsection (3)(a) of this section are unchanged, no additional documentation of reasons is necessary at the time of plan of care review.

(4) The nursing home must initiate discharge planning on residents described in subsection (3) of this section:

(a) At the request of the resident or the resident's representative; and

(b) When there is a change in the resident's situation or status which indicates a potential for transfer or discharge within the next three months.

(5) Each resident has the right to request transfer or discharge and to choose a new location. If the resident chooses to leave, the nursing home must assist with and coordinate the resident's transfer or discharge. The Medicaid resident, resident's representative, or nursing facility may request assistance from the department's home and community services or, where applicable, the division of developmental disabilities or mental health in the transfer or discharge planning and implementation process.

(6) The nursing home must coordinate all resident transfers and discharges with the resident, the resident's representative and any other involved individual or entity.

(7) When a nursing home anticipates discharge, a resident must have a discharge summary that includes:

(a) A recapitulation of the resident's stay;

(b) A final summary of the resident's status to include items in WAC 388-97-085(1), at the time of discharge that is available for release to authorized individuals and agencies, with the consent of the resident or and surrogate decision maker; and

(c) A postdischarge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-032, filed 2/24/00, effective 3/26/00.]

WAC 388-97-037 Utilization review. (1) To assure appropriate use of Medicaid services, the nursing facility must determine whether each Medicaid resident's health has improved sufficiently so the resident no longer needs nursing facility care.

(a) The nursing facility must base its determination on:

(i) An accurate, comprehensive assessment process; and

(ii) Documentation by the resident's physician.

(b) The nursing facility must not make this determination for residents the department is responsible to assess under WAC 388-97-251.

(2) When the nursing facility determines a resident no longer needs nursing facility care under subsection (1) of this section, the nursing facility must initiate transfer or discharge in accordance with WAC 388-97-042, 388-97-043, and 42 C.F.R. § 483.12, or successor laws, unless the resident voluntarily chooses to transfer or discharge.

(3) When a nursing facility initiates a transfer or discharge of a Medicaid recipient under subsection (2) of this section:

(a) The resident will be ineligible for Medicaid nursing facility payment:

(i) Thirty days after the receipt of written notice of transfer or discharge; or

(ii) If the resident appeals the facility determination, thirty days after the final order is entered upholding the nursing home's decision to transfer or discharge a resident.

(b) The department's home and community services may grant extension of a resident's Medicaid nursing facility payment after the time specified in subsection (3)(a) of this section, when the department's home and community services staff determine:

(i) The nursing facility is making a good faith effort to relocate the resident; and

(ii) A location appropriate to the resident's medical and other needs is not available.

(4) Department designees may review any assessment or determination made by a nursing facility of a resident's need for nursing facility care.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-037, filed 2/24/00, effective 3/26/00.]

WAC 388-97-042 Individual transfer and discharge rights and procedures. (1) The skilled nursing facility and nursing facility must comply with all of the requirements of 42 C.F.R. § 483.10 and § 483.12, and RCW 74.42.450, or successor laws, and the nursing home must comply with all of the requirements of RCW 74.42.450 (1) through (4) and (7), or successor laws, including the following provisions and must not transfer or discharge any resident unless:

(a) At the resident's request;

(b) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(c) The transfer or discharge is appropriate because the resident's health has improved enough so the resident no longer needs the services provided by the facility;

(d) The safety of individuals in the facility is endangered;

(e) The health of individuals in the facility would otherwise be endangered; or

(f) The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility.

(2) The following notice requirements apply if a nursing home/facility initiates the transfer or discharge of a resident. The notice must:

(a) Include all information required by 42 C.F.R. § 483.12 when given in a nursing facility;

(b) Be in writing, in language the resident understands;

(c) Be given to the resident, the resident's surrogate decision maker, if any, the resident's family and to the department;

(d) Be provided thirty days in advance of a transfer or discharge initiated by the nursing facility, except that the notice may be given as soon as practicable when the facility cannot meet the resident's urgent medical needs, or under the conditions described in (1)(c), (d), and (e) of this section; and

(e) Be provided fifteen days in advance of a transfer or discharge initiated by the nursing home, unless the transfer is an emergency.

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(3) The nursing home must:

(a) Provide sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the nursing home;

(b) Attempt to avoid the transfer or discharge of a resident from the nursing home through the use of reasonable accommodations unless agreed to by the resident and the requirements of WAC 388-97-032 are met; and

(c) Develop and implement a bed-hold policy. This policy must be consistent with any bed-hold policy that the department develops.

(4) The nursing home must provide the bed-hold policy, in written format, to the resident, and a family member, before the resident is transferred or goes on therapeutic leave. At a minimum the policy must state:

(a) The number of days, if any, the nursing home will hold a resident's bed pending return from hospitalization or social/therapeutic leave;

(b) That a Medicaid eligible resident, whose hospitalization or social/therapeutic leave exceeds the maximum number of bed-hold days will be readmitted to the first available semi-private bed, provided the resident needs nursing facility services. Social/therapeutic leave is defined under WAC 388-97-005. The number of days of social/therapeutic leave allowed for Medicaid residents and the authorization process is found under WAC 388-97-047; and

(c) That a Medicaid eligible resident may be charged if he or she requests that a specific bed be held, but may not be charged a bed-hold fee for the right to return to the first available bed in a semi-private room.

(5) The nursing facility must send a copy of the federally required transfer or discharge notice to:

(a) The department's home and community services when the nursing home has determined under WAC 388-97-037, that the Medicaid resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility; and

(b) The department's designated local office when the transfer or discharge is for any of the following reasons:

(i) The resident's needs cannot be met in the facility;

(ii) The health or safety of individuals in the facility is endangered; or

(iii) The resident has failed to pay for, or to have paid under Medicare or Medicaid, a stay at the facility.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-042, filed 2/24/00, effective 3/26/00.]

WAC 388-97-043 Transfer and discharge appeals for residents in Medicare or Medicaid certified facilities. (1) A skilled nursing facility and a nursing facility that initiates transfer or discharge of any resident, regardless of payor status, must:

(a) Provide the required written notice of transfer or discharge to the resident and, if known or appropriate, to a family member or the resident's representative;

(b) Attach a department-designated hearing request form to the transfer or discharge notice;

(c) Inform the resident in writing, in a language and manner the resident can understand, that:

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(i) An appeal request may be made any time up to ninety days from the date the resident receives the notice of transfer or discharge; and

(ii) Transfer or discharge will be suspended when an appeal request is received by the office of administrative hearings on or before the date the resident actually transfers or discharges; and

(iii) The nursing home will assist the resident in requesting a hearing to appeal the transfer or discharge decision.

(2) A skilled nursing facility or nursing facility must suspend transfer or discharge pending the outcome of the hearing when the resident's appeal is received by the office of administrative hearings on or before the date of the transfer or discharge set forth in the written transfer or discharge notice, or before the resident is actually transferred or discharged.

(3) The resident is entitled to appeal the skilled nursing facility or nursing facility's transfer or discharge decision. The appeals process is set forth in chapter 388-02 WAC and this chapter. In such appeals, the following will apply:

(a) In the event of a conflict between a provision in this chapter and a provision in chapter 388-02 WAC, the provision in this chapter will prevail;

(b) The resident must be the appellant and the skilled nursing facility or the nursing facility will be the respondent;

(c) The department must be notified of the appeal and may choose whether to participate in the proceedings. If the department chooses to participate, its role is to represent the state's interest in assuring that skilled nursing facility and nursing facility transfer and discharge actions comply substantively and procedurally with the law and with federal requirements necessary for federal funds;

(d) If a Medicare certified or Medicaid certified facility's decision to transfer or discharge a resident is not upheld, and the resident has been relocated, the resident has the right to readmission immediately upon the first available bed in a semi-private room if the resident requires and is eligible for the services provided by a nursing facility or skilled nursing facility.

(e) Any review of the administrative law judge's initial decision shall be conducted under WAC 388-02-0600(1).

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-043, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-043, filed 2/24/00, effective 3/26/00.]

WAC 388-97-047 Discharge or leave of a nursing facility resident. (1) A nursing facility or hospital must send immediate written notification of the date of discharge or death of a Medicaid resident to the department's local home and community service office.

(2) The nursing facility must:

(a) Notify the department of nursing facility discharge and readmission for all Medicaid recipients admitted as hospital inpatients; and

(b) Document in the resident's clinical record all social/therapeutic leave exceeding twenty-four hours.

(3) The department will pay the nursing facility for a Medicaid resident's social/therapeutic leave not to exceed a total of eighteen days per calendar year per resident.

(4) The department's home and community services may authorize social/therapeutic leave exceeding eighteen days per calendar year per resident when requested by the nursing

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facility or by the resident. In the absence of prior authorization from the department's home and community services, the department will not make payment to a nursing facility for leave days exceeding eighteen per calendar year per resident.

(5) An individual who is on social/therapeutic leave retains the status of a nursing facility resident.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-047, filed 2/24/00, effective 3/26/00.]

Resident Rights

WAC sections 388-97-055, 388-97-060, and 388-97-065 implement the federal Patient Self-Determination Act and clarify requirements under chapter 11.94 RCW, Power of attorney; chapter 7.70 RCW, Actions for injuries resulting from health care; and chapter 70.122 RCW, Natural Death Act; chapter 11.88 RCW, Guardianship-appointment, qualification, removal of guardians and limited guardians; chapter 11.92 RCW, Guardianship-powers and duties of guardian or limited guardian.

WAC 388-97-051 Resident rights. (1) The nursing home must meet the resident rights requirements of this section and those in the rest of the chapter.

(2) The resident has a right to a dignified existence, self-determination, and communication with, and access to individuals and services inside and outside the nursing home.

(3) A nursing home must promote and protect the rights of each resident, including those with limited cognition or other barriers that limit the exercise of rights.

(4) The resident has the right to:

(a) Exercise his or her rights as a resident of the nursing home and as a citizen or resident of the United States. Refer to WAC 388-97-055;

(b) Be free of interference, coercion, discrimination, and reprisal from the nursing home in exercising his or her rights; and

(c) Not be asked or required to sign any contract or agreement that includes provisions to waive:

(i) Any resident right set forth in this chapter or in the applicable licensing or certification laws; or

(ii) Any potential liability for personal injury or losses of personal property.

(5) The nursing home must take steps to safeguard residents and their personal property from foreseeable risks of injury or loss.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-051, filed 2/24/00, effective 3/26/00.]

WAC 388-97-052 Free choice. The resident has the right to:

(1) Choose a personal attending physician.

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

(3) Participate in planning care and treatment or changes in care and treatment.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-052, filed 2/24/00, effective 3/26/00.]

WAC 388-97-053 Statutes implemented in resident decision making, informed consent and advance directives. WAC 388-97-055, 388-97-060, and 388-97-065 implement the federal Patient Self-Determination Act and clarify requirements under chapters 11.94; 7.70; 70.122; 11.88; and 11.92 RCW.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-053, filed 2/24/00, effective 3/26/00.]

WAC 388-97-055 Resident decision making. (1) At the time of admission, or not later than the completion of the initial comprehensive resident assessment, the nursing home must determine if the resident:

(a) Has appointed another individual to make his or her health care, financial, or other decisions;

(b) Has created any advance directive or other legal documents that will establish a surrogate decision maker in the future; and

(c) Is not making his or her own decisions, and identify who has the authority for surrogate decision making, and the scope of the surrogate decision maker's authority.

(2) The nursing home must review the requirements of (1) of this section when the resident's condition warrants the review or when there is a significant change in the resident's condition.

(3) In fulfilling its duty to determine who, if anyone, is authorized to make decisions for the resident, the nursing home must:

(a) Obtain copies of the legal documents that establish the surrogate decision maker's authority to act; and

(b) Document in the resident's clinical record:

(i) The name, address, and telephone number of the individual who has legal authority for substitute decision making;

(ii) The type of decision making authority such individual has; and

(iii) Where copies of the legal documents are located at the facility.

(4) In accordance with state law or at the request of the resident, the resident's surrogate decision maker is, in the case of:

(a) A capacitated resident, the individual authorized by the resident to make decisions on the resident's behalf;

(b) A resident adjudicated by a court of law to be incapacitated, the court appointed guardian; and

(c) A resident who has been determined to be incapacitated, but is not adjudicated incapacitated established through:

(i) A legal document, such as a durable power of attorney for health care; or

(ii) Authority for substitute decision making granted by state law, including RCW 7.70.065.

(5) Determination of an individual's incapacity must be a process according to state law not a medical diagnosis only and be based on:

(a) Demonstrated inability in decision making over time that creates a significant risk of personal harm;

(b) A court order; or

(c) The criteria contained in a legal document, such as durable power of attorney for health care.

(6) The nursing home must promote the resident's right to exercise decision making and self-determination to the

fullest extent possible, taking into consideration his or her ability to understand and respond. Therefore, the nursing home must presume that the resident is the resident's own decision maker unless:

(a) A court has established a full guardianship of the individual;

(b) The capacitated resident has clearly and voluntarily appointed a surrogate decision maker;

(c) A surrogate is established by a legal document such as a durable power of attorney for health care; or

(d) The facility determines that the resident is an incapacitated individual according to RCW 11.88.010 and (5)(a) of this section.

(7) The nursing home must honor the exercise of the resident's rights by the surrogate decision maker as long as the surrogate acts in accordance with this section and with state and federal law which govern his or her appointment.

(8) If a surrogate decision maker exercises a resident's rights, the nursing home must take into consideration the resident's ability to understand and respond and must:

(a) Inform the resident that a surrogate decision maker has been consulted;

(b) Provide the resident with the information and opportunity to participate in all decision making to the maximum extent possible; and

(c) Recognize that involvement of a surrogate decision maker does not lessen the nursing home's duty to:

(i) Protect the resident's rights; and

(ii) Comply with state and federal laws.

(9) The nursing home must:

(a) Regularly review any determination of incapacity based on (4)(b) and (c) of this section;

(b) Except for residents with a guardian, cease to rely upon the surrogate decision maker to exercise the resident's rights, if the resident regains capacity, unless so designated by the resident or by court order; and

(c) In the case of a guardian notify the court of jurisdiction in writing if:

(i) The resident regains capacity;

(ii) The guardian is not respecting or promoting the resident's rights;

(iii) The guardianship should be modified; or

(iv) A different guardian needs to be appointed.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-055, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-055, filed 9/15/94, effective 10/16/94.]

WAC 388-97-060 Informed consent. (1) The nursing home must ensure that the informed consent process is followed with:

(a) The resident to the maximum extent possible, taking into consideration his or her ability to understand and respond; and

(b) The surrogate decision maker when the resident is determined to be incapacitated as established through the provision of a legal document such as durable power of attorney for health care, a court proceeding, or as authorized by state law, including RCW 7.70.065. The surrogate decision maker must:

(i) First determine if the resident would consent or refuse the proposed or alternative treatment;

(ii) Discuss determination of consent or refusal with the resident whenever possible; and

(iii) When a determination of the resident's consent or refusal of treatment cannot be made, make the decision in the best interest of the resident.

(2) The informed consent process must include, in words and language that the resident, or if applicable the resident's surrogate decision maker, understands, a description of:

(a) The nature and character of the proposed treatment;

(b) The anticipated results of the proposed treatment;

(c) The recognized possible alternative forms of treatment;

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment including nontreatment; and

(e) The right of the resident to choose not to be informed.

(3) To ensure informed consent or refusal by a resident, or if applicable the resident's surrogate decision maker, regarding plan or care options, the nursing home must:

(a) Provide the informed consent process to the resident in a neutral manner and in a language, words, and manner the resident can understand;

(b) Inform the resident of the right to consent to or refuse care and service options at the time of resident assessment and plan of care development (see WAC 388-97-085 and 388-97-090) and with condition changes, as necessary to ensure that the resident's wishes are known;

(c) Inform the resident at the time of initial plan of care decisions and periodically of the right to change his or her mind about an earlier consent or refusal decision;

(d) Ensure that evidence of informed consent or refusal is consistent with WAC 388-97-085 and 388-97-090; and

(e) Where appropriate, include evidence of resident's choice not to be informed as required in subsections (2) and (3) of this section.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-060, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-060, filed 9/15/94, effective 10/16/94.]

WAC 388-97-065 Advance directives. (1) "Advance directive" as used in this chapter means any document indicating a resident's choice with regard to a specific service, treatment, medication or medical procedure option that may be implemented in the future such as power of attorney, health care directive, limited or restricted treatment cardiopulmonary resuscitation (CPR), do not resuscitate (DNR), and organ tissue donation.

(2) The nursing home must carry out the provisions of this section in accordance with the applicable provisions of WAC 388-97-055 and 388-97-060, and with state law.

(3) The nursing home must:

(a) Document in the clinical record whether or not the resident has an advance directive;

(b) Not request or require the resident to have any advance directives and not condition the provision of care or otherwise discriminate against a resident on the basis of whether or not the resident has executed an advance directive;

(c) In a language and words the resident understands, inform the resident in writing and orally at the time of admis-

sion, and thereafter as necessary to ensure the resident's right to make informed choices, about:

(i) The right to make health care decisions, including the right to change his or her mind regarding previous decisions;

(ii) Nursing home policies and procedures concerning implementation of advance directives, including how the nursing home implements emergency responses; and

(d) Review and update as needed the resident advance directive information:

(i) At the resident's request;

(ii) When the resident's condition warrants review; and

(iii) When there is a significant change in the resident's condition.

(4) When the nursing home becomes aware that a resident's health care directive is in conflict with facility practices and policies which are consistent with state and federal law, the nursing home must:

(a) Inform the resident of the existence of any nursing home practice or policy which would preclude implementing the health care directive;

(b) Provide the resident with written policies and procedures that explain under what circumstances a resident's health care directive will or will not be implemented by the nursing home;

(c) Meet with the resident to discuss the conflict; and

(d) Determine, in light of the conflicting practice or policy, whether the resident chooses to remain at the nursing home:

(i) If the resident chooses to remain in the nursing home, develop with the resident a plan in accordance with chapter 70.122 RCW to implement the resident's wishes. The nursing home may need to actively participate in ensuring the execution of the plan, including moving the resident at the time of implementation to a care setting that will implement the resident's wishes. Attach the plan to the resident's directive in the resident's clinical record; or

(ii) If, after recognizing the conflict between the resident's wishes and nursing home practice or policy the resident chooses to seek other long-term care services, or another physician who will implement the directive, the nursing home must assist the resident in locating other appropriate services.

(5) If a terminally ill resident, in accordance with state law, wishes to die at home, the nursing home must:

(a) Use the informed consent process as described in WAC 388-97-060, and explain to the resident the risks associated with discharge; and

(b) Discharge the resident as soon as reasonably possible.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-065, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-065, filed 9/15/94, effective 10/16/94.]

WAC 388-97-07005 Notice of rights and services. (1)

The nursing home must provide the resident, before admission, or at the time of admission in the case of an emergency, and as changes occur during the resident's stay, both orally and in writing and in language and words that the resident understands, with the following information:

(a) All rules and regulations governing resident conduct, resident's rights and responsibilities during the stay in the nursing home;

(b) Advanced directives, and of any nursing home policy or practice that might conflict with the resident's advance directive if made;

(c) Advance notice of transfer requirements, consistent with RCW 70.129.110;

(d) Advance notice of deposits and refunds, consistent with RCW 70.129.150; and

(e) Items, services and activities available in the nursing home and of charges for those services, including any charges for services not covered under Medicare or Medicaid or by the home's per diem rate.

(2) The resident has the right to:

(a) Upon an oral or written request, to access all records pertaining to the resident including clinical records within twenty-four hours; and

(b) After receipt of his or her records for inspection, to purchase at a cost not to exceed twenty-five cents a page, photocopies of the records or any portions of them upon request and two working days advance notice to the nursing home. For the purposes of this chapter, "**working days**" means Monday through Friday, except for legal holidays.

(3) The resident has the right to:

(a) Be fully informed in words and language that he or she can understand of his or her total health status, including, but not limited to, his or her medical condition;

(b) Accept or refuse treatment; and

(c) Refuse to participate in experimental research.

(4) The nursing home must inform each resident:

(a) Who is entitled to Medicaid benefits, in writing, prior to the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items, services and activities:

(i) That are included in nursing facility services under the Medicaid state plan and for which the resident may not be charged; and

(ii) That the nursing home offers and for which the resident may be charged, and the amount of charges for those services;

(b) That deposits, admission fees and prepayment of charges cannot be solicited or accepted from Medicare or Medicaid eligible residents; and

(c) That minimum stay requirements cannot be imposed on Medicare or Medicaid eligible residents.

(5) The nursing home must, except for emergencies, inform each resident in writing, thirty days in advance before changes are made to the availability or charges for items, services or activities specified in section (4)(a)(i) and (ii), or before changes to the nursing home rules.

(6) The private pay resident has the right to the following, regarding fee disclosure-deposits:

(a) Prior to admission, a nursing home that requires payment of an admission fee, deposit, or a minimum stay fee, by or on behalf of an individual seeking admission to the nursing home, must provide the individual:

(i) Full disclosure in writing in a language the potential resident or his representative understands:

(A) Of the nursing home's schedule of charges for items, services, and activities provided by the nursing home; and

(B) Of what portion of the deposits, admissions fees, pre-paid charges or minimum stay fee will be refunded to the resident if the resident leaves the nursing home.

(ii) The amount of any admission fees, deposits, or minimum stay fees.

(iii) If the nursing home does not provide these disclosures, the nursing home must not keep deposits, admission fees, prepaid charges or minimum stay fees.

(b) If a resident dies or is hospitalized or is transferred and does not return to the nursing home, the nursing home:

(i) Must refund any deposit or charges already paid, less the home's per diem rate, for the days the resident actually resided or reserved or retained a bed in the nursing home, regardless of any minimum stay or discharge notice requirements; except that

(ii) The nursing home may retain an additional amount to cover its reasonable, actual expenses incurred as a result of a private pay resident's move, not to exceed five days per diem charges, unless the resident has given advance notice in compliance with the admission agreement.

(c) The nursing home must refund any and all refunds due the resident within thirty days from the resident's date of discharge from the nursing home; and

(d) Where the nursing home requires the execution of an admission contract by or on behalf of an individual seeking admission to the nursing home, the terms of the contract must be consistent with the requirements of this section.

(7) The nursing home must furnish a written description of legal rights which includes:

(a) A description of the manner of protecting personal funds, under WAC 388-97-07015.

(b) In the case of a nursing facility only, a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels;

(c) A posting of names, addresses, and telephone numbers of all relevant state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and

(d) A statement that the resident may file a complaint with the state survey and certification agency concerning resident abandonment, abuse, neglect, financial exploitation, and misappropriation of resident property in the nursing home.

(8) The nursing home must:

(a) Inform each resident of the name, and specialty of the physician responsible for his or her care; and

(b) Provide a way for each resident to contact his or her physician.

(9) The skilled nursing facility and nursing facility must prominently display in the facility written information, and provide to residents and individuals applying for admission oral and written information, about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(10) The written information provided by the nursing home pursuant to this section, and the terms of any admission contract executed between the nursing home and an individual seeking admission to the nursing home, must be consistent with the requirements of chapters 74.42 and 18.51 RCW and, in addition, for facilities certified under Medicare or Medicaid, with the applicable federal requirements.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-07005, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-07005, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07010 Notification of changes. (1) A nursing home must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's surrogate decision maker, and when appropriate, with resident consent, interested family member(s) when there is:

(a) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(b) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychological status in either life-threatening conditions or clinical complications); refer to WAC 388-97-055;

(c) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(d) A decision to transfer or discharge the resident from the facility.

(2) The nursing home must also promptly notify the resident and, if known, the resident's surrogate decision maker, and when appropriate, with the resident's consent, interested family member(s) when there is:

(a) A change in room or roommate assignment, refer to the timing requirements in WAC 388-97-07065; or

(b) A change in resident rights under federal or state law or regulations as specified in WAC 388-97-07005.

(3) The nursing home must record and periodically update the address and phone number of the resident's legal surrogate decision maker and interested family member(s).

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-07010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07015 Protection of resident funds. (1) The resident has the right to manage his or her financial affairs and the nursing home may not require residents to deposit their personal funds with the nursing home.

(2) Upon written authorization of a resident, the nursing home must hold, safeguard, manage and account for the personal funds of the resident deposited with the nursing home.

(3) The nursing home must establish and maintain a system that assures a full, complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing home on the resident's behalf and must:

(a) Deposit any resident's personal funds in excess of fifty dollars, one hundred dollars for Medicare residents, in an interest-bearing resident personal fund account or accounts, separate from any nursing home operating accounts, and credit all interest earned to the account;

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(b) Keep personal funds under fifty dollars, one hundred dollars for Medicare residents, in a noninterest-bearing account or petty cash fund maintained for residents; and

(c) Make the individual financial record available to the resident or his or her surrogate decision maker through quarterly statements and on request.

(4) The nursing facility must notify each resident that receives Medicaid benefits:

(a) When the amount in the resident's account reaches two hundred dollars less than the SSI resource limit for one individual; and

(b) That if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one individual, the resident may lose eligibility for Medicaid or SSI.

(5) The nursing home must convey the resident's funds, and a final accounting of those funds, to the individual or jurisdiction administering the resident's estate, within thirty days of the death of any resident with a personal fund deposited with the nursing home. For a Medicaid resident, the funds must be sent to the state of Washington, department of social and health services, office of financial recovery.

(6) The nursing facility must purchase a surety bond, or an approved alternative, to assure security of personal funds of residents deposited with the facility.

(7) Medicare certified and Medicaid certified facilities may not impose a charge against a resident's personal funds for any item or service for which payment is made under Medicaid or Medicare as described in 42 C.F.R. § 483.10 (c)(8).

(8) Medicare certified and Medicaid certified nursing facilities must:

(a) Not charge a resident (or the resident's representative) for any item or service not requested by the resident;

(b) Not require a resident, or the resident's representative, to request any item or service as a condition of admission or continued stay; and

(c) Inform the resident, or the resident's representative, requesting an item or services for which a charge will be made that there will be a charge for the item or service and what the charge will be.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-07015, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07020 Privacy and confidentiality. (1) The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes:

(a) Accommodations;

(b) Medical treatment;

(c) Written and telephone communications

(d) Personal care;

(e) Visits; and

(f) Meetings with family and resident groups.

(2) The resident may approve or refuse the release of personal and clinical records to any individual outside the nursing home, unless the resident has been adjudged incapacitated according to state law.

(3) The resident's right to refuse release of personal and clinical records does not apply when:

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- (a) The resident is transferred to another health care institution; or
- (b) Record release is required by law.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-07020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07025 Work. The resident has the right to:

- (1) Refuse to perform services for the nursing home; and
- (2) Perform services for the nursing home, if he or she chooses, when:
 - (a) The facility has documented the need or desire for work in the plan of care;
 - (b) The plan specifies the nature of the services performed and whether the services are voluntary or paid;
 - (c) Compensation for paid services is at or above prevailing rates; and
 - (d) The resident agrees to the work arrangement described in the plan of care.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-07025, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07030 Self-administration of drugs. A resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-07030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07035 Grievance rights. A resident has the right to:

- (1) Voice grievances without discrimination or reprisal. Grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.
- (2) Prompt efforts by the nursing home to resolve voiced grievances, including those with respect to the behavior of other residents.
- (3) File a complaint, contact, or provide information to the department, the long-term care ombudsman, the attorney general's office, and law enforcement agencies without interference, discrimination, or reprisal. All forms of retaliatory treatment are prohibited, including those listed in chapter 74.39A RCW.
- (4) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-07035, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07040 Examination of survey results. (1) The resident has the right to examine the results of:

- (a) The most recent survey of the nursing home conducted by federal and state surveyors;
 - (b) Surveys related to any current or subsequent complaint investigation; and
 - (c) Any required accompanying plan of correction, completed or not.
- (2) Upon receipt of any deficiency citation report, the nursing home must publicly post a notice:

(a) That the results of the survey or complaint investigation, or both, are available regardless of whether the plan of correction is completed or not;

(b) Of the location of the deficiency citation reports.

(3) For a report posted prior to the plan of correction being completed, the nursing home may attach an accompanying notice that explains the purpose and status of the plan of correction, informal dispute review, administrative hearing and other relevant information.

(4) Upon receipt of any citation report, the nursing home must publicly post a copy of the most recent full survey and all subsequent complaint investigation deficiency citation reports, including the completed plans of correction, when one is required.

(5) The notices and any survey reports must be available for viewing or examination in a place or places:

(a) Readily accessible to residents, which does not require staff interventions to access; and

(b) In plain view of the nursing home residents, including individuals visiting those residents, and individuals who inquire about placement in the nursing home.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-07040, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-07040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07045 Resident mail. The resident has the right to privacy in written communications, including the right to:

- (1) Send and promptly receive mail that is unopened; and
- (2) Have access to stationery, postage and writing implements at the resident's own expense.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-07045, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07050 Access and visitation rights. (1) The resident has the right and the nursing home must provide immediate access to any resident by the following:

(a) For Medicare and Medicaid residents any representative of the U.S. Department of Health and Human Services (DHHS);

(b) Any representative of the state;

(c) The resident's personal physician;

(d) Any representative of the state long term care ombudsman program (established under section 307 (a)(12) of the Older American's Act of 1965);

(e) Any representative of the Washington protection and advocacy system, or any other agency (established under part c of the Developmental Disabilities Assistance and Bill of Rights Act);

(f) Any representative of the Washington protection and advocacy system, or any agency (established under the Protection and Advocacy for Mentally Ill Individuals Act);

(g) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

(h) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(2) The nursing home must provide reasonable access to any resident by any entity or individual that provides health,

social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The nursing home must allow representatives of the state ombudsman, described in subsection (1)(d) of this section, to examine a resident's clinical records with the permission of the resident or the resident's surrogate decision maker, and consistent with state law. The ombudsman may also, under federal and state law, access resident's records when the resident is incapacitated and has no surrogate decision maker, and may access records over the objection of a surrogate decision maker if access is authorized by the state ombudsman pursuant to 42 U.S.C. § 3058g(b) and RCW 43.190.065.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-07050, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-07050, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07055 Telephone. The resident has the right to have twenty-four hour access to a telephone which:

- (1) Provides auditory privacy;
- (2) Is accessible to an individual with a disability and accommodates an individual with sensory impairment; and
- (3) Does not include the use of telephones in staff offices and at the nurses station(s).

[Statutory Authority: RCW 18.51.070 and 74.42.620, 00-06-028, § 388-97-07055, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07060 Personal property. (1) The resident has the right, unless to do so would infringe upon the rights or health and safety of other residents, to:

- (a) Retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits; and
- (b) Provide his or her own bed and other furniture, if desired and space permits; and
- (c) Not be required to keep personal property locked in the facility office, safe, or similar arrangement.

(2) The nursing home must:

- (a) Not request or require residents to sign waivers of potential liability for losses of personal property; and
- (b) Have a system in place to safeguard personal property within the nursing home that protects the personal property and yet allows the resident to use his or her property.

[Statutory Authority: RCW 18.51.070 and 74.42.620, 00-06-028, § 388-97-07060, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07065 Roommates/rooms. (1) A resident has the right to:

- (a) Share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement; and
- (b) Receive three days notice of change in room or roommate except:

(i) For room changes: The move is at the resident's request; and

(ii) For room or roommate changes: A longer or shorter notice is required to protect the health or safety of the resident or another resident; or an admission to the facility is necessary, and the resident is informed in advance. The nursing home must recognize that the change may be traumatic for the resident and take steps to lessen the trauma.

(2007 Ed.)

(2) The nursing home must make reasonable efforts to accommodate residents wanting to share the same room.

[Statutory Authority: RCW 18.51.070 and 74.42.620, 00-06-028, § 388-97-07065, filed 2/24/00, effective 3/26/00.]

WAC 388-97-07070 Refusal of certain transfers. In dually certified facilities all beds are Medicaid certified. Therefore the beds in a certified distinct part for Medicare are also nursing facility beds for Medicaid.

(1) Each resident has the right to refuse a transfer to another room within the facility, if the purpose of the transfer is to relocate:

(a) A resident from the Medicare distinct part of the facility to a part of the facility that is not a Medicare distinct part; or

(b) A resident from the part of the facility that is not a Medicare distinct part to the Medicare distinct part of the facility.

(2) A resident's exercise of the right to refuse transfer under subsection (1)(a) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

(3) The skilled nursing facility or nursing facility must inform residents of their rights under subsection (1) and (2) of this section at the time of the proposed transfer or relocation.

[Statutory Authority: RCW 18.51.070 and 74.42.620, 00-06-028, § 388-97-07070, filed 2/24/00, effective 3/26/00.]

WAC 388-97-075 Chemical and physical restraints.

(1) The resident has the right to be free from any physical or chemical restraint imposed for purposes of:

(a) Discipline or convenience, and not required to treat the resident's medical symptoms; or

(b) Preventing or limiting independent mobility or activity.

(2) The nursing home must develop and implement written policies and procedures governing:

(a) The emergency use of restraints;

(b) The use of chemical and physical restraints, required for the treatment of the resident's medical symptoms, not for discipline or convenience;

(c) The personnel authorized to administer restraints in an emergency; and

(d) Monitoring and controlling the use of restraints.

(3) Physical restraints may be used in an emergency only when:

(a) It has been assessed as necessary to prevent a resident from inflicting injury to self or to others;

(b) The restraint is the least restrictive form of restraint possible;

(c) A physician's order is obtained:

(i) Within twenty-four hours; and

(ii) The order includes treatments to assist in resolving the emergency situation and eliminating the need for the restraint; and

(b) The resident is released from the restraint as soon as the emergency no longer exists.

(4) In certain situations, chemical or physical restraints may be necessary for residents with acute or chronic mental or physical impairments. When chemical or physical restraints are used the nursing home must ensure that:

[Title 388 WAC—p. 513]

(a) The use of the restraint is related to a specific medical need or problem identified through a multidisciplinary assessment;

(b) The informed consent process is followed as described under WAC 388-97-060; and

(c) The resident's plan of care provides approaches to reduce or eliminate the use of the restraint, where possible.

(5) The nursing home must ensure that any resident physically restrained is released:

(a) At intervals not to exceed two hours; and

(b) For periods long enough to provide for ambulation, exercise, elimination, food and fluid intake, and socialization as independently as possible.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-075, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-075, filed 9/15/94, effective 10/16/94.]

WAC 388-97-076 Prevention of abuse. (1) Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

(2) The nursing home must develop and implement written policies and procedures that:

(a) Prohibit abandonment, abuse, and neglect of residents, financial exploitation, and misappropriation of resident property; and

(b) Require staff to report possible abuse, and other related incidents, as required by chapter 74.34 RCW, and for skilled nursing facilities and nursing facilities as required by 42 C.F.R. § 483.13.

(3) The nursing home must not allow staff to:

(a) Engage in verbal, mental, sexual, or physical abuse;

(b) Use corporal punishment;

(c) Involuntarily seclude, abandon, neglect, or financially exploit residents; or

(d) Misappropriate resident property.

(4) The nursing home must report any information it has about an action taken by a court of law against an employee to the department's complaint resolution unit and the appropriate department of health licensing authority, if that action would disqualify the individual from employment as described in RCW 43.43.842.

(5) The nursing home must ensure that all allegations involving abandonment, abuse, neglect, financial exploitation, or misappropriation of resident property, including injuries of unknown origin, are reported immediately to the department, other applicable officials, and the administrator of the facility. The nursing home must:

(a) Ensure that the reports are made through established procedures in accordance with state law including chapter 74.34 RCW, and guidelines developed by the department; and

(b) Not have any policy or procedure that interferes with the requirement of chapter 74.34 RCW that employees and other mandatory reporters file reports directly with the department, and also with law enforcement, if they suspect sexual or physical assault has occurred.

(6) The nursing home must:

(a) Have evidence that all alleged violations are thoroughly investigated;

(b) Prevent further potential abandonment, abuse, neglect, financial exploitation, or misappropriation of resident property while the investigation is in progress; and

(c) Report the results of all investigations to the administrator or his designated representative and to other officials in accordance with state law and established procedures (including the state survey and certification agency) within five working days of the incident, and if the alleged violation is verified appropriate action must be taken.

(7) When a mandated reporter has:

(a) Reasonable cause to believe that a vulnerable adult has been abandoned, abused, neglected, financially exploited, or a resident's property has been misappropriated, the individual mandatory reporter must immediately report the incident to the department's aging and disability services administration ADSA;

(b) Reason to suspect that a vulnerable adult has been sexually or physically assaulted, the individual mandatory reporter must:

(i) Immediately report the incident to the department's aging and disability services administration (ADSA);

(ii) Notify local law enforcement in accordance with the provisions of chapter 74.34 RCW.

(8) Under RCW 74.34.053, it is:

(a) A gross misdemeanor for a mandated reporter knowingly to fail to report as required under this section; and

(b) A misdemeanor for a person to intentionally, maliciously, or in bad faith make a false report of alleged abandonment, abuse, financial exploitation, or neglect of a vulnerable adult.

(9) The nursing home must not employ individuals who are disqualified under the requirements of WAC 388-97-203.

[Statutory Authority: RCW 74.34.165, 74.34.020, 74.34.035, 2003 c 230. 03-23-021, § 388-97-076, filed 11/10/03, effective 12/11/03. Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-076, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-076, filed 2/24/00, effective 3/26/00.]

WAC 388-97-077 Resident protection program. (1)

As used in this section, the term "**individual**," means any individual, including a volunteer, used by the facility to provide services to residents.

(2) The department will review all allegations of resident abandonment, abuse, neglect, financial exploitation, or misappropriation of resident property, as defined in this chapter and RCW 74.34.020.

(3) If, after the review of an allegation, the department concludes that there is reason to believe that an individual has abused or neglected a resident, or has misappropriated a resident's property, then the department will initiate an investigation.

(4) The department's investigation may include, but is not limited to:

(a) The review of facility and state agency records;

(b) Interviews with any individuals who may have relevant information about the allegation; and

(c) The collection of any evidence deemed necessary by the investigator.

(5) If, after review of the results of the investigation, the department makes a preliminary determination that the resident abuse, neglect, or misappropriation of resident funds has

occurred, the department will make a preliminary finding to that effect; except that a preliminary finding of neglect will not be made if the individual is able to demonstrate, that the neglect was caused by factors beyond the control of the individual.

(6) Within ten days of making its preliminary determination, the department must send notice of a preliminary finding:

(a) To the individual by first class and certified mail, return receipt requested. The department may choose to substitute personal service for certified mail;

(b) To the current administrator of the facility where the incident occurred; and

(c) To the appropriate licensing agency.

(7) The notice will include the following information:

(a) A description of the allegation;

(b) The date and time of the incident, if known;

(c) That the individual may appeal the preliminary finding; and

(d) That the preliminary finding will become final unless the individual makes a written request for a hearing within thirty days of the date of the notice.

(8) The individual may appeal the department's preliminary finding of abuse, neglect or misappropriation of resident property by notifying the office of administrative hearings in writing within thirty days of the date of the notice.

(9) If, within one hundred eighty days of the date of the notice of the preliminary finding, an individual requests a hearing and can demonstrate good cause for failing to request a hearing within thirty days, the office of administrative hearing may grant the request. The individual's name will remain on the nursing assistant registry pending the outcome of the hearing.

(10) Upon receipt of a written request for a hearing from an individual, the office of administrative hearings will schedule a hearing, taking into account the following requirements:

(a) The hearing decision must be issued within one hundred twenty days of the date the office of administrative hearings receives a hearing request;

(b) The hearing will be conducted at a reasonable time and at a place that is convenient for the individual;

(c) The hearing, and any subsequent appeals, shall be governed by this chapter, chapter 34.05 RCW, and chapter 388-08 WAC, or its successor regulations;

(d) A continuance may be granted upon the request of any party for good cause, as long as the hearing decision can still be issued within one hundred twenty days of the date of the receipt of the appeal. Neither the department nor the individual can waive the one hundred twenty-day requirement. If, however, the administrative law judge finds that extenuating circumstances exist that will make it impossible to complete the record within one hundred twenty days, the administrative law judge may extend the one hundred twenty-day requirement a maximum of sixty days; and

(e) If the administrative law judge upholds the department's preliminary finding, it becomes final.

(11) The department will report a final finding of abuse, neglect and misappropriation of resident property within ten working days to the following:

(a) The individual;

(b) The current administrator of the facility in which the incident occurred;

(c) The administrator of the facility that currently employs the individual;

(d) The department's nursing assistant registry; and

(e) The appropriate licensing authority.

(12) The individual against whom a finding is made is entitled to submit a statement disputing the allegations. Information about the finding, including the individual's statement, must be made available to all requesters.

(13) The findings will remain on the department's nursing assistant registry permanently unless:

(a) The finding is set aside by further administrative or judicial review as provided for in chapter 34.05 RCW;

(b) The department determines that the finding was made in error;

(c) The department removed a single finding of neglect from the nursing assistant registry based upon a petition by the individual as provided in 42 U.S.C. 1396r (g)(1)(C); or

(d) The department is notified of the individual's death.

(14) Information obtained during the investigation into allegations of abuse, neglect and misappropriation of property, and any documents generated by the department will be maintained and disseminated with regard for the privacy of the resident and any reporting individuals and in accordance with laws and regulations regarding confidentiality and privacy.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-077, filed 2/24/00, effective 3/26/00.]

Quality of Life

WAC 388-97-08010 Resident dignity and accommodation of needs. (1) Dignity. The nursing home must ensure that:

(a) Resident care is provided in a manner to enhance each resident's dignity, and to respect and recognize his or her individuality; and

(b) Each resident's personal care needs are provided in a private area free from exposure to individuals not involved in providing the care.

(2) Accommodation of needs. Each resident has the right to reasonable accommodation of personal needs and preferences, except when the health or safety of the individual or other residents would be endangered.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-08010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-08020 Environment. The nursing home must provide and maintain:

(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

(3) Comfortable and safe temperature levels:

(a) Facilities licensed after October 1, 1990 must maintain a temperature range of seventy-one to eighty-one degrees Fahrenheit; and

(b) Regardless of external weather conditions, all nursing homes must develop and implement procedures and pro-

cesses to maintain a temperature level that is comfortable and safe for residents;

(4) Comfortable sound levels, to include:

(a) Minimizing the use of the public address system to ensure each use is in the best interest of the residents; and

(b) Taking reasonable precautions with noisy services so as not to disturb residents, particularly during their sleeping time; and

(5) Lighting suitable for any task the resident chooses to do, and any task the staff must do.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-08020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-08030 Self-determination and participation. The resident has the right to:

(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plan of care;

(2) Interact with members of the community both inside and outside the nursing home;

(3) Make choices about aspects of his or her life in the facility that are significant to the resident; and

(4) Participate in social, religious, and community activities that do not interfere with the rights of other residents in the nursing home.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-08030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-08040 Participation in resident and family groups. (1) A resident has the right to organize and participate in resident groups in the nursing home.

(2) The nursing home must provide a resident or family group, if one exists, with private space.

(3) Staff or visitors may attend meetings only at the group's invitation.

(4) The nursing home must provide a designated staff individual responsible for providing assistance and responding to written requests that result from group meetings.

(5) When a resident or family group exists, the nursing home must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the nursing home.

(6) A resident's family has the right to meet in the nursing home with the families of other residents in the facility.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-08040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-08050 Activities. The nursing home must:

(1) Provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident;

(2) Provide activities meaningful to the residents at various times throughout every day and evening based on each resident's need and preference; and

(3) Ensure that the activities program is directed by a qualified professional who:

(a) Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a

therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or

(b) Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting; or

(c) Is a qualified occupational therapist or occupational therapy assistant.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-08050, filed 2/24/00, effective 3/26/00.]

WAC 388-97-08060 Social services. The nursing home must:

(1) Provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; and

(2) Employ a qualified social worker on a full-time basis if the nursing home has more than one hundred twenty beds. A qualified social worker is an individual with:

(a) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and

(b) One year of supervised social work experience in a health care setting working directly with patients or residents.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-08060, filed 2/24/00, effective 3/26/00.]

WAC 388-97-08070 Pets. (1) Each resident must have a reasonable opportunity to have regular contact with animals, if desired.

(2) The nursing home must:

(a) Consider the recommendations of nursing home residents, resident councils, and staff;

(b) Determine how to provide residents access to animals;

(c) Determine the type and number of animals available in the facility, which the facility can safely manage. Such animals should include only those customarily considered domestic pets.

(d) Ensure that any resident's rights, preferences, and medical needs are not compromised by the presence of an animal; and

(e) Ensure any animal visiting or living on the premises has a suitable temperament, is healthy, and otherwise poses no significant health or safety risks to residents, staff, or visitors.

(3) Animals living on the nursing home premises must:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state; and

(b) Be veterinarian certified to be free of diseases transmittable to humans.

(4) Pets must be restricted from:

(a) Central food preparation areas; and

(b) Residents who object to the presence of pets.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-08070, filed 2/24/00, effective 3/26/00.]

Resident Assessment and Plan of Care

WAC 388-97-085 Resident assessment. (1) The nursing home must:

(a) Provide resident care based on a systematic, comprehensive, interdisciplinary assessment, and care planning process in which the resident participates, to the fullest extent possible.

(b) Conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity;

(c) At the time each resident is admitted:

(i) Have physician's orders for the resident's immediate care; and

(ii) Ensure that the resident's immediate care needs are identified in an admission assessment; and

(d) Ensure that the comprehensive assessment of a resident's needs describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The comprehensive assessment must include at least the following information:

(a) Identification and demographic information;

(b) Customary routine;

(c) Cognitive patterns;

(d) Communication;

(e) Vision;

(f) Mood and behavior patterns;

(g) Psychosocial well-being;

(h) Physical functioning and structural problems;

(i) Continence;

(j) Disease diagnosis and health conditions;

(k) Dental and nutritional status;

(l) Skin conditions;

(m) Activity pursuit;

(n) Medications;

(o) Special treatments and procedures;

(p) Discharge potential;

(q) Documentation of summary information regarding the assessment performed; and

(r) Documentation of participation in assessment.

(3) The nursing home must conduct comprehensive assessments:

(a) No later than fourteen days after the date of admission;

(b) Promptly after a significant change in the resident's physical or mental condition; and

(c) In no case less often than once every twelve months.

(4) The nursing home must ensure that:

(a) Each resident is assessed no less than once every three months, and as appropriate, the resident's assessment is revised to assure the continued accuracy of the assessment; and

(b) The results of the assessment are used to develop, review and revise the resident's comprehensive plan of care under WAC 388-97-090.

(5) The skilled nursing facility and nursing facility must:

(a) For the required assessment, complete the state approved resident assessment instrument (RAI) for each resident in accordance with federal requirements;

(b) Place copies of the completed state approved RAI in each resident's clinical record, unless all charting is computerized;

(c) Maintain all copies of resident assessments completed within the resident's active clinical record for fifteen months;

(d) Assess each resident not less than every three months, using the state approved assessment instrument; and

(e) Transmit all state and federally required RAI information for each resident to the department:

(i) In a manner approved by the department;

(ii) Within ten days of completion of any RAI required under this subsection; and

(iii) Within ten days of discharging or readmitting a resident.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-085, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-085, filed 9/15/94, effective 10/16/94.]

WAC 388-97-090 Comprehensive plan of care. (1)

The nursing home must develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.

(2) The comprehensive plan of care must:

(a) Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under WAC 388-97-110;

(b) Describe any services that would otherwise be required, but are not provided due to the resident's exercise of rights, including the right to refuse treatment (refer to WAC 388-97-07005 and 388-97-060);

(c) Be developed within seven days after completion of the comprehensive assessment;

(d) Be prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the residents needs;

(e) Consist of an ongoing process which includes a meeting if desired by the resident or the resident's representative; and

(f) Include the ongoing participation of the resident to the fullest extent possible, the resident's family or the resident's surrogate decision maker.

(3) The nursing home must implement a plan of care to meet the immediate needs of newly admitted residents, prior to the completion of the comprehensive assessment and plan of care.

(4) The nursing home must:

(a) Follow the informed consent process with the resident as specified in WAC 388-97-060, regarding the interdisciplinary team's plan of care recommendations;

(b) Respect the resident's right to decide plan of care goals and treatment choices, including acceptance or refusal of plan of care recommendations;

(c) Include in the interdisciplinary plan of care process:

(i) Staff members requested by the resident; and

(ii) Direct care staff who work most closely with the resident;

(d) Respect the resident's wishes regarding which individuals, if any, the resident wants to take part in resident plan of care functions;

(e) Provide reasonable advance notice to and reasonably accommodate the resident family members or other individuals the resident wishes to have attend, when scheduling plan of care meeting times; and

(f) Where for practical reasons any individuals significant to the plan of care process, including the resident, are unable to attend plan of care meetings, provide a method for such individuals to give timely input and recommendations.

(5) The nursing home must ensure that each comprehensive plan of care:

(a) Designates the discipline of the individuals responsible for carrying out the program; and

(b) Is reviewed at least quarterly by qualified staff, as part of the ongoing process of monitoring the resident's needs and preferences.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-090, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-090, filed 9/15/94, effective 10/16/94.]

WAC 388-97-097 Dementia care. (1) A nursing home must ensure that it provides residents with dementia with an environment designed to attain or maintain the highest level of functioning and well-being possible, taking into consideration the resident's medical condition and functional status. Therefore, the nursing home must:

(a) Have a program designed to meet the identified needs of the residents;

(b) Develop and implement program policies and procedures.

(c) Train all staff, who have resident contact, in the special needs and care approaches applicable to residents with dementia. This training must be ongoing and consistent with requirements under WAC 388-97-170 (2)(b).

(2) A nursing home that has a locked or secured dementia unit must:

(a) Always have staff present in the unit, available to meet the needs of the residents and to protect them in the event of an emergency;

(b) Have staff available to assist residents, as needed, in accessing outdoor areas;

(c) Have admission, transfer, and discharge criteria which ensures that:

(i) The process of informed consent is followed before admission to or transfer/discharge from the unit;

(ii) The resident is provided with unit specific admission or transfer/discharge criteria, prior to admission to the unit;

(iii) The resident's need for admission to the unit from another part of the nursing home, or transfer/discharge from the unit, is based on the comprehensive assessment and plan of care;

(iv) Through an evaluation prior to admission, a resident admitted directly from outside the nursing home meets the cognitive and functional criteria of the unit;

(v) In the case of an individual admitted directly to the unit from outside the nursing home, as specified in subsection (2)(b)(iv) above, the nursing home may complete the comprehensive assessment after the individual's admission to the unit, provided that the nursing home complies with required

time frames for completion of the resident assessment under WAC 388-97-085.

(d) Provide private pay residents, or their surrogate decision maker written notification:

(i) If admitted from outside the nursing home, of additional charges, if any, for services, items, and activities in the unit, prior to admission; and

(ii) If admitted from another part of the nursing home, thirty days in advance of changes to those charges.

(e) Comply with physical plant requirements in WAC 388-97-350 through 388-97-35060, for existing facilities and for new construction.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-097, filed 2/24/00, effective 3/26/00.]

Quality of Care

WAC 388-97-110 Quality of care. (1) Consistent with resident rights, the nursing home must provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, self-care and independence in accordance with his or her comprehensive assessment and plan of care.

(2) Based on the comprehensive assessment of a resident, the nursing home must ensure that:

(a) A resident's abilities in activities of daily living do not decline unless circumstances of the resident's clinical condition demonstrate that the decline was unavoidable. This includes the resident's ability to:

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and

(v) Use speech, language, or other functional communication systems.

(b) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities in activities of daily living specified in subsection (2)(a) of this section; and

(c) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(3) The nursing home must ensure that the appropriate care and services are provided to the resident in the following areas, as applicable in accordance with the resident's individualized assessments and plan of care:

(a) Vision and hearing;

(b) Skin;

(c) Continence;

(d) Range of motion;

(e) Mental and psychosocial functioning and adjustment;

(f) Nasogastric and gastrostomy tubes;

(g) Accident prevention;

(h) Nutrition;

(i) Hydration;

(j) Special needs, including:

(i) Injections;

(ii) Parenteral and enteral fluids;

(iii) Colostomy, ureterostomy, or ileostomy care;

(iv) Tracheostomy care;

(v) Tracheal suction;

- (vi) Respiratory care;
- (vii) Dental care;
- (viii) Foot care; and
- (ix) Prostheses.
- (k) Medications, including freedom from:
 - (i) Unnecessary drugs;
 - (ii) Nursing home error rate of five percent or greater;
- and
 - (iii) Significant medication errors.
 - (l) Self-administration of medication; and
 - (m) Independent living skills.

(4) The nursing home must ensure that each resident is monitored for desired responses and undesirable side effects of prescribed drugs.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-110, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-110, filed 9/15/94, effective 10/16/94.]

Nursing Services

WAC 388-97-115 Nursing services. (1) The nursing home must ensure that a sufficient number of qualified nursing personnel are available on a twenty-four hour basis seven days per week to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care.

(2) The nursing home must:

(a) Designate a registered nurse or licensed practical nurse to serve as charge nurse, who is accountable for nursing services on each tour of duty; and

(b) Have a full time director of nursing service who is a registered nurse.

(3) The nursing home must have:

(a) A registered nurse on duty directly supervising resident care a minimum of sixteen hours per day, seven days per week; and

(b) A registered nurse or licensed practical nurse on duty directly supervising resident care the remaining eight hours per day, seven days per week. **"Directly supervising"** means the supervising individual is on the premises and is quickly and easily available to provide necessary assessments and other direct care of residents; and oversight of supervised staff.

(4) The nursing home must ensure that staff respond to each resident's requests for assistance in a manner which promptly meets the quality of life and quality of care needs of all the residents.

(5) The director of nursing services is responsible for:

(a) Coordinating the plan of care for each resident;

(b) Ensuring that registered nurses and licensed practical nurses comply with chapter 18.79 RCW; and

(c) Ensuring that the nursing care provided is based on the nursing process in accordance with nationally recognized and accepted standards of professional nursing practice.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-115, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-115, filed 9/15/94, effective 10/16/94.]

(2007 Ed.)

Dietary Services

WAC 388-97-120 Dietary services. The nursing home must:

(1) Provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs.

(2) Serve food in an attractive manner and at temperatures safe and acceptable to each resident.

(3) Ensure that food service is in compliance with chapter 246-215 WAC.

(4) Retain dated menus, dated records of foods received, a record of the number of meals served, and standardized recipes for at least three months for department review as necessary.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-120, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-120, filed 9/15/94, effective 10/16/94.]

WAC 388-97-12010 Meal provision. The nursing home must:

(1) Provide a minimum of three meals in each twenty-four period, at regular times similar to normal meal times in the community;

(2) Make fresh fruits and vegetables, in season, available to residents on a daily basis;

(3) Make reasonable efforts to:

(a) Accommodate individual mealtime preferences and portion sizes, as well as preferences for between meal and evening snacks when not medically contraindicated;

(b) Offer a late breakfast or an alternative to the regular breakfast for late risers; and

(c) Provide food consistent with the cultural and religious needs of the residents.

(4) Use input from residents and the resident council, if the nursing home has one, in meal planning, scheduling, and the meal selection process.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-12010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-12020 Individual dietary needs. The nursing home must:

(1) Encourage residents to continue eating independently;

(2) Provide effective adaptive utensils as needed to promote independence;

(3) Allow sufficient time for eating in a relaxed manner;

(4) Provide individualized assistance as needed;

(5) Provide table service, for all residents capable of eating at a table, in a dining area/room, located outside of the resident's room; and

(6) Offer a substitute of similar nutritive value when a resident refuses food served.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-12020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-12030 Dietary personnel. The nursing home must have sufficient support personnel capable of carrying out the functions of dietary services and must:

(1) Employ a qualified dietitian either full-time, part-time or on a consultant basis who must:

(a) Approve regular and therapeutic menus which meet the dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;

(b) Prepare dated menus for general and modified diets at least three weeks in advance;

(c) Provide services which include:

(i) Nutrition assessment;

(ii) Liaison with medical and nursing staff, and administrator;

(iii) Inservice training; and

(iv) Guidance to the director of food service, and food service staff.

(2) If a qualified dietitian is not employed full-time as the food service manager the nursing home must employ a food service manager to serve as the director of food service.

(3) The food service manager means:

(a) An individual who is a qualified dietitian; or

(b) An individual:

(i) Who has completed a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association/Dietary Manager Association; and

(ii) Receives regularly scheduled consultation from a qualified dietitian.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-12030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-12040 Dietary menus. The nursing home must:

(1) Ensure that menus are followed;

(2) Post the current dated general menu, including substitutes, in the food service area and in a place accessible and conspicuous to residents and visitors, in print the residents can read; and

(3) Note any changes to the regular menu on the posted menu.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-12040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-12050 Diet orders. The nursing home must:

(1) Ensure that residents' diets are provided as prescribed by the physician. Diet modifications, for texture only, may be used as an interim measure when ordered by a registered nurse; and

(2) Provide supplementary fluid and nourishment in accordance with each resident's needs as determined by the assessment process.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-12050, filed 2/24/00, effective 3/26/00.]

WAC 388-97-12060 Modified diets. The nursing home must review a resident's modified diet to ensure that the food form and texture are consistent with the resident's current needs and functional level:

(1) At the request of the resident.

(2) When the resident's condition warrants.

(3) At the time of the plan of care review.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-12060, filed 2/24/00, effective 3/26/00.]

[Title 388 WAC—p. 520]

WAC 388-97-12070 Tube feedings. If the nursing home prepares tube feeding formula, or mixes additives to the prepared formula it must ensure that:

(1) Each resident's tube feedings are of uniform consistency and quality; and

(2) Tube feeding formulas are prepared, stored, distributed, and served in such a manner so as to maintain uniformity and to prevent contamination.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-12070, filed 2/24/00, effective 3/26/00.]

Physician Services

WAC 388-97-125 Physician services. (1) The nursing home must ensure that the resident is seen by the physician whenever necessary.

(2) Except as specified in RCW 74.42.200, a physician must personally approve in writing a recommendation that an individual be admitted to a nursing home.

(3) The nursing home must ensure that:

(a) Except as specified in RCW 74.42.200, the medical care of each resident is supervised by a physician;

(b) Another physician supervises the medical care of residents when their attending physician is unavailable; and

(c) Physician services are provided twenty-four hours per day, in case of emergency.

(4) The physician must:

(a) Write, sign and date progress notes at each visit;

(b) Sign and date all orders; and

(c) In Medicare and Medicare/Medicaid certified facilities, review the resident's total program of care, including medications and treatments, at each federally required visit.

(5) Except as specified in subsections (6), (7), and (9) of this section, a physician may delegate tasks to a physician's assistant or advanced registered nurse practitioner who is:

(a) Licensed by the state;

(b) Acting within the scope of practice as defined by state law; and

(c) Under the supervision of the physician.

(6) The physician may not delegate a task when the delegation is prohibited under state law or by the facility's own policies.

(7) If the resident's primary payor source is Medicare, the physician may:

(a) Alternate federally required physician visits between personal visits by:

(i) The physician; and

(ii) An advanced registered nurse practitioner or physician's assistant; and

(b) Not delegate responsibility for the initial required physician visit. This initial visit must occur within the first thirty days of admission to the facility.

(8) If the resident's payor source is Medicaid, the physician may delegate any federally required physician task, including tasks which the regulations specify must be performed personally by the physician, to a physician's assistant or advanced registered nurse practitioner who is not an employee of the facility but who is working in collaboration with a physician.

(9) If the resident's payor source is not Medicare or Medicaid:

(a) In the Medicare only certified facility or in the Medicare certified area of a Medicare/Medicaid facility, the physician may alternate federally required physician visits between personal visits by the physician and an advanced registered nurse practitioner or physician's assistant. The physician may not delegate responsibility for the initial required physician visit.

(b) In the Medicaid only certified facility or in the Medicaid certified area of a Medicare/Medicaid facility, the physician may delegate any federally required physician task,

including tasks which the regulations specify must be performed personally by the physician, to a physician's assistant or advanced registered nurse practitioner who is not an employee of the facility but who is working in collaboration with a physician.

(10) The following table describes the physician visit requirements related to Medicare or Medicaid certified area and payor type.

	Beds in Medicare only certified area	Beds in Medicare/Medicaid certified area	Beds in Medicaid only certified area
Payor source: Medicare	Initial by physician; Physician may delegate alternate visits	Initial by physician; Physician may delegate alternate visits	N/A
Payor source: Medicaid	N/A	Delegate all tasks Nonemployee	Delegate all tasks Nonemployee
Payor source: Others: such as insurance, private pay, Veteran Affairs	Initial by physician; Physician may delegate alternate visits	Initial by physician; Physician may delegate alternate visits	Delegate all tasks Nonemployee

(11) The attending physician, or the physician-designated advanced registered nurse practitioner or physician's assistant must:

(a) Participate in the interdisciplinary plan of care process as described in WAC 388-97-090;

(b) Provide to the resident, or where applicable the resident's surrogate decision maker, information so that the resident can make an informed consent to care or refusal of care (see WAC 388-97-060); and

(c) Order resident self-medication when appropriate.

(12) The nursing home must obtain from the physician the following medical information before or at the time of the resident's admission:

(a) A summary or summaries of the resident's current health status, including history and physical findings reflecting a review of systems;

(b) Orders, as necessary for medications, treatments, diagnostic studies, specialized rehabilitative services, diet, and any restrictions related to physical mobility; and

(c) Plans for continuing care and discharge.

[Statutory Authority: RCW 18.51.070, 74.42.620, 74.42.200 and 42 C.F.R. 483.40, 04-23-085, § 388-97-125, filed 11/16/04, effective 12/17/04. Statutory Authority: RCW 18.51.070 and 74.42.620, 00-06-028, § 388-97-125, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-125, filed 9/15/94, effective 10/16/94.]

Specialized Habilitative and Rehabilitative Services

WAC 388-97-130 Specialized habilitative and rehabilitative services. (1) If specialized habilitative and rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must:

(a) Provide the required services; or

(b) Obtain the required services from an outside provider of specialized rehabilitative services.

(2) As determined by the resident's individualized comprehensive plan of care, qualified therapists, as defined in RCW 74.46.020(40), will provide specialized habilitative or

rehabilitative services under the written order of the physician. According to state law and at the qualified therapist's discretion, certain services may be delegated to and provided by support personnel under appropriate supervision.

(3) The nursing facility must:

(a) Ensure that residents who display mental or psychosocial adjustment difficulties receive appropriate treatment and services to correct the assessed problem; and

(b) Provide or arrange for the mental health or mental retardation services needed by residents that are of a lesser intensity than the specialized services defined at WAC 388-97-251.

(4) The nursing home may provide specialized rehabilitative and habilitative services to outpatients on the facility premises, only if the nursing home continues to also meet the needs of current residents.

[Statutory Authority: RCW 18.51.070 and 74.42.620, 00-06-028, § 388-97-130, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-130, filed 9/15/94, effective 10/16/94.]

Pharmacy Services

WAC 388-97-135 Pharmacy services. (1) The nursing home must:

(a) Obtain routine and emergency drugs and biologicals for its residents under an agreement with a licensed pharmacy;

(b) Ensure that pharmaceutical services:

(i) Meet the needs of each resident;

(ii) Establish and monitor systems for the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals; and

(c) Employ or obtain the services of a licensed pharmacist who must:

(i) Provide consultation on all aspects of the provision of pharmacy services in the nursing home;

(ii) Determine that nursing home drug records are in order;

(iii) Perform regular reviews at least once each month of each resident's drug therapy; and

(iv) Document and report drug irregularities to the attending physician and the director of nursing.

(2) Drugs and biologicals used in the nursing home must be labeled and stored in accordance with applicable state and federal laws.

(3) The nursing home must provide pharmaceutical services that:

(a) Meet recognized and accepted standards of pharmacy practice; and

(b) Comply with chapter 246-865 WAC, except nursing home staff administering drugs to residents may document administration at the time of pouring the drug or immediately after administration.

(4) The nursing home must ensure:

(a) Education and training for nursing home staff by the licensed pharmacist on drug-related subjects including, but not limited to:

(i) Recognized and accepted standards of pharmacy practice and applicable pharmacy laws and rules;

(ii) Appropriate monitoring of residents to determine desired effect and undesirable side effects of drug regimens; and

(iii) Use of psychotropic drugs.

(b) Reference materials regarding medication administration, adverse reactions, toxicology, and poison center information are readily available;

(c) Pharmacist monthly drug review reports are acted on in a timely and effective manner;

(d) Accurate detection, documentation, reporting and resolution of drug errors and adverse drug reactions; and

(e) Only individuals authorized by state law to do so will receive drug orders and administer drugs;

(5) The resident has the right to a choice of pharmacies when purchasing prescription and nonprescription drugs as long as the following conditions are met to ensure the resident is protected from medication errors:

(a) The medications are delivered in a unit of use compatible with the established system of the facility for dispensing drugs; and

(b) The medications are delivered in a timely manner to prevent interruption of dose schedule.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-135, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-135, filed 9/15/94, effective 10/16/94.]

Infection Control

WAC 388-97-140 Infection control. (1) The nursing home must:

(a) Establish and maintain an effective infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection;

(b) Prohibit any employee with a communicable disease or infected skin lesion from direct contact with residents or their food, if direct contact could transmit the disease; and

(c) Require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

(2) Under the infection control program, the nursing home must:

(a) Investigate, control and prevent infections in the facility;

(b) Decide what procedures should be applied in individual circumstances; and

(c) Maintain a record of incidence of infection and corrective action taken.

(3) Nursing home personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(4) The nursing home must develop and implement effective methods for the safe storage, transport and disposal of garbage, refuse and infectious waste, consistent with all applicable local, state, and federal requirements for such disposal.

(5) The nursing home must provide areas, equipment, and supplies to implement an effective infection control program and ensure:

(a) Ready availability of hand cleaning supplies and appropriate drying equipment or material at each sink;

(b) Safe use of disposable and single service supplies and equipment;

(c) Effective procedures for cleaning, disinfecting or sterilizing according to equipment use;

(d) Chemicals and equipment used for cleaning, disinfecting, and sterilizing, including chemicals used to launder personal clothing, are used in accordance with manufacturer's directions and recommendations; and

(e) Safe and effective procedures for disinfecting:

(i) All bathing and therapy tubs between each resident use; and

(ii) Swimming pools, spas and hot tubs.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-140, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-140, filed 9/15/94, effective 10/16/94.]

WAC 388-97-143 Influenza and pneumococcal immunizations. (1) The nursing home shall provide residents access on-site or make available elsewhere, the ability to obtain the influenza virus immunization on an annual basis.

(2) Upon admission, the nursing home shall inform residents or the resident's representative, verbally and in writing, of the benefits of receiving the influenza virus immunization and the pneumococcal disease immunization.

(3) Nursing homes who rely exclusively upon treatment by nonmedical religious healing methods, including prayer, are exempt from the above rules.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-23-030, § 388-97-143, filed 11/12/02, effective 12/13/02.]

WAC 388-97-147 Surveillance, management and early identification of individuals with active tuberculosis. (1) The nursing home must develop and implement policies and procedures that comply with nationally recognized tuberculosis standards set by the Centers for Disease Control (CDC), and applicable state law. Such policies and procedures include, but are not limited to, the following:

(a) Evaluation of any resident or employee with symptoms suggestive of tuberculosis whether tuberculin skin test results were positive or negative;

(b) Identifying and following up residents and personnel with suspected or actual tuberculosis, in a timely manner; and

(c) Identifying and following up visitors and volunteers with symptoms suggestive of tuberculosis.

(2) The nursing home must comply with chapter 49.17 RCW, Washington Industrial Safety and Health Act (WISHA) requirements to protect the health and safety of employees.

(3) The nursing home must ensure that tuberculosis screening is carried out as follows:

(a) Skin testing, whether documented historically or performed currently, must be by intradermal (Mantoux) administration of purified protein derivative (PPD) and read in forty-eight to seventy-two hours of administration, by trained personnel, and with results recorded in millimeters of induration;

(b) The nursing home must conduct tuberculin skin testing of residents and personnel, within three days of admission or hire, to establish tuberculosis status.

(c) The skin test must consist of a baseline two step test, given no more than one to three weeks apart, unless the individual meets the requirements in (d) or (e) of this subsection.

(d) An individual does not need to be skin tested for tuberculosis if he/she has:

(i) A documented history of a previous positive skin test results;

(ii) Documented evidence of adequate therapy for active disease; or

(iii) Documented evidence of adequate preventive therapy for infection.

(e) An individual needs to have only a one-step skin test upon admission or employment if:

(i) There was documented history of a negative result from previous two step testing; or

(ii) There was a documented negative result from one step skin testing in the previous twelve months.

(f) Annual one step skin testing for personnel, thereafter.

(4) If the skin test results in a positive reaction the nursing home must:

(a) Ensure that the individual has a chest X ray within seven days; and

(b) Evaluate each resident or employee, with a positive test result, for signs and symptoms of tuberculosis.

(5) Where tuberculosis is suspected, by presenting symptoms, or diagnosed, for a resident or an employee, the nursing home must:

(a) Notify the local public health officer so that appropriate contact investigation can be performed;

(b) Institute appropriate measures for the control of the transmission of droplet nuclei;

(c) Apply living or work restrictions where residents or personnel are, or may be, infectious and pose a risk to other residents and personnel; and

(d) Ensure that personnel caring for a resident with suspected tuberculosis comply with the WISHA standard for respiratory protection found in WAC 296-62-071.

(6) The nursing home must:

(a) Retain records of the tuberculin test results, reports of X-ray findings, physician or public health official orders, and declaration in the nursing home; and

(b) Retain employee tuberculin testing results for the duration of employment; and

(2007 Ed.)

(c) Provide the employee a copy of his/her testing results.

(7) The local health department may require additional tuberculin testing of residents or personnel as necessary for contact investigation.

(8) A resident or employee who has reason to decline skin testing may submit a signed statement to the nursing home giving the reason for declining and evidence to support the reason.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-147, filed 2/24/00, effective 3/26/00.]

WAC 388-97-155 Care of residents with active tuberculosis. (1) When the nursing home accepts the care of a resident with suspected or confirmed tuberculosis, the nursing home must:

(a) Coordinate the resident's admission, nursing home care, discharge planning, and discharge with the local health officer or officer designee;

(b) Provide necessary education about tuberculosis for staff, visitors, and residents; and

(c) Ensure that personnel caring for a resident with active tuberculosis comply with the WISHA standards for respiratory protection, WAC 246-62-071.

(2) For a resident who requires respiratory isolation for tuberculosis, the nursing home must:

(a) Provide a private or semiprivate isolation room:

(i) In accordance with WAC 388-97-33040;

(ii) In which, construction review of the department of health determines that room air is maintained under negative pressure; and appropriately exhausted, either directly to the outside away from intake vents or through properly designed, installed, and maintained high efficiency particulate air (HEPA) filters, or other measures deemed appropriate to protect others in the facility;

(iii) However, when a semiprivate isolation room is used, only residents requiring respiratory isolation for confirmed or suspected tuberculosis are placed together.

(b) Provide supplemental environment approaches, such as ultraviolet lights, where deemed to be necessary;

(c) Provide appropriate protective equipment for staff and visitors; and

(d) Have measures in place for the decontamination of equipment and other items used by the resident.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-155, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-155, filed 9/15/94, effective 10/16/94.]

Administration

WAC 388-97-160 General administration. (1) The nursing home must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(2) The nursing home must:

(a) Be licensed under chapter 18.51 RCW;

(b) Operate and provide services in compliance with:

(i) All applicable federal, state and local laws, regulations, and codes;

(ii) Accepted professional standards and principles that apply to professionals providing services in nursing homes; and

(c) Have a governing body or designated individuals functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the nursing home.

(3) The governing body of the nursing home must appoint the administrator who:

(a) Is licensed by the state;

(b) Is responsible for management of the nursing home;

(c) Keeps the licensee informed of all surveys and notices of noncompliance;

(d) Complies with all requirements of chapter 18.52 RCW, and all regulations adopted under that chapter;

(e) Is an on-site, full-time individual in active administrative charge at the premises of only one nursing home, a minimum of four days and an average of forty hours per week. Exception: On-site, full-time administrator with small resident populations or in rural areas will be defined as an individual in active administrative charge at the premises of only one nursing home:

(i) A minimum of four days and an average of twenty hours per week at facilities with one to thirty beds; or

(ii) A minimum of four days and an average of thirty hours per week at facilities with thirty-one to forty-nine beds.

(4) Nursing homes temporarily without an administrator may operate up to four continuous weeks under a responsible individual authorized to act as nursing home administrator designee.

(a) The designee must be qualified by experience to assume designated duties; and

(b) The nursing home must have a written agreement with a nursing home administrator, licensed in the state of Washington, who must be readily available to consult with the designee.

(c) The nursing home may request from the department's designated local aging and adult services administration (AASA) field office in writing, an extension of the four weeks by stating why an extension is needed, how a resident's safety or well-being is maintained during an extension and giving the estimated date by which a full-time, qualified nursing home administrator will be on-site.

(5) The nursing home must employ on a full-time, part time or consultant basis those professionals necessary to carry out the requirements of this chapter.

(6) If the nursing home does not employ a qualified professional individual to furnish a specific service to be provided by the nursing home, the nursing home must:

(a) Have that service furnished to residents by an individual or agency outside the nursing home under a written arrangement or agreement; and

(b) Ensure the arrangement or agreement referred to in (a) of this subsection specifies in writing that the nursing home assumes responsibility for:

(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in nursing homes; and

(ii) The timeliness of services.

(7) The nursing home must:

(a) Report to the local law enforcement agency and the department any individual threatening bodily harm or causing a disturbance which threatens any individual's welfare and safety;

(b) Identify, investigate, and report incidents involving residents, according to department established nursing home guidelines; and

(c) Comply with "whistle blower" rules as defined in chapter 74.34 RCW.

(8) The department will:

(a) Investigate complaints, made to the department according to established protocols including protocols described in RCW 74.39A.060;

(b) Take action against a nursing home that is found to have used retaliatory treatment toward a resident or employee who has voiced grievances to nursing home staff or administration, or lodged a good faith complaint with the department;

(c) Report to local law enforcement:

(i) Any mandated reporter that knowingly fails to report in accordance with WAC 388-97-076; and

(ii) Any person that intentionally, maliciously or in bad faith makes a false report of alleged abandonment, abuse, financial exploitation, or neglect of a vulnerable adult.

(9) Refer also to WAC 388-97-204, Retaliation.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-160, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-160, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-160, filed 9/15/94, effective 10/16/94.]

WAC 388-97-162 Required notification and reporting. (1) The nursing home must immediately notify the department's aging and adult services administration (AASA) of:

(a) Any allegations of resident abandonment, abuse, or neglect, including substantial injuries of an unknown source, financial exploitation and misappropriation of a resident's property;

(b) Any unusual event, having an actual or potential negative impact on residents, requiring the actual or potential implementation of the nursing home's disaster plan. These unusual events include but are not limited to those listed under WAC 388-97-185 (1)(a) through (k), and could include the evacuation of all or part of the residents to another area of the nursing home or to another address; and

(c) Circumstances which threaten the nursing home's ability to ensure continuation of services to residents.

(2) Mandated reporters must notify the department and law enforcement as directed in WAC 388-97-076, and according to department established nursing home guidelines.

(3) The nursing home must notify the department's AASA of:

(a) Physical plant changes, including but not limited to:

(i) New construction;

(ii) Proposed resident area or room use change;

(iii) Resident room number changes; and

(iv) Proposed bed banking;

(b) Mechanical failure of equipment important to the everyday functioning of the nursing home, which cannot be repaired within a reasonable time frame, such as an elevator; and

(c) An actual or proposed change of ownership (CHOW).

(4) The nursing home must notify, in writing, the department's AASA and each resident, of a loss of, or change in, the nursing home's administrator or director of nursing services at the time the loss or change occurs.

(5) The nursing home licensee must notify the department's AASA in writing of any change in the name of the licensee, or of the nursing home, at the time the change occurs.

(6) If a licensee operates in a building it does not own, the licensee must immediately notify the department of the occurrence of any event of default under the terms of the lease, or if it receives verbal or written notice that the lease agreement will be terminated, or that the lease agreement will not be renewed.

(7) The nursing home must report any case or suspected case of a reportable disease to the appropriate department of health officer and must also notify the appropriate department(s) of other health and safety issues, according to state and local laws.

(8) The nursing home licensee must notify the department in writing of a nursing home's voluntary closure.

(a) The licensee must send this written notification sixty days before closure to the department's designated local aging and adult administration office and to all residents and resident representatives.

(b) Relocation of residents must be in accordance with WAC 388-97-595(2).

(9) The nursing home licensee must notify the department in writing of voluntary termination of its Medicare or Medicaid contract.

(a) The license must send this written notification sixty days before contract termination, to the department's designated local aging and adult services administration office and to all residents and resident representatives.

(b) If the contractor continues to provide nursing facility services, the contract termination will be subject to federal law prohibiting the discharge of residents who are residing in the facility on the day before the effective date of the contract termination.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-162, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-162, filed 2/24/00, effective 3/26/00.]

WAC 388-97-165 Staff and equipment. (1) The nursing home must ensure that:

(a) Sufficient numbers of appropriately qualified and trained staff are available to provide necessary care and services safely under routine conditions, as well as fire, emergency, and disaster situations;

(b) Adequate equipment, supplies and space are available to carry out all functions and responsibilities of the nursing home;

(c) All staff, including management, provide care and services consistent with:

(i) Empowering each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, self-care and independence;

(ii) Respecting resident rights; and

(iii) Enhancing each resident's quality of life.

(2007 Ed.)

(2) The nursing home must ensure that any employee giving direct resident care, excluding professionally licensed nursing staff:

(a) Has successfully completed or is a student in a DSHS-approved nursing assistant training program; and

(b) Meets other requirements applicable to individuals performing nursing related duties in a nursing home, including those which apply to minors.

(3) The nursing home must ensure:

(a) Students in an DSHS-approved nursing assistant training program:

(i) Complete training and competency evaluation within four months of beginning work as a nursing assistant;

(ii) Complete at least sixteen hours of training in communication and interpersonal skills, infection control, safety/emergency procedures including the Heimlich maneuver, promoting residents' independence, and respecting residents' rights before any direct contact with a resident; and

(iii) Wear name tags which clearly identify student or trainee status at all times in all interactions with residents and visitors in all nursing homes, including the nursing homes in which the student completes clinical training requirements and in which the student is employed;

(b) Residents and visitors have sufficient information to distinguish between the varying qualifications of nursing assistants; and

(c) Each employee hired as a nursing assistant applies for registration with the department of health within three days of employment in accordance with chapter 18.88A RCW.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-165, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-165, filed 9/15/94, effective 10/16/94.]

WAC 388-97-170 Staff development. (1) The nursing home must have a staff development program that is under the direction of a designated registered nurse or licensed practical nurse.

(2) The nursing home must:

(a) Ensure each employee receives initial orientation to the facility and its policies and is initially assigned only to duties for which the employee has demonstrated competence;

(b) Ensure all employees receive appropriate inservice education to maintain a level of knowledge appropriate to, and demonstrated competence in, the performance of ongoing job duties consistent with the principle of assisting the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. To this end, the nursing home must:

(i) Assess the specific training needs of each employee and address those needs; and

(ii) Determine the special needs of the nursing home's resident population which may require training emphasis.

(c) Comply with other applicable training requirements, such as, but not limited to, the bloodborne pathogen standard.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-170, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-170, filed 9/15/94, effective 10/16/94.]

WAC 388-97-175 Medical director. (1) The nursing home must designate a physician to serve as medical director.

(2) The medical director is responsible for:

[Title 388 WAC—p. 525]

- (a) Implementation of resident care policies; and
- (b) The coordination of medical care in the facility.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-175, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-175, filed 9/15/94, effective 10/16/94.]

WAC 388-97-180 Clinical records. (1) The nursing home must:

(a) Maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

- (i) Complete;
- (ii) Accurately documented;
- (iii) Readily accessible; and
- (iv) Systematically organized.

(b) Safeguard clinical record information against alteration, loss, destruction, and unauthorized use; and

(c) Keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

- (i) Transfer to another health care institution;
- (ii) Law;
- (iii) Third party payment contract; or
- (iv) The resident.

(2) The nursing home must ensure the clinical record of each resident includes at least the following:

(a) Resident identification and sociological data, including the name and address of the individual or individuals the resident designates as significant;

(b) Medical information required under WAC 388-97-125;

- (c) Physician's orders;
- (d) Assessments;
- (e) Plans of care;
- (f) Services provided;

(g) In the case of the Medicaid-certified nursing facility, records related to preadmission screening and resident review;

- (h) Progress notes;
- (i) Medications administered;
- (j) Consents, authorizations, releases;
- (k) Allergic responses;
- (l) Laboratory, X ray, and other findings; and
- (m) Other records as appropriate.

(3) The nursing home must:

(a) Designate an individual responsible for the record system who:

(i) Has appropriate training and experience in clinical record management; or

(ii) Receives consultation from a qualified clinical record practitioner, such as a registered health information administrator or registered health information technician.

(b) Make all records available to authorized representatives of the department for review and duplication as necessary; and

(c) Maintain the following:

(i) A master resident index having a reference for each resident including the health record number, if applicable; full name; date of birth; admission dates; and discharge dates; and

(ii) A chronological census register, including all admissions, discharge, deaths and transfers, and noting the receiving facility. The nursing home must ensure the register includes discharges for social leave and transfers to other treatment facilities in excess of twenty-four hours.

(4) The nursing home must ensure the clinical record of each resident:

(a) Is documented and authenticated accurately, promptly and legibly by individuals giving the order, making the observation, performing the examination, assessment, treatment or providing the care and services. **"Authenticated"** means the authorization of a written entry in a record by signature, including the first initial and last name and title, or a unique identifier allowing identification of the responsible individual; and:

(i) Documents from other health care facilities that are clearly identified as being authenticated at that facility will be considered authenticated at the receiving facility; and

(ii) The original or a durable, legible, direct copy of each document will be accepted.

(b) Contains appropriate information for a deceased resident including:

- (i) The time and date of death;
- (ii) Apparent cause of death;
- (iii) Notification of the physician and appropriate resident representative; and
- (iv) The disposition of the body and personal effects.

(5) In cases where the nursing home maintains records by computer rather than hard copy, the nursing home must:

(a) Have in place safeguards to prevent unauthorized access; and

(b) Provide for reconstruction of information.

(6) The nursing home licensee must:

(a) Retain health records for the time period required in RCW 18.51.300:

(i) For a period of no less than eight years following the most recent discharge of the resident; except

(ii) That the records of minors must be retained for no less than three years following the attainment of age eighteen years, or ten years following their most recent discharge, whichever is longer.

(b) In the event of a change of ownership, provide for the orderly transfer of clinical records to the new licensee; and

(c) In the event a nursing home ceases operation, make arrangements prior to cessation, as approved by the department, for preservation of the clinical records. The nursing home licensee must provide a plan for preservation of clinical records to the department's designated local aging and adult administration (AASA) office no later than seven days after the date of notice of nursing home closure as required by WAC 388-97-162 (8) and (9) unless an alternate date has been approved by the department.

(d) Provide a resident access to all records pertaining to the resident as required under WAC 388-97-07005(2).

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-180, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-180, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-180, filed 9/15/94, effective 10/16/94.]

WAC 388-97-185 Disaster and emergency preparedness. (1) The nursing home must develop and implement

detailed written plans and procedures to meet potential emergencies and disasters. At a minimum the nursing home must ensure these plans provide for:

- (a) Fire or smoke;
- (b) Severe weather;
- (c) Loss of power;
- (d) Earthquake;
- (e) Explosion;
- (f) Missing resident, elopement;
- (g) Loss of normal water supply;
- (h) Bomb threats;
- (i) Armed individuals;
- (j) Gas leak, or loss of service; and
- (k) Loss of heat supply.

(2) The nursing home must train all employees in emergency procedures when they begin work in the nursing home, periodically review emergency procedures with existing staff, and carry out unannounced staff drills using those procedures.

(3) The nursing home must ensure emergency plans:

- (a) Are developed and maintained with the assistance of qualified fire, safety, and other appropriate experts as necessary;
- (b) Are reviewed annually; and
- (c) Include evacuation routes prominently posted on each unit.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-185, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-185, filed 9/15/94, effective 10/16/94.]

WAC 388-97-190 Quality assessment and assurance.

(1) The nursing home must maintain a process for quality assessment and assurance. The department may not require disclosure of the records of the quality assessment and assurance committee except in so far as such disclosure is related to ensuring compliance with the requirements of this section.

(2) The nursing home must ensure the quality assessment and assurance process:

- (a) Seeks out and incorporates input from the resident and family councils, if any, or individual residents and support groups; and
- (b) Reviews expressed concerns and grievances.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-190, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-190, filed 9/15/94, effective 10/16/94.]

WAC 388-97-195 Policies and procedures. (1) The nursing home must develop and implement written policies and procedures, including those specified in RCW 74.42.430, for all services provided in the facility.

(2) The nursing home must ensure the written policies and procedures:

- (a) Promote and protect each resident's:
 - (i) Rights, including health care decision making;
 - (ii) Personal interests; and
 - (iii) Financial and property interests;
- (b) Are readily available to staff, residents, members of residents' families, the public, and representatives of the department;
- (c) Are current, and continued without interruption in the event of staff changes; and

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(d) Are consistent with other state and federal laws applicable to nursing home operations.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-195, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-195, filed 9/15/94, effective 10/16/94.]

WAC 388-97-202 Criminal history disclosure and background inquiries. (1) A nursing home licensed under chapter 18.51 RCW must make a background inquiry request to one of the following:

- (a) The Washington state patrol;
- (b) The department;
- (c) The most recent employer licensed under chapters 18.51, 18.20, and 70.128 RCW provided termination of that employment was within twelve months of the current employment application and provided the inquiry was completed by the department or the Washington state patrol within the two years of the current date of application; or

(d) A nurse pool agency licensed under chapter 18.52C RCW, or hereafter renamed, provided the background inquiry was completed by the Washington state patrol within two years before the current date of employment in the nursing home; and

(e) A nursing home may not rely on a criminal background inquiry from a former employer, including a nursing pool, if the nursing home knows or has reason to know that the individual applying for the job has, or may have, a disqualifying conviction or finding.

(2) Nursing homes must:

(a) Request a background inquiry of any individual employed, directly or by agreement or contract, or accepted as a volunteer or student; and

(b) Notify appropriate licensing or certification agency of any individual resigning or terminated as a result of having a conviction record.

(3) Before a nursing home employs any individual, directly or by contract, or accepts any individual as a volunteer or student, a nursing home must:

(a) Inform the individual that the nursing home must make a background inquiry and require the individual to sign a disclosure statement, under penalty or perjury and in accordance with RCW 43.43.834;

(b) Inform the individual that he or she may make a request for a copy of a completed background inquiry of this section; and

(c) Require the individual to sign a statement authorizing the nursing home, the department, and the Washington state patrol to make a background inquiry; and

(d) Verbally inform the individual of the background inquiry results within seventy-two hours of receipt.

(4) The nursing home must establish procedures ensuring that:

(a) The individual is verbally informed of the background inquiry results within seventy-two hours of receipt;

(b) All disclosure statements and background inquiry responses and all copies are maintained in a confidential and secure manner;

(c) Disclosure statements and background inquiry responses are used for employment purposes only;

(d) Disclosure statements and background inquiry responses are not disclosed to any individual except:

[Title 388 WAC—p. 527]

(i) The individual about whom the nursing home made the disclosure or background inquiry;

(ii) Authorized state employees including the department's licensure and certification staff, resident protection program staff and background inquiry unit staff;

(iii) Authorized federal employees including those from the Department of Health and Human Services, Centers for Medicare and Medicaid Services;

(iv) The Washington state patrol auditor; and

(v) Potential employers licensed under chapters 18.51, 18.20, and 70.128 RCW who are making a request as provided for under subsection (1) of this section; and

(e) A record of findings be retained by the nursing home for twelve months beyond the date of employment termination.

(5) The nursing home must not employ individuals who are disqualified under the requirements of WAC 388-97-203.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-202, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-202, filed 2/24/00, effective 3/26/00.]

WAC 388-97-203 Disqualification from nursing home employment. (1) The nursing home must not employ directly or by contract, or accept as a volunteer or student, any individual:

(a) Who has been found to have abused, neglected, exploited or abandoned a minor or vulnerable adult by a court of law, by a disciplining authority, including the state department of health, or by the department's resident protection program;

(b) Against whom a finding of abuse, neglect, exploitation, misappropriation of property or abandonment has been entered on any state registry, including the nursing assistant registry; or

(c) Who has been subject to an order of protection under chapter 74.34 RCW for abandonment, abuse, neglect, or financial exploitation of a vulnerable adult, or misappropriation of resident property.

(2) Except as provided in this section, the nursing home must not employ directly or by contract, or accept as a volunteer or student, any individual who may have unsupervised access to residents if the individual:

(a) Has been convicted of a "crime against children and other persons" as defined in RCW 43.43.830, unless the individual has been convicted of one of the five crimes listed below and the required number of years has passed between the most recent conviction and the date of the application for employment:

(i) Simple assault, assault in the fourth degree, or the same offense as it may hereafter be renamed, and three or more years have passed;

(ii) Prostitution, or the same offense as it may hereafter be renamed, and three or more years have passed;

(iii) Theft in the second degree, or the same offense as it may hereafter be renamed, and five or more years have passed;

(iv) Theft in the third degree, or the same offense as it may hereafter be renamed, and three or more years have passed; or

(v) Forgery, or the same offense as forgery may hereafter be renamed, and five or more years have passed.

(b) Has been convicted of crimes relating to financial exploitation as defined under RCW 43.43.830.

(3) The term "vulnerable adult" is defined in RCW 74.34.020; the term "unsupervised access" is defined in RCW 43.43.830.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-203, filed 6/27/02, effective 7/28/02.]

WAC 388-97-204 Retaliation or discrimination prohibited. (1) The licensee or the nursing home must not discriminate or retaliate in any manner against a resident or employee in its nursing home who has initiated or participated in any action or proceeding authorized under nursing home licensing law. Examples of such participation include, but are not limited to the following:

(a) The resident, or someone acting on behalf of the resident, or the employee:

(i) Made a complaint, including a whistle blower complaint, to the department, the department of health, the long-term care ombudsman, attorney general's office, the courts or law enforcement;

(ii) Provided information to the department, the department of health, the long-term care ombudsman, attorney general's office, the courts or law enforcement; or

(iii) Testified in a proceeding related to the nursing home or its staff.

(2) For purposes of this chapter, "**retaliation**" or "**discrimination**" against a resident means an act including, but not limited to:

(a) Verbal or physical harassment or abuse;

(b) Any attempt to expel the resident from the facility;

(c) Nonmedically indicated social, dietary, or mobility restriction(s);

(d) Lessening of the level of care when not medically appropriate; or

(e) Nonvoluntary relocation within a nursing home without appropriate medical, psychosocial, or nursing justification;

(f) Neglect or negligent treatment;

(g) Withholding privileges;

(h) Monitoring resident's phone, mail or visits without resident's permission;

(i) Withholding or threatening to withhold food or treatment unless authorized by terminally ill resident or the resident's representative;

(j) Persistently delaying responses to resident's request for services of assistance; or

(k) Infringement on a resident's rights described in chapter 74.42 RCW, RCW 74.39A.060(7), WAC 388-97-051, and also, for Medicaid and Medicare certified nursing facilities, in federal laws and regulations.

(3) For purposes of this chapter, "**retaliation**" or "**discrimination**" against an employee means an act including, but not limited to:

(a) Harassment;

(b) Unwarranted firing;

(c) Unwarranted demotion;

(d) Unjustified disciplinary action;

(e) Denial of adequate staff to perform duties;

(f) Frequent staff changes;

(g) Frequent and undesirable office changes;

- (h) Refusal to assign meaningful work;
 - (i) Unwarranted and unsubstantiated report of misconduct under Title 18 RCW;
 - (j) Unsubstantiated letters of reprimand;
 - (k) Unsubstantiated unsatisfactory performance evaluations;
 - (l) Denial of employment;
 - (m) A supervisor or superior encouraging coworkers to behave in a hostile manner toward the whistle blower; or
 - (n) Workplace reprisal or retaliatory action as defined in RCW 74.34.180 (3)(b).
- (4) For purposes of this chapter, a "**whistle blower**" is defined in WAC 388-97-005.

(5) If, within one year of the complaint by or on behalf of a resident, the resident is involuntarily discharged from the nursing home, or is subjected to any type of discriminatory treatment, there will be a presumption that the action was in retaliation for the filing of the complaint. Under these circumstances, the nursing home will have the burden of establishing that the action was not retaliatory, in accordance with RCW 18.51.220 and 74.34.180(2).

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-204, filed 6/27/02, effective 7/28/02.]

Miscellaneous Services

WAC 388-97-205 Laundry services. (1) The nursing home must meet the requirements of WAC 388-97-347, and:

- (a) Launder nursing home linens on the premises; or
 - (b) Contract with a laundry capable of meeting quality standards, infection control, and turn-around time requirements; and
 - (c) Make provision for laundering of residents' personal clothing.
- (2) For residents' personal clothing, the nursing home:
- (a) Must have a system in place to ensure that personal clothing is not damaged or lost during handling and laundering; and
 - (b) May use a chemical disinfectant in lieu of hot water disinfection provided that the nursing home:
 - (i) Uses the product according to the manufacturer's instructions; and
 - (ii) Has readily available, current documentation from the manufacturer that supports the claim that the product is effective as a laundry disinfectant and such documentation is based on scientific studies or other rational data. "**Disinfectant**" means a germicide that inactivates virtually all recognized pathogenic microorganisms (but not necessarily all microbial forms, such as bacterial spores) on inanimate objects.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-205, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-205, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-205, filed 9/15/94, effective 10/16/94.]

WAC 388-97-212 Short-term care, including respite services and adult day or night care. (1) The nursing home may provide short-term care to individuals which include:

- (a) Respite services to provide relief care for families or other caregivers of individuals with disabilities which must:

- (i) Provide short-term care and supervision in substitution for the caregiver;
 - (ii) Be for short-term stays up to a maximum of thirty-one days; and
 - (iii) Not be used as a short-term placement pending the individual's admission to the nursing home; and
 - (b) Adult day or night care to provide short-term nursing home care:
 - (i) Not to exceed sixteen hours each day; and
 - (ii) May be on a regular or intermittent basis.
- (2) The nursing home providing respite services, and adult day or night care must:

- (a) Develop and implement policies and procedures consistent with this section;
- (b) Ensure that individuals receiving short-term services under respite or adult day or night care are treated and cared for in accordance with the rights and choices of long-term residents, except for transfer and discharge rights which are provided under the program for short-term services which covers the individual in the nursing home;
- (c) Have appropriate and adequate staff, space, and equipment to meet the individual's needs without jeopardy to the care of regular residents;
- (d) Before or at the time of admission, obtain sufficient information to meet the individual's anticipated needs. At a minimum, such information must include:

- (i) The name, address, and telephone number of the individual's attending physician, and alternate physician if any;
 - (ii) Medical and social history, which may be obtained from a respite care assessment and service plan performed by a case manager designated by an area agency on aging under contract with the department, and mental and physical assessment data; and
 - (iii) Physician's orders for diet, medication and routine care consistent with the individual's status on admission.
- (e) Ensure the individuals have assessments performed, where needed, and where the assessment of the individual reveals symptoms of tuberculosis, follow tuberculosis testing requirements under WAC 388-97-147;
- (f) With the participation of the individual and, where appropriate, their representative, develop a plan of care to maintain or improve their health and functional status during their stay or care in the nursing home;

- (g) Provide for the individual to:
 - (i) Bring medications from home in accordance with nursing home policy; and
 - (ii) Self-medicate where determined safe.
- (h) Promptly report injury, illness, or other adverse change in health condition to the attending physician; and
- (i) Inquire as to the need for and comply with any request of the individual, or where appropriate, the individual's representative, to secure cash and other valuables brought to the nursing home during the stay/care.

(3) The nursing home may, in lieu of opening a new record, reopen the individual's clinical record with each period of stay or care up to one year from the previous stay or care, provided the nursing home reviews and updates the recorded information.

- (4) Medicaid certified nursing facilities must complete the state-approved resident assessment instrument, within

fourteen days, for any individual whose respite stay exceeds fourteen days.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-212, filed 2/24/00, effective 3/26/00.]

WAC 388-97-220 Dialysis services. (1) The nursing home must ensure that appropriate care, treatment, and services are provided to each nursing home resident receiving dialysis. "Dialysis" means the process of separating crystalloids and colloids in solution by means of the crystalloids and colloids unequal diffusion through a natural or artificial semi-permeable membrane.

(2) Dialysis for acute renal failure must not be administered in a nursing home.

(3) A nursing home may only administer maintenance dialysis in the nursing home after the:

(a) Analysis of other options and elimination of these options based on the resident's best interest; and

(b) Decision is made jointly by a team of individuals representing the kidney center, the resident, the resident's nephrologist, and the nursing home. A "**kidney center**" means those facilities as defined and certified by the federal government to provide end stage renal (ESRD) services.

(4) The nursing home must ensure that:

(a) A current written agreement is in effect with each kidney center responsible for the management and care of each nursing home resident undergoing dialysis; and

(b) Such agreement delineates the functions, responsibilities, and services of both the kidney center and the nursing home.

(5) The kidney center must assist the nursing home in ensuring appropriate care, treatment, and services related to dialysis. Responsibilities of the kidney center must include, but not be limited to:

(a) The provision of clinical and chemical laboratory services;

(b) The services of a qualified dietitian;

(c) Social services;

(d) Preventative maintenance and emergency servicing of dialysis and water purification equipment;

(e) The certification and continuing education of dialysis helpers and periodic review and updating of dialysis helpers' competencies. A "dialysis helper" means an individual who has completed an inservice class approved by the kidney center and has been hired by the resident to provide to the resident care related only to the dialysis treatment;

(f) An in-hospital dialysis program for the care and treatment of a dialysis resident with a complication or acute condition necessitating hospital care;

(g) A continuing in-service education program for nursing home staff working with a dialysis resident;

(h) A program for periodic, on-site review of the nursing home's dialysis rooms;

(i) Selection, procurement, and installation of dialysis equipment;

(j) Selection and procurement of dialysis supplies;

(k) Proper storage of dialysis supplies; and

(l) Specification, procurement, and installation of the purification process for treatment of water used as a diluent in the dialyzing fluid.

(6) Only a registered nurse from the kidney center or a dialysis helper may administer dialysis in the nursing home.

(a) A dialysis helper may be a registered nurse; and

(b) When a dialysis helper is not a registered nurse, the nursing home must have a registered nurse who has completed an in-service class approved by the kidney center, on the premises during dialysis.

(7) A physician, designated or approved by the kidney center, must be on call at all times dialysis is being administered in the nursing home.

(8) The resident's attending physician and the kidney center must provide, or direct and supervise, the continuing medical management and surveillance of the care of each nursing home resident receiving dialysis.

(9) The nursing home must:

(a) Ensure the kidney center develops a dialysis treatment plan; and

(b) Incorporate this treatment plan into the resident's comprehensive plan of care and include specific medical orders for medications, treatment, and diet.

(10) The dialysis room in the nursing home must be in compliance with federal standards established for ESRD facilities. This includes:

(a) Storage space available for equipment and supplies;

(b) A telephone at the bedside of each dialysis resident; and

(c) A mechanical means of summoning additional staff to the dialysis area in the event of a dialysis emergency.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-220, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-220, filed 9/15/94, effective 10/16/94.]

Preadmission Screening and Resident Review (Pasrr) in Medicaid Certified Facilities

WAC 388-97-247 Preadmission screening—Level I.

(1) Preadmission screening (PAS) is a process by which individuals are evaluated:

(a) For the presence of a serious mental illness or a developmental disability, before admission to the nursing facility;

(b) For nursing facility level of care; and

(c) If the individual does have either a serious mental illness or a developmental disability, to determine whether there is a need for specialized services, or services of a lesser intensity.

(2) The referring hospital, physician, or other referral source must:

(a) Perform the identification screen using a standardized department-specified Level I screening form for all individuals seeking admission to a nursing facility unless they:

(i) Are being readmitted to the nursing facility from the hospital; or

(ii) Are being transferred from one nursing facility to another, with or without an intervening hospital stay.

(b) Identify whether the individual may have a serious mental illness or a developmental disability as defined under 42 C.F.R. § 483.102, or successor laws; and

(c) Refer all individuals identified as likely to have a serious mental illness or a developmental disability to the

department for a nursing facility level of care assessment and a Level II screening.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-247, filed 2/24/00, effective 3/26/00.]

WAC 388-97-249 Advanced categorical determinations, not subject to preadmission screening—Level II. Individuals identified as having symptoms of mental illness or a developmental disability and meeting any of the advanced categorical determinations do not need to be referred for a Level II screening. The determinations include that the individual:

(1) Is admitted to the nursing facility for respite care as defined under WAC 388-97-212, or convalescent care, following treatment in an acute care hospital, not to exceed thirty days;

(2) Cannot accurately be diagnosed because of delirium. NOTE: The individual would be subject to a Level II screening when the delirium cleared;

(3) Has been certified by a physician to be terminally ill as defined under section 1861 (dd)(3)(A) of the Social Security Act;

(4) Has been diagnosed with a severe physical illness such as coma, ventilator dependence, and is functioning at a brain stem level;

(5) Has a severe level of impairment from diagnoses such as:

(a) Chronic obstructive pulmonary disease;

(b) Parkinson's disease;

(c) Huntington's chorea;

(d) Amyotrophic lateral sclerosis;

(e) Congestive heart failure; or

(6) Has a primary diagnosis of dementia, including Alzheimer's disease or a related disorder. NOTE: There must be evidence to support this determination.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-249, filed 2/24/00, effective 3/26/00.]

WAC 388-97-251 Preadmission screening—Level II.

(1) For individuals likely to have a serious mental illness or developmental disability, the department must determine their need for nursing facility level of care. If they meet the nursing facility level of care, the department refers them to the department's designee, either the mental health PASRR contractor or the division of developmental disabilities, for a Level II screening.

(2) In the Level II screening, the department's designee will verify the diagnosis and determine whether the referred individuals need specialized services, or services of a lesser intensity:

(a) **"Specialized services"** for an individual with mental retardation or related conditions is defined under 42 C.F.R. § 483.120 (a)(2), and § 483.440 (a)(1), or successor laws. These specialized services do not include services to maintain a generally independent individual able to function with little supervision or in the absence of a treatment program; and

(b) **"Specialized services"** for an individual with a serious mental illness is defined under 42 C.F.R. § 483.120 (a)(1), or successor laws. These services are generally con-

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sidered acute psychiatric inpatient care, emergency respite care, or stabilization and crisis services.

(3) The need for specialized services, for a nursing facility applicant, will be determined as follows:

(a) If the individual is identified as likely to have a serious mental illness, a qualified mental health professional will verify whether the individual has a serious mental illness and, if so, will recommend whether the individual needs specialized services; and

(b) If the individual is identified as likely to have a developmental disability, a licensed psychologist will verify whether the individual has a developmental disability and, if so, staff of the division of developmental disabilities will assess and determine whether the individual requires specialized services.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-251, filed 2/24/00, effective 3/26/00.]

WAC 388-97-253 Resident review. After a resident's admission the nursing facility must:

(1) Review the Level I screening form for accuracy and make changes as needed if the resident develops a qualifying diagnosis or if the resident's symptoms were undetected or misdiagnosed; and

(2) Refer residents who have qualifying diagnoses and who require further PASRR assessment to the mental health PASRR contractor or division of development disabilities;

(3) Record the identification screen information or subsequent changes on the resident assessment instrument according to the schedule required under 42 C.F.R. § 483.20;

(4) Maintain the identification screen form and PASRR assessment information, including recommendations, in the resident's active clinical record; and

(5) Promptly notify the mental health PASRR contractor or division of developmental disabilities after a significant change in the physical or mental condition of any resident that is mentally ill or mentally retarded.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-253, filed 2/24/00, effective 3/26/00.]

WAC 388-97-260 Preadmission screening and resident review (PASRR) determination and appeal rights.

(1) The resident has the right to choose to remain in the nursing facility and receive specialized services if:

(a) He or she has continuously resided in a nursing facility since October 1, 1987; and

(b) The department determined, in 1990, that the resident required specialized services for a serious mental illness or developmental disability but did not require nursing facility services.

(2) In the event that residents chose to remain in the nursing facility as outlined in subsection (1) above, the department, or designee, will clarify the effect on eligibility for Medicaid services under the state plan if the resident chooses to leave the facility, including its effect on readmission to the facility.

(3) An individual applying for admission to a nursing facility or a nursing facility resident who has been adversely impacted by a PASRR determination may appeal the department's determination that the individual is:

(a) Not in need of nursing facility care as defined under WAC 388-71-0700;

(b) Not in need of specialized services as defined under WAC 388-97-251; or

(c) Need for specialized services as defined under WAC 388-97-251.

(4) The nursing facility must assist the individual applying for admission or resident, as needed, in requesting a hearing to appeal the department's PASRR determination.

(5) If the department's PASRR determination requires that a resident be transferred or discharged, the department will:

(a) Provide the required notice of transfer or discharge to the resident, the resident's surrogate decision maker, and if appropriate, a family member or the resident's representative thirty days or more before the date of transfer or discharge;

(b) Attach a hearing request form to the transfer or discharge notice;

(c) Inform the resident, in writing in a language and manner the resident can understand, that:

(i) An appeal request may be made any time up to ninety days from the date the resident receives the notice of transfer or discharge;

(ii) Transfer or discharge will be suspended when an appeal request is received by the office of administrative hearings on or before the date of transfer or discharge set forth in the written transfer or discharge notice; and

(iii) The resident will be ineligible for Medicaid nursing facility payment:

(A) Thirty days after the receipt of written notice of transfer or discharge; or

(B) If the resident appeals under subsection (1)(a) of this section, thirty days after the final order is entered upholding the department's decision to transfer or discharge a resident.

(6) The department's home and community services may pay for the resident's nursing facility services after the time specified in subsection (5)(c)(iii) of this section, if the department determines that a location appropriate to the resident's medical and other needs is not available.

(7) The department will:

(a) Send a copy of the transfer/discharge notice to the resident's attending physician, the nursing facility and, where appropriate, a family member or the resident's representative;

(b) Suspend transfer or discharge:

(i) If the office of administrative hearings receives an appeal on or before the date set for transfer or discharge or before the resident is actually transferred or discharged; and

(ii) Until the office of appeals makes a determination; and

(c) Provide assistance to the resident for relocation necessitated by the department's PASRR determination.

(8) Resident appeals of PASRR determinations will be in accordance with 42 C.F.R. § 431 Subpart E, chapter 388-02 WAC, and the procedures defined in this section. In the event of a conflict between a provision in this chapter and a provision in chapter 388-02 WAC, the provision in this chapter will prevail.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-260, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-260, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-260, filed 9/15/94, effective 10/16/94.]

Intermediate Care Facilities for the Mentally Retarded

WAC 388-97-285 Intermediate care facilities for the mentally retarded (ICF/MR). (1) ICF/MR nursing facilities must meet the requirements of 42 C.F.R. § 483 Subpart I and the requirements of this subchapter except that in an ICF/MR nursing facility:

(a) There must be at least one registered nurse or licensed practical nurse on duty eight hours per day, and additional licensed staff on any shift if indicated. WAC 388-97-115 (2)(a) and (3)(a) and (b) do not apply to ICF/MR nursing facilities; and

(b) A medical director is not required.

(2) Staff from the division of developmental disabilities will approve of social/therapeutic leave for individuals who reside in ICF/MR nursing facilities.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-285, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-285, filed 2/24/00, effective 3/26/00.]

SUBCHAPTER II PHYSICAL ENVIRONMENT

General

WAC 388-97-295 Design. The design of a nursing home must facilitate resident-centered care and services in a safe, clean, comfortable and homelike environment that allows the resident to use his or her personal belongings to the greatest extent possible.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-295, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-295, filed 9/15/94, effective 10/16/94.]

WAC 388-97-29510 New construction compliance. The nursing home must ensure that:

(1) New construction complies with all the requirements of subchapter II;

(2) New construction approved by the department of health, certificate of need and construction review, before the effective date of this chapter complies with the rules in effect at the time of the plan approval;

(3) The department of health, certificate of need and construction review, is contacted for review and issues an applicable determination and approval for all new construction; and

(4) The department has done a pre-occupancy survey and has determined that the new construction is in compliance with these regulations before the area is placed in use.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-29510, filed 2/24/00, effective 3/26/00.]

WAC 388-97-29520 Fire standards and approval, and other standards. The nursing home must:

(1) Conform to at least the minimum standards for the prevention of fire, and for the protection of life and property against fire, according to the Uniform Fire Code, RCW 19.27.031, the federal Life Safety Code, and additional state guidelines in chapter 212-12 WAC; and

(2) Comply with all other applicable requirements of state and federal law.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-29520, filed 2/24/00, effective 3/26/00.]

WAC 388-97-29530 Maintenance and repair. All nursing homes must:

- (1) Maintain electrical, mechanical, and patient care equipment in safe and operating condition; and
- (2) Ensure floors, walls, ceilings, and equipment surfaces are maintained in clean condition and in good repair.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-29530, filed 2/24/00, effective 3/26/00.]

WAC 388-97-29540 Noise. (1) All nursing homes must maintain comfortable sound levels, to include minimizing the use of the public address system and taking reasonable precautions with noisy services so residents are not disturbed, particularly during their sleeping time; and

(2) **In new construction**, the nursing home must:

- (a) Have walls, floor/ceiling and roof/ceiling assemblies constructed with materials that provide comfortable sound levels in all resident areas, rated at an STC 50 or greater; and
- (b) Utilize an alternative to the public address system for nonemergency communication that best serves the residents' needs.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-29540, filed 2/24/00, effective 3/26/00.]

WAC 388-97-29550 Accessibility in new construction. The nursing home must be readily accessible to a person with disability and comply with WAC 388-97-410.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-29550, filed 2/24/00, effective 3/26/00.]

WAC 388-97-29560 Types of new construction. New construction includes, but is not limited to:

- (1) New structures.
 - (a) A new building to be licensed as a nursing home; or
 - (b) An addition to a building currently licensed as a nursing home.
- (2) Existing buildings.
 - (a) Conversion of another building to a nursing home;
 - (b) Change in the use of space for access by residents within an existing nursing home; and
 - (c) Alterations including physical, mechanical, or electrical changes made to an existing nursing home, except for normal routine maintenance and repair.
- (3) See WAC 388-97-400(3) for less extensive alterations.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-29560, filed 2/24/00, effective 3/26/00.]

WAC 388-97-310 ICF/MR exceptions to physical plant requirements. The following regulations do not apply to nursing homes certified exclusively under 42 C.F.R. § 483, Subpart I, or successor laws.

- (1) WAC 388-97-33020, regarding the required number of square feet per bed; and
- (2) WAC 388-97-33570, regarding cubicle curtains.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-310, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-310, filed 9/15/94, effective 10/16/94.]

(2007 Ed.)

WAC 388-97-315 Emergency power. (1) The nursing home must have an alternate source of power and automatic transfer equipment to connect the alternate source within ten seconds of the failure of the normal source.

(2) The nursing home must ensure the alternate source is a generator:

- (a) With on-site fuel supply;
- (b) Permanently fixed in place;
- (c) Approved for emergency service; and
- (d) An on premises emergency generator, as defined in NFPA 99, Health care facilities, when life support systems are used.

(3) The nursing home must ensure the emergency power supply provides a minimum of four hours of effective power for lighting for night lights, exit signs, exit corridors, stairways, dining and recreation areas, work stations, medication preparation areas, boiler rooms, electrical service room and emergency generator locations.

(4) A nursing home first licensed on or after October 1, 1981, must have emergency power supplied to:

- (a) Communication systems, all alarm systems, an elevator that reaches every resident floor including the ground floor, equipment to provide heating for resident rooms or a room to which all residents can be moved; and
- (b) Electrical outlets located in medication preparation areas, pharmacy dispensing areas, staff work stations, dining areas, resident corridors, and resident bed locations designated for use with life support systems.

(5) **In new construction** the emergency power equipment must meet the:

- (a) Earthquake standards for the facility's geographic locale; and
- (b) Requirements in NFPA 110, Generators.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-315, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-315, filed 9/15/94, effective 10/16/94.]

Resident Care Unit

WAC 388-97-325 Location of the resident care unit. The nursing home must ensure that:

- (1) Each resident care unit is located to minimize through traffic to any general service, diagnostic, treatment, or administrative area; and
- (2) **In new construction**, the resident care unit, and the services to support resident care and nursing needs, are designed to serve a maximum of sixty beds on the same floor.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-325, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-325, filed 9/15/94, effective 10/16/94.]

WAC 388-97-32510 Required service areas on resident care units. (1) The nursing home must ensure each resident care unit has at least the following required service areas:

- (a) A staff work station;
- (b) A medicine storage and preparation area;
- (c) A utility room that maintains separated clean and soiled functions;
- (d) Storage space for linen, other supplies, and equipment; and

[Title 388 WAC—p. 533]

(e) Housekeeping services and janitor's closet.

(2) **In new construction** resident care units may share required services if the units are in close proximity to each other and the combined units serve a total of not more than sixty residents; except the nursing home must have a separate staff work station on a secured dementia care unit.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-32510, filed 2/24/00, effective 3/26/00.]

WAC 388-97-32520 Staff work stations on resident care units. (1) On each unit, the nursing home must have a staff work station appropriate to the needs of staff using the space. At a minimum, the nursing home must equip the area with:

- (a) A charting surface;
- (b) A rack or other storage for current health records;
- (c) Storage for record and clerical supplies;
- (d) A telephone;
- (e) A resident call system; and
- (f) A clock.

(2) **In new construction** the work station space must be open to the corridor.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-32520, filed 2/24/00, effective 3/26/00.]

WAC 388-97-32530 Call systems on resident care units. The nursing home must provide the following, or an equivalent system that meets these standards:

(1) A wired or wireless communication system which registers a call by distinctive light at the room door and by distinctive light and audible tone at the staff work station. The system must be equipped to receive resident calls from:

- (a) The bedside of each resident;
- (b) Every common area, dining and activity areas, common use toilet rooms, and other areas used by residents; and
- (c) Resident toilet, bath and shower rooms.

(2) An emergency signal device activated by a nonconductive pull cord, or adapted to meet the needs of the resident. The nursing home must locate the signal device for easy reach by the resident. A signal device must be adapted to meet resident needs and, in the dementia unit, may be adapted for staff and family use, see WAC 388-97-35050.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-32530, filed 2/24/00, effective 3/26/00.]

WAC 388-97-32540 Telephones on resident care units. The nursing home must provide twenty-four hour access to a telephone for resident use which:

- (1) Provides auditory privacy;
- (2) Is accessible to a person with a disability and accommodates a person with sensory impairment;
- (3) Is not located in a staff office or at a nurse's station; and
- (4) Does not require payment for local calls.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-32540, filed 2/24/00, effective 3/26/00.]

WAC 388-97-32550 Utility service rooms on resident care units. (1) All nursing homes must:

[Title 388 WAC—p. 534]

(a) Provide utility rooms designed, equipped, and maintained to ensure separation of clean and sterile supplies and equipment from those that are contaminated;

(b) Ensure that each clean utility room has:

- (i) A work counter;
- (ii) A sink equipped with single use hand drying towels and soap for handwashing; and
- (iii) Closed storage units for supplies and small equipment; and

(c) Ensure that each soiled utility room has:

- (i) A work counter and a sink large enough to totally submerge the items being cleaned and disinfected;
- (ii) Storage for cleaning supplies and other items, including equipment, to meet nursing home needs;
- (iii) Locked storage for cleaning agents, disinfectants and other caustic or toxic agents;
- (iv) Adequate space for waste containers, linen hampers, and other large equipment; and
- (v) Adequate ventilation to remove odors and moisture.

(2) **In new construction:**

(a) A resident room must not be more than ninety feet from a clean utility room and a soiled utility room;

(b) The clean utility room and the soiled utility room must be separate rooms;

(c) Each soiled utility room must contain:

(i) A double-compartment sink with inside dimensions of each compartment deep enough to totally submerge items being cleaned and disinfected;

(ii) Sufficient, available work surface on each side of the sink to adequately process and dry equipment with a minimum of three feet of work surface on the clean side;

(iii) Drying/draining racks for wet equipment;

(iv) Work counters, sinks, and other fixed equipment arranged to prevent intermingling of clean and contaminated items during the cleaning process; and

(v) A siphon jet type clinic service sink or equivalent installed on the soiled side of the utility room away from the door.

(d) The nursing home's space for waste containers, linen hampers, and other large equipment, must not block work areas; and

(e) The utility rooms must meet the ventilation requirements of Table 5, WAC 388-97-47020.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-32550, filed 2/24/00, effective 3/26/00.]

WAC 388-97-32560 Drug facilities on resident care units. The nursing home must provide an area designed and equipped for drug preparation and locked storage convenient to each work station. The nursing home must ensure:

(1) The drug facilities are well illuminated, ventilated, and equipped with a work counter, sink with hot and cold running water, and drug storage units;

(2) The drug storage units are one or more of the following:

(a) Locked cabinetry constructed in accordance with board of pharmacy regulations for drug storage which has:

(i) Separately keyed storage for Schedule II and III controlled substances; and

(ii) Segregated storage of different residents' drugs, or

(2007 Ed.)

(b) An automated medication distribution device or storage.

(3) There is a refrigerator for storage of thermolabile drugs in the drug facility;

(4) Locks and keys for drug facilities are different from other locks and keys within the nursing home; and

(5) **In new construction**, the drug facility must be a separate room.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-32560, filed 2/24/00, effective 3/26/00.]

WAC 388-97-32570 Linen storage on resident care units. The nursing home must provide:

(1) A clean area for storage of clean linen and other bedding. This may be an area within the clean utility room;

(2) A soiled linen area for the collection and temporary storage of soiled linen. This may be within the soiled utility room; and

(3) **In new construction**, storage for linen barrels and clean linen carts.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-32570, filed 2/24/00, effective 3/26/00.]

WAC 388-97-32580 Janitors closets on resident care units. (1) The nursing home must have a janitors closet with a service sink and adequate storage space for housekeeping equipment and supplies convenient to each resident unit.

(2) **In new construction** a janitor's closet must meet the ventilation requirements of Table 5, WAC 388-97-47020.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-32580, filed 2/24/00, effective 3/26/00.]

Resident Rooms

WAC 388-97-330 Resident rooms. (1) The nursing home must ensure that each resident bedroom:

(a) Has direct access to a hall or corridor;

(b) Is located on an exterior wall with a transparent glass window; and

(c) Is located to prevent through traffic.

(2) **In a new building or addition**, each resident bedroom must:

(a) Have an exterior transparent glass window:

(i) With an area equal to at least one-tenth of the bedroom usable floor area;

(ii) Located twenty-four feet or more from another building or the opposite wall of a court, or ten feet or more away from a property line, except on street sides;

(iii) Located eight feet or more from any exterior walkway, paved surface, or driveway; and

(iv) With a sill three feet or less above the floor.

(b) Be located on a floor level at or above grade level except for earth berms. "Grade" means the level of ground adjacent to the building floor level measured at the required exterior window. The ground must be level or slope downward for a distance of at least ten feet from the wall of the building. From there the ground may slope upward to the maximum sill height of the required window at a rate of one foot vertical for two feet horizontal.

(2007 Ed.)

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-330, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-330, filed 9/15/94, effective 10/16/94.]

WAC 388-97-33010 Capacity of resident rooms. (1) The nursing home must ensure that any resident bedroom has:

(a) No more than two beds between any resident bed and exterior window wall; and

(b) A maximum capacity of four beds.

(2) **In a new building, addition, or change of use to a resident bedroom** the maximum capacity is two beds per room, for plans submitted after September 1, 1995.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33020 Size of resident rooms. The nursing home must ensure that minimum usable room space exclusive of toilet rooms, closets, lockers, wardrobes, must:

(1) In existing facilities, be at least eighty square feet per bed in each multibed room and at least one hundred square feet for each single bed room;

(2) **In a new building or addition**, be one-hundred and ten square feet per bed in multibed rooms, and one-hundred square feet in single bed rooms;

(3) **In new construction**, ensure that the minimum usable room space is also exclusive of vestibules; and

(4) For exceptions to room size requirements refer to WAC 388-97-310.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33030 Privacy in resident rooms. The nursing home must ensure that each resident bedroom is designed or equipped to ensure full visual privacy for each resident.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33040 Resident isolation rooms. If a nursing home provides an isolation room, the nursing home must ensure the room is uncarpeted and contains:

(1) A handwashing sink with water supplied through a mixing valve;

(2) Its own adjoining toilet room containing a bathing facility; and

(3) **In new construction**, the handwashing sink must be located between the entry door and the nearest bed.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33050 Resident room size variance. The director of residential care services, aging and adult services administration, or their designee, may permit exceptions to WAC 388-97-33010 (1)(a) and 388-97-33020(1) when the nursing home demonstrates in writing that the exception:

(1) Is in accordance with the special needs of the resident; and

(2) Will not adversely affect any resident's health or safety.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33050, filed 2/24/00, effective 3/26/00.]

Resident Room Equipment

WAC 388-97-335 Resident room equipment. The nursing home must determine a resident's furniture and equipment needs at the time of admission and routinely thereafter to ensure resident comfort. Except as specified in WAC 388-97-07060, the nursing home must provide each resident with the following items required in WAC 388-97-33510 through 388-97-33580.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-335, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-335, filed 9/15/94, effective 10/16/94.]

WAC 388-97-33510 Resident bed and bedside equipment. The nursing home must provide:

- (1) A comfortable bed of size and height to maximize a resident's independent functioning. Beds may be arranged to satisfy the needs and desires of the individual resident provided the arrangement does not negatively impact the health or safety of other residents;
- (2) Appropriate bedding; and
- (3) A bedside cabinet that allows for storage of small personal articles and a separate drawer or enclosed compartment for storage of resident care utensils/equipment.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33510, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33520 Lockable storage space in a resident room. The nursing home must provide:

- (1) A lockable storage space accessible to each resident for storage of small personal items, upon request; and
- (2) **In a new building or addition**, a lockable cabinet space or drawer for storage of personal belongings for each resident bed, in addition to the bedside cabinet.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33520, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33530 Wardrobes in a resident room. The nursing home must provide:

- (1) A separated, enclosed wardrobe or closet for each resident's clothing and belongings accessible to the resident; and
- (2) **In a new building or addition**, each bed in each room must have a separate, enclosed wardrobe or closet accessible to the resident with:

(a) Minimum inside dimensions of twenty-two inches deep by a minimum of twenty-six inches wide by sixty inches high; and

(b) Inside space including a rod, at least fifteen inches long, and allowing for fifty-four inches of clear hanging length adjustable to meet the needs of the resident.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33530, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33540 Seating in a resident room. The nursing home must provide comfortable seating for residents and visitors, not including resident care equipment, that provides proper body alignment and support.

[Title 388 WAC—p. 536]

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33540, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33550 Lighting in resident rooms. The nursing home must provide a permanently mounted or equivalent light suitable for any task the resident chooses to do or any task the staff must do.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33550, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33560 Call signal device in resident rooms. The nursing home must provide a resident call signal device that complies with WAC 388-97-32530.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33560, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33570 Cubicle curtains in resident rooms. The nursing home must provide:

- (1) Flame-retardant cubicle curtains in multibed rooms that ensures full visual privacy for each resident;
- (2) **In a new building or addition**, the cubicle curtain or enclosed space ensures full visual privacy for each bed in a multibed room with enclosed space containing at least sixty-four square feet of floor area with a minimum dimension of seven feet. "Full visual privacy" in a multibed room prevents staff, visitors and other residents from seeing a resident in bed, while allowing staff, visitors, and other residents access to the toilet room, handwashing sink, exterior window, and the entrance door;
- (3) For exceptions to cubicle curtain requirements refer to WAC 388-97-310.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33570, filed 2/24/00, effective 3/26/00.]

WAC 388-97-33580 Miscellaneous equipment in resident rooms in a new building or addition. The nursing home must provide:

- (1) A phone jack for each bed in each room;
- (2) A handwashing sink in each multibed room and a handwashing sink in each single room that does not have an adjoining toilet room containing a handwashing sink. A handwashing sink located in a resident bedroom must be located between the corridor entry door and the nearest resident bed; and
- (3) Storage that meets the requirements of WAC 388-97-357, 388-97-35710, and 388-97-35720.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-33580, filed 2/24/00, effective 3/26/00.]

Resident Toilet and Bathing Facilities

WAC 388-97-340 Resident toilet facilities or rooms. The nursing home must ensure that:

- (1) Each resident room is equipped with or located convenient to toilet facilities.
- (2) **For new construction**, a toilet room must:
 - (a) Be directly accessible from each resident room and from each bathing facility without going through or entering a general corridor while maintaining resident dignity;
 - (b) Serve two bedrooms or less;

(2007 Ed.)

- (c) Be designed to accommodate a person in a wheelchair;
- (d) Contain at least one handwashing sink; and
- (e) Provide a properly located and securely mounted grab bar at each side and the back of each toilet fixture in each toilet room and stall. Grab bars on the open side must be located twelve to eighteen inches from the center line of the toilet. Grab bars on the open side must be able to swing up.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-340, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-340, filed 9/15/94, effective 10/16/94.]

WAC 388-97-34010 Resident bathing facilities or rooms. The nursing home must ensure:

- (1) Each resident room is equipped with or located near bathing facilities;
- (2) At least one bathing unit for no more than thirty residents that is not located in a room served by an adjoining bathroom;
- (3) At least one bathing device for immersion per floor;
- (4) At least one roll in shower or equivalent on each resident care unit:
 - (a) Designed and equipped for unobstructed ease of shower chair entry and use; and
 - (b) With a spray attachment equipped with a backflow prevention device.
- (5) Resident bathing equipment is smooth, cleanable, and able to be disinfected after each use.
- (6) **For new construction**, in each bathing unit containing more than one bathing facility:
 - (a) Each bathtub, shower, or equivalent, is located in a separate room or compartment with three solid walls;
 - (b) The entry wall may be a "shower" type curtain or equivalent;
 - (c) The area for each bathtub and shower is sufficient to accommodate a shower chair, an attendant, and provide visual privacy for bathing, drying, and dressing;
 - (d) Shower and tub surfaces are slip-resistant;
 - (e) Bathing areas are constructed of materials that are impervious to water and cleanable; and
 - (f) Grab bars are installed on all three sides of a shower with the shower head grab bar being "L" shaped.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-34010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-34020 Locks in toilet and bathing facilities. The nursing home must ensure:

- (1) All lockable toilet facilities and bathrooms have a readily available means of unlocking from the outside; and
- (2) Locks are operable from the inside with a single motion.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-34020, filed 2/24/00, effective 3/26/00.]

Dining, Dayrooms, and Resident Activity Areas

WAC 388-97-345 Dining, dayrooms, and resident activity areas. (1) The nursing home must provide one or more rooms designated for resident dining and activities that are:

- (a) Well lighted;

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- (b) Well ventilated;
- (c) Adequately furnished; and
- (d) Large enough to accommodate all activities.

(2) **In a new building or addition**, the nursing home must design space for dining rooms, dayrooms, and activity areas for resident convenience and comfort and to provide a homelike environment. These areas must be located on the same floor as the residents who will use the areas. The nursing home must:

- (a) Ensure these rooms or areas are exterior rooms with windows that have a maximum sill height of thirty-six inches;
- (b) Provide space for dining, day use, and activities with a minimum combined total of thirty square feet for each licensed bed;
- (c) Design any multipurpose rooms to prevent program interference with each other;
- (d) Locate a day room on each resident care unit;
- (e) Provide storage spaces for all activity and recreational equipment and supplies, adjoining or adjacent to the facilities provided; and
- (f) Locate a common use toilet facility, with handwashing sink and accessories, providing direct access from the hallway and within a maximum of forty feet from these spaces.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-345, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-345, filed 9/15/94, effective 10/16/94.]

Laundry Services

WAC 388-97-347 Laundry services and storage. The nursing home must comply with WAC 388-97-205 and ensure:

- (1) Sufficient laundry washing and drying facilities to meet the residents' care and comfort needs without delay.
- (2) The temperature and time of the hot water cycle to disinfect nursing home linen is in accordance with the following table:

Water temperature	Cycle length
160 degrees F	At least 5 minutes
140 degrees F	At least 15 minutes

(3) **In new construction**, soiled linens and soiled clothing are stored and sorted in a room ventilated according to Table 5, WAC 388-97-47020. The room must:

- (a) Have self-closing doors;
- (b) Be separated from the washing and drying facilities;
- (c) Contain a handwashing sink;
- (d) Have a floor drain; and
- (e) Contain a clinic service sink.

(4) **In new construction**, clean linen is stored in a room ventilated according to Table 5, WAC 388-97-47020. The room must:

- (a) Be separated from the washing and drying facilities; and
- (b) Have self closing doors.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-347, filed 2/24/00, effective 3/26/00.]

Dementia Care Unit

WAC 388-97-350 Dementia care unit. A nursing home that began operating a dementia care unit at any time after November 13, 1989, must meet all requirements of this section, WAC 388-97-35010 through 388-97-35060, and the resident care unit requirements of WAC 388-97-325 through 388-97-32580. Refer to WAC 388-97-097, for program requirements.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-350, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-350, filed 9/15/94, effective 10/16/94.]

WAC 388-97-35010 Dining areas on a dementia care unit. (1) The nursing home must provide dining areas in the dementia care unit which may also serve as day areas for the unit.

(2) **In a new building or addition**, the dining, dayroom, and activity area or areas on the unit must provide a minimum of thirty square feet per resident.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35020 Outdoor areas on a dementia care unit. The nursing home must provide the dementia care unit with:

- (1) Secured outdoor space and walkways;
- (2) An ambulation area with accessible walking surfaces that:
 - (a) Are firm, stable, and free from cracks and abrupt changes with a maximum of one inch between sidewalk and adjoining landscape areas;
 - (b) Have slip-resistant surfaces if subject to wet conditions; and
 - (c) Sufficient space and outdoor furniture with flexibility in arrangement of the furniture to accommodate residents who use wheelchairs and mobility aids; and
- (3) Nontoxic outdoor plants in areas accessible to residents.
- (4) **In new construction** the outdoor areas must also meet the requirements of WAC 388-97-45510.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35030 Indoor areas on a dementia care unit. The nursing home must provide the dementia care unit with:

- (1) Indoor ambulation areas that meet the needs of the residents and are maintained free of equipment; and
- (2) Nontoxic indoor plants in areas accessible to residents.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35040 Ambulation route on a dementia care unit in a new building or addition. The nursing home must ensure that the dementia care unit has a continuous ambulation route which may include outdoor ambulation areas and allows the resident to return to the resident's starting point without reversing direction.

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[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-35040, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-35040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35050 Physical plant on a dementia care unit. The nursing home must:

- (1) Provide a staff toilet room with a handwashing sink;
- (2) Ensure that floors, walls, and ceiling surfaces display contrasting color for identification:
 - (a) Surfaces may have a disguise design to obscure or conceal areas that residents should not enter, except for exit doors and doorways; and
 - (b) Exit doors must be marked so that they are readily distinguishable from adjacent construction and the way of exit travel is obvious and direct;
- (3) Ensure that door thresholds are one-half inch high or less;
- (4) Provide a signal device adapted:
 - (a) To meet residents' needs; and
 - (b) For staff and family use, if necessary;
- (5) Ensure that the public address system is used only for emergency use; and
- (6) Refer to WAC 388-97-470(2) for dementia care unit exceptions to individual temperature controls.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35050, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35060 Special egress control devices on a dementia care unit. In dementia care units the nursing home must:

- (1) Have proof that required approvals for any special egress control devices were obtained from the state fire marshal, department of social and health services, and the local official who enforces the uniform building code and uniform fire code; and
- (2) **In a new building or addition, or when adding special egress control devices to be used on doors and gates which are a part of the exit system, the building must:**
 - (a) Have obtained approval from department of health construction review and the local official who enforces the Uniform Building Code and Uniform Fire Code;
 - (b) Have an approved automatic fire alarm system;
 - (c) Have an approved supervised automatic fire sprinkler system which is electrically interconnected with the fire alarm system; and
 - (d) Have a system which must:
 - (i) Automatically release if power to the system is lost;
 - (ii) Automatically release with activation of the building's fire alarm system;
 - (iii) Release with an override switch installed at each staff work station or at a constantly staff attended location within the building; and
 - (iv) Have directions for releasing the device at each egress controlled door and gate; and
 - (e) Prohibit the use of keyed locks at all doors and gates in all egress pathways.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35060, filed 2/24/00, effective 3/26/00.]

Specialized and Outpatient Rehabilitation

WAC 388-97-352 Specialized rehabilitation. (1) If nursing homes initially licensed after October 1, 1981 provide inpatient specialized rehabilitation, they must ensure that those services provide:

- (a) Easy access in general service areas;
- (b) Exercise, treatment, and supportive equipment as required by the narrative program in the construction documents;
- (c) Adequate space for exercise equipment and treatment tables with sufficient work space on each side;
- (d) Privacy cubicle curtains on tracks or the equivalent around treatment areas;
- (e) A sink in the treatment area and a toilet and hand-washing sink in a toilet room nearby;
- (f) Space and a desk or equivalent for administrative, clerical, interviewing, and consultative functions;
- (g) Adequate enclosed storage cabinets for clean linen and supplies and locked storage for cleaning chemicals in the rehabilitation room or nearby janitor's closet;
- (h) Adequate storage space for large equipment;
- (i) A janitor's closet close to the area;
- (j) Soiled linen storage; and
- (k) A separate room or area for hydrotherapy tanks, or the equivalent, if provided.

(2) **For any new construction** under WAC 388-97-29560, nursing homes licensed before October 1, 1981, must comply with the requirements in subsection (1) of this section.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-352, filed 2/24/00, effective 3/26/00.]

WAC 388-97-353 Outpatient rehabilitation. The nursing home must ensure that facilities with outpatient programs provide:

- (1) A designated reception and waiting room or area and space for interviewing or counseling individual outpatients and their families;
- (2) Adequate space for the program so that disruption to designated resident care units is minimized;
- (3) Accessible toilet and shower facilities nearby;
- (4) Lockers or a safe place to store outpatient personal belongings;
- (5) A separate room or area for hydrotherapy tanks, or the equivalent, if provided; and
- (6) **In new construction**, required access must come from the exterior without passing through the interior of the facility.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-353, filed 2/24/00, effective 3/26/00.]

Food Service Areas

WAC 388-97-355 Food service areas. The nursing home must ensure food service areas are in compliance with chapter 246-215 WAC, state board of health rules governing food service sanitation. The nursing home must:

- (1) Ensure food service areas are provided for the purpose of preparing, serving, and storing food and drink unless (2007 Ed.)

food service is provided from another licensed food service facility;

(2) Ensure food service areas are located to facilitate receiving of food supplies, disposal of kitchen waste, and transportation of food to dining and resident care areas;

(3) Locate and arrange the kitchen to avoid contamination of food, to prevent heat and noise entering resident care areas, and to prevent through traffic;

(4) Locate the receiving area for ready access to storage and refrigeration areas;

(5) Conveniently locate a handwashing sink near the food preparation and dishwashing area, and include a waste receptacle and dispensers stocked with soap and paper towels;

(6) Adequately ventilate, light, and equip the dishwashing room or area for sanitary processing of dishes;

(7) Locate the garbage storage area in a well-ventilated room or an outside area;

(8) Provide hot and cold water and a floor drain connected to the sanitary sewage system in a can wash area, unless located in outside covered area;

(9) Provide space for an office or a desk and files for food service management located central to deliveries and kitchen operations; and

(10) Include housekeeping facilities or a janitor's closet for the exclusive use of food service with a service sink and storage of housekeeping equipment and supplies.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-355, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-355, filed 9/15/94, effective 10/16/94.]

Storage

WAC 388-97-357 Storage of equipment. The nursing home must:

(1) Provide adequate storage space for wheelchairs and other ambulation equipment;

(2) Ensure stored equipment does not impinge upon the required corridor space; and

(3) **In new construction**, provide adequate storage of four square feet or more of storage space per bed which does not impinge upon required corridor space.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-357, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35710 Storage of resident room equipment in a new building or addition. The nursing home must provide separate storage for extra pillows and blankets for each bed. This may be in a location convenient to the resident room or combined with the wardrobe or closet if it does not impinge upon the required space for clothing.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35710, filed 2/24/00, effective 3/26/00.]

WAC 388-97-35720 General storage in new construction. A nursing home must have general storage space of not less than five square feet per bed in addition to the closets and storage required in WAC 388-97-33520.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-35720, filed 2/24/00, effective 3/26/00.]

Lighting and Electrical

WAC 388-97-360 Lighting. The nursing home must ensure that lighting and lighting levels:

- (1) Are adequate and comfortable for the functions being conducted in each area of the nursing home;
- (2) Are suitable for any task the resident chooses or any task the staff must do;
- (3) Support the independent functioning of the resident;
- (4) Provide a homelike environment; and
- (5) Minimize glare.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-360, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-360, filed 9/15/94, effective 10/16/94.]

WAC 388-97-36010 Natural or artificial light. (1) The nursing home must ensure that adequate natural or artificial light for inside illumination is provided in every useable room area, including but not limited to storerooms, attic and basement rooms, hallways, stairways, inclines, and ramps.

(2) **In new buildings and additions**, the nursing home must utilize:

(a) Windows and skylights to minimize the need for artificial light and to allow a resident to experience the natural daylight cycle; and

(b) Windows and skylights near entrances/exits in order to avoid difficulty in adjusting to light levels when entering or leaving the facility.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36020 Outside lighting. The nursing home must ensure:

(1) Lighting levels in parking lots and approaches to buildings are appropriate for resident and visitor convenience and safety; and

(2) All outside areas where nursing home equipment and machinery are stored have proper lighting.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36030 Light shields. The nursing home must ensure that light shields are provided in food preparation and serving areas, utility rooms, medication rooms, exam rooms, pool enclosures, laundry areas, and on ceiling mounted fluorescent lights in resident rooms.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36040 Illumination levels in new buildings and additions. The nursing home must ensure:

(1) Lighting fixtures and circuitry provide at least the illumination levels shown within Table B;

(2) Design takes into consideration that lighting systems normally decrease in output with age and dirt accumulation; and

(3) Light fixture locations and switching arrangements are appropriate for the needs of the occupants of the spaces and follow Illuminating Engineering Society (IES) recommendations for health care facilities.

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TABLE B
Average Maintained
Footcandles

Area	Ambient Light¹	Task Light²
Adm and lobby, day	30	NA
Adm and lobby, night	20	NA
Barber, beautician	50	NA
Chapel, quiet area	30	NA
Corridors, interior ramps	30	NA
Corridors, at night		20
Dining areas	50	NA
Doorways, exterior	20	NA
Exam, treatment table	NA	100
Exam, treatment room	30	50
Exit stairways and landings	30	NA
Food preparation areas	50	75
Janitor's closet	30	NA
Laundry	30	50
Medicine prep area	30	100
Nurses' desk	30	70
Nurses' station, day	30	50
Nurses' station, night	20	50
Physical therapy	30	50
Resident room	30	50
Resident reading light	NA	75
Recreation area	30	50
Toilet, hand washing sinks, and mirrors	30	50
Toilet and bathing facilities, general	30	NA
Utility room, general	30	
Utility room, work counter	NA	50
Worktable, course work	30	70
Worktable, fine work	50	100

^{1/} Ambient light measurements are taken two and one-half feet from the floor (plus or minus six inches). Minimum footcandles are based upon average measurement. A minimum of three measurements should be taken, including a measurement at the center of each area, near the outer perimeter, and at a point equidistant from the center and the perimeter measurement.

^{2/} Task light measurements are taken at the work surface. Minimum footcandles for task light are based upon average measurement. A minimum of three measurements should be taken, including a measurement at the center of each work surface, near the outer perimeter of the work surface, and at a point equidistant from the center and the perimeter measurement.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36050 Night lights in new construction.

The nursing home must install in each resident room a night light that is:

- (1) Flush mounted on the wall;
- (2) Designed to prevent viewing the light source from thirty inches or more above the floor;
- (3) Designed to provide a maximum illumination level of 10 footcandles;
- (4) Located to provide safe pathway lighting for the staff and residents; and
- (5) Controlled by a switch at each resident room entrance door or by a master switch.

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[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36050, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36060 Switches in new construction.

The nursing home must install quiet operating switches for general illumination adjacent to doors in all areas and accessible to residents in resident rooms.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36060, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36070 Electrical outlets. (1) The nursing home must provide enough electrical outlets to meet the care and personal appliance needs of each resident. An approved power tap may be used only for portable appliances with specific overcurrent protection needs, such as a computer. A "power tap" is a device for indoor use consisting of an attachment plug on the end of a flexible cord and two or more receptacles on the opposite end, with overcurrent protection. A power tap must be:

- (a) Polarized or grounded;
- (b) UL listed; and
- (c) Directly connected to a permanently installed electrical outlet.

(2) **In new construction**, the nursing home must ensure:

- (a) There are a minimum of seven outlets:
 - (i) Four hospital grade electrical outlets located convenient to each residents' bed and centered at forty to forty-four inches above the floor, with a minimum of:
 - (ii) Two additional electrical outlets at separate, convenient locations in each resident room; and
 - (iii) One duplex electrical outlet located adjacent to each handwashing sink intended for resident use.
- (b) All electrical outlets located within five feet of any sink, toilet, bath, or shower must be protected by a ground fault circuit interrupter.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36070, filed 2/24/00, effective 3/26/00.]

Safety

WAC 388-97-365 Safety. The nursing home must provide:

- (1) A safe, functional, sanitary, and comfortable environment for the residents, staff, and the public; and
- (2) Signs to designate areas of hazard.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-365, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-365, filed 9/15/94, effective 10/16/94.]

WAC 388-97-36510 Safety—Poisons and nonmedical chemicals. The nursing home must ensure that poisons and nonmedicinal chemicals are stored in containers identified with warning labels. The containers must be stored:

- (1) In a separate locked storage when not in use by staff; and
- (2) Separate from drugs used for medicinal purposes.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36510, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36520 Safety—Storage of equipment and supplies. The nursing home must ensure that the manner

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in which equipment and supplies are stored does not jeopardize the safety of residents, staff, or the public.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36520, filed 2/24/00, effective 3/26/00.]

WAC 388-97-36530 Safety—Handrails. The nursing home must:

- (1) Provide handrails on each side of all corridors and stairwells accessible to residents; and
- (2) **In new construction** ensure that:
 - (a) Ends of handrails are returned to the walls;
 - (b) Handrails are mounted thirty to thirty-four inches above the floor and project not more than three and three-quarters inches from the wall; and
 - (c) Handrails terminate not more than six inches from a door.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-36530, filed 2/24/00, effective 3/26/00.]

Water Supply

WAC 388-97-370 Water supply. The nursing home must comply with the requirements of the group A, Public Water Systems, chapter 246-290 WAC or group B, Public Water Systems, chapter 246-291 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-370, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-370, filed 9/15/94, effective 10/16/94.]

WAC 388-97-37010 Hot water. The nursing home must ensure:

- (1) The hot water system maintains water temperatures at one hundred ten degrees Fahrenheit, plus or minus ten degrees Fahrenheit, at fixtures used by residents and staff.
- (2) For laundry temperatures, refer to WAC 388-97-347.
- (3) For dishwashing temperatures, refer to chapter 246-215 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-37010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-37020 Cross connections. The nursing home must:

- (1) Prohibit all cross connections between potable and nonpotable water;
- (2) Use backflow prevention devices on plumbing fixtures, equipment, facilities, buildings, premises or areas which are actual or potential cross-connections to prevent the backflow of water or other liquids, gases, mixtures or substances into a water distribution system or other fixtures, equipment, facilities, buildings or areas; and
- (3) Follow guidelines, practices, procedures, interpretations and enforcement as outlined in the manual titled "Accepted Procedure and Practice in Cross-Connection Control; Pacific NW Edition; American Waterworks Association," or any successor manual, referenced in chapter 246-290 WAC for public water supply.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-37020, filed 2/24/00, effective 3/26/00.]

Pest Control and Sewage and Waste Disposal

WAC 388-97-375 Pest control. The nursing home must:

- (1) Maintain an effective pest control program so that the facility is free of pests such as rodents and insects;
- (2) Construct and maintain buildings to prevent the entrance of pests such as rodents and insects; and
- (3) Provide mesh screens or equivalent with a minimum mesh of one-sixteenth inch on all windows and other openings that can be left open.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-375, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-375, filed 9/15/94, effective 10/16/94.]

WAC 388-97-385 Sewage and liquid waste disposal. The nursing home must ensure:

- (1) All sewage and liquid wastes are discharged into an approved public sewage system where such system is available; or
- (2) Sewage and liquid wastes are collected, treated, and disposed of in an on-site sewage system in accordance with chapter 246-272 WAC and meets with the approval of the local health department and/or the state department of health.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-385, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-385, filed 9/15/94, effective 10/16/94.]

New Construction Documents

WAC 388-97-400 General new construction documents. (1) The project sponsor must submit plans for all new construction to the department of health, construction review, for review and approval. Documents must be approved before the work begins. The project sponsor must also submit documents to department of health, certificate of need for review and applicable determination.

(2) The nursing home may request exemptions to new construction requirements as described in WAC 388-97-405.

(3) If the proposed project is not extensive enough to require professional architectural or engineering services, the project sponsor must submit a written description to the department of health, construction review, to determine if WAC 388-97-401 applies.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-400, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-400, filed 9/15/94, effective 10/16/94.]

WAC 388-97-40010 Preliminary new construction documents. If preliminary documents and specifications are submitted, they must:

(1) Include a narrative program with drawings. Copies of these documents must be sent to the department of health, certificate of need and construction review, and to aging and adult services administration. The narrative program must identify:

- (a) How the design promotes a homelike environment and facilitates resident-centered care and services;
- (b) Functional space requirements;
- (c) Staffing patterns;
- (d) Each function to be performed;

- (e) Types of equipment required; and
- (f) Services that will not be provided directly, but will instead be provided through contract.

(2) Refer to WAC 388-97-400(3), if the proposed project is not extensive enough to require professional architectural or engineering services.

(3) Be drawn to scale and include:

(a) A site plan showing streets, entrance ways, drive-ways, parking, design statements for adequate water supply, sewage and disposal systems, space for the storage of recycled materials, and the arrangement of buildings on the site noting handicapped accessible parking and entrances;

(b) Floor plans showing existing and proposed arrangements within the building, including the fixed and major movable equipment; and

(c) Each room, space, and corridor identified by function and number.

(4) Include a general description of construction and materials, including interior finishes.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-40010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-401 Final new construction documents.

(1) Construction must not start until at least two sets of final construction documents drawn to scale with complete specifications have been submitted to and approved by the department of health, construction review, in coordination with aging and adult services administration and the department of health, certificate of need.

(2) An architect or engineer licensed by the state of Washington must prepare, stamp, sign, and date the final construction documents.

(3) Construction documents that are changed after approval by the department of health, construction review, require resubmission before any construction on the proposed change is started.

(4) The construction of the facility must follow the final approved construction documents.

(5) These drawings and specifications must show complete details to be furnished to contractors for construction of the buildings, including:

- (a) Site plan;
- (b) Drawings of each floor of the building, including fixed equipment;
- (c) Elevations, sections, and construction details;
- (d) Schedule of floor, wall, and ceiling finishes, door and window sizes and types, and door finish hardware;
- (e) Mechanical and electrical systems;
- (f) Provision for noise, dust, smoke, and draft control, fire protection, safety and comfort of the residents if construction work takes place in or near occupied areas; and
- (g) Landscape plans and vegetation planting schedules for dementia care units.

(6) A reduced set of the final construction floor plans on eight and one half by eleven inch or eleven by seventeen inch sheets showing each room function and number must be submitted.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-401, filed 2/24/00, effective 3/26/00.]

WAC 388-97-402 Preinstallation submissions for new construction. The department of health, construction review, must receive and approve preinstallation submissions prior to installation. Preinstallation submissions may include any or all of the following:

- (1) Stamped shop drawings, hydraulic calculations, and equipment information sheets for fire sprinkler system(s);
- (2) Shop drawings, battery calculations, and equipment information sheets for fire detection and alarm systems;
- (3) Shop drawings and equipment information sheets for a kitchen hood and duct automatic fire extinguishing system;
- (4) Drawings and equipment information sheets for special egress control devices; and
- (5) Drawings and/or a finish schedule denoting areas to be carpeted with:
 - (a) A coding system identifying type of carpet in each area;
 - (b) A copy the manufacturer's specifications for each type of carpet; and
 - (c) A copy of a testing laboratory report of the radiant panel and smoke density tests for each type of carpet.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-402, filed 2/24/00, effective 3/26/00.]

WAC 388-97-403 New construction timelines. (1) Construction documents must be resubmitted for review as a new project according to current requirements if construction:

- (a) Has not started within one year from the date of approval; or
 - (b) Is not completed within two years from the date of approval.
- (2) To obtain an extension beyond two years, a written request must be submitted and approved thirty days prior to the end of the two-year period.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-403, filed 2/24/00, effective 3/26/00.]

WAC 388-97-405 Exemptions to new construction requirements. (1) The director of residential care services, aging and adult services administration, may grant exemptions to new construction requirements for:

- (a) Alterations when the applicant demonstrates the proposed alterations will serve to correct deficiencies or will upgrade the nursing home in order to better serve residents; and
- (b) Substitution of procedures, materials, or equipment for requirements specified in this chapter when such procedures, materials, or equipment have been demonstrated to the director's satisfaction to better serve residents.

(2) The nursing home must ensure requests for exemptions are in writing and include any necessary approvals from the local code enforcement authority and the state fire marshal.

(3) The nursing home must ensure all exemptions granted under the foregoing provisions are kept on file at the nursing home.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-405, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-405, filed 9/15/94, effective 10/16/94.]

(2007 Ed.)

Codes and Standards in New Construction

WAC 388-97-410 State building code in new construction. The nursing home must through its design, construction and necessary permits demonstrate compliance with the following codes and local jurisdiction standards:

(1) The Uniform Building Code, and Uniform Building Code Standards, as published by the International Conference of Building Officials as amended and adopted by the Washington state building code council and published as chapter 51-40 WAC, or successor laws;

(2) The Uniform Mechanical Code, including chapter 22, Fuel Gas Piping, Appendix B, as published by the International Conference of Building Officials and the International Association of Plumbing and Mechanical Officials as amended and adopted by the Washington state building code council and published as chapter 51-42 WAC, or successor laws;

(3) The Uniform Fire Code, and Uniform Fire Code Standards, as published by the International Conference of Building Officials and the Western Fire Chiefs Association as amended and adopted by the Washington state building code council and published as chapters 51-44 and 51-45 WAC, or successor laws;

(4) The Uniform Plumbing Code, and Uniform Plumbing Code Standards, as published by the International Association of Plumbing and Mechanical Officials, as amended and adopted by the Washington state building code council and published as chapters 51-46 and 51-47 WAC, or successor laws;

(5) The Washington state ventilation and indoor air quality code, as adopted by the Washington state building code council and filed as chapter 51-13 WAC, or successor laws; and

(6) The Washington state energy code, as amended and adopted by the Washington state building code council and filed as chapter 51-11 WAC, or successor laws.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-410, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-410, filed 9/15/94, effective 10/16/94.]

WAC 388-97-415 Electrical codes and standards in new construction. The nursing home must ensure that all electrical wiring complies with state and local electrical codes including chapter 296-46 WAC, and the National Electric Code of the National Fire Protection Association (NFPA-70) as adopted by the Washington state department of labor and industry.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-415, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-415, filed 9/15/94, effective 10/16/94.]

WAC 388-97-420 Elevator codes in new construction. The nursing home must ensure that elevators are installed in accordance with chapter 296-81 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-420, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-420, filed 9/15/94, effective 10/16/94.]

WAC 388-97-425 Local codes and ordinances in new construction. The nursing home must:

(1) Follow all local ordinances relating to zoning, building, and environmental standards; and

(2) Obtain all local permits before construction and keep permits on file at the nursing home.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-425, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-425, filed 9/15/94, effective 10/16/94.]

Administration and Public Areas in New Construction

WAC 388-97-430 Entrances and exits in new construction. The nursing home must have the main entrances and exits sheltered from the weather and barrier free accessible in accordance with chapter 51-40 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-430, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-430, filed 9/15/94, effective 10/16/94.]

WAC 388-97-43010 Lobbies in new construction. The nursing home must have a lobby or area in close proximity to the main entrance that is barrier free accessible and includes:

- (1) Waiting space with seating accommodations;
- (2) A reception and information area;
- (3) Space to accommodate persons in wheelchairs;
- (4) A public restroom;
- (5) A drinking fountain; and
- (6) A public telephone.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-43020 Interview space in new construction. The nursing home must have interview spaces for private interviews relating to social service and admission.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-43030 Offices in new construction. The nursing home must provide:

- (1) Office space convenient to the work area for the administrator, the director of nursing services, medical records staff, social services staff, activities director, and other personnel as appropriate;
- (2) Work space for physicians and outside consultants;
- (3) Space for locked storage of health records which provides for fire and water protection; and
- (4) Space for the safe storage and handling of financial and business records.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-43040 Inservice education space in new construction. The nursing home must provide space for employee inservice education that will not infringe upon resident space.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43040, filed 2/24/00, effective 3/26/00.]

WAC 388-97-43050 Staff areas in new construction. The nursing home must ensure a lounge, lockers, and toilets

are provided convenient to the work areas for employees and volunteers.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-43050, filed 2/24/00, effective 3/26/00.]

Visiting, Private, and Outdoor Recreation Space and Walkways in New Construction

WAC 388-97-455 Visiting and private space in new construction. The nursing home must design a separate room or areas for residents to have family and friends visit and for residents to spend time alone. The nursing home must ensure these areas provide:

- (1) Space which facilitates conversation and privacy; and
- (2) Access to a common-use toilet facility.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-455, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-455, filed 9/15/94, effective 10/16/94.]

WAC 388-97-45510 Outdoor recreation space and walkways in new construction. A nursing home must provide a safe, protected outdoor area for resident use. The nursing home must ensure the outdoor area has:

- (1) Shaded and sheltered areas to meet residents needs;
- (2) Accessible walking surfaces which are firm, stable, and free from cracks and abrupt changes with a maximum of one inch between sidewalk and adjoining landscape areas;
- (3) Sufficient space and outdoor furniture provided with flexibility in arrangement of the furniture to accommodate residents who use wheelchairs and mobility aids;
- (4) Shrubs, natural foliage, and trees; and
- (5) If used as a resident courtyard, the outdoor area must not be used for public or service deliveries.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-45510, filed 2/24/00, effective 3/26/00.]

Pools and Pharmacies in New Construction

WAC 388-97-460 Pools in new construction. The nursing home must ensure swimming pools, spas, and tubs which remain filled between uses meet the requirements in chapter 246-260 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-460, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-460, filed 9/15/94, effective 10/16/94.]

WAC 388-97-46010 Pharmacies in new construction. The nursing home must ensure that an on-site pharmacy meets the requirements of the Washington state board of pharmacy per chapters 18.64 RCW and 246-865 WAC.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46010, filed 2/24/00, effective 3/26/00.]

General Design Requirements in New Construction

WAC 388-97-465 Elevators in new construction. The nursing home must:

- (1) Ensure that all buildings having residential use areas or service areas that are not located on the main entrance floor, have an elevator; and

(2) Have at least one elevator sized to accommodate a resident bed and attendant for each sixty beds on floors other than the main entrance floor.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-465, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-465, filed 9/15/94, effective 10/16/94.]

WAC 388-97-46510 Stairways, ramps, and corridors in new construction. The nursing home must ensure stairways, ramps and corridors conform with the Uniform Building Code.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46510, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46520 Walking surfaces in a new building or addition. The nursing must ensure that:

(1) An abrupt change in the walking surface level including at door thresholds which are greater than one quarter inch are beveled to a one vertical in two horizontal; and

(2) Changes in the walking surface level greater than one half inch are accomplished by means of a ramp with a maximum slope of one vertical in twelve horizontal.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46520, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46530 Doors in new construction. The nursing home must ensure doors to:

(1) Resident rooms provide a minimum of forty-four inches clear width;

(2) Resident bathrooms and toilet rooms are a minimum of thirty-two inches clear width for wheelchair access;

(3) All resident toilet rooms and bathing facilities open outward except if doors open directly into a resident occupied corridor;

(4) Toilet rooms and bathrooms have single action locks, and a means of unlocking doors from the outside;

(5) Occupied areas do not swing into corridors; and

(6) All passages are arranged so that doors do not open onto or obstruct other doors while maintaining resident dignity.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46530, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46540 Floor finishes in new construction. The nursing home must ensure:

(1) Floors at all outside entrances have slip-resistant finishes both inside and outside the entrance even when wet; and

(2) All uncarpeted floors are smooth, nonabsorbent and easily cleanable.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46540, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46550 Carpets in new construction. The nursing home must ensure that department of health, construction review approves of all carpet installation.

(1) Carpets may be used in all areas except: Toilet rooms, bathrooms, kitchen, laundry, utility rooms, medication rooms, maintenance, isolation rooms if provided, and areas subject to high moisture or flooding. Specifications for acceptable carpeting are:

(a) Pile yarn fibers are easily cleanable;

(b) Pile is looped texture in all resident use areas. Cut pile may be used in nonresident use areas;

(c) Average pile density of five thousand ounces per cubic yard in resident use areas and four thousand ounces per cubic yard in nonresident areas. The formula for calculating the density of the carpet is: Yarn weight in ounces times 36, divided by pile height in inches equals ounces per cubic yard of density; and

(d) A maximum pile height of .255 inches in resident use areas and .312 inches in nonresident use areas.

(2) Carpets must:

(a) Be cemented to the floor; and

(b) Have the edges covered and top set base with toe at all wall junctures.

(3) When recarpeting, the safety of residents must be assured during and after recarpeting installation within the room or area. The nursing home must ensure the room or area is:

(a) Well ventilated;

(b) Unoccupied; and

(c) Unavailable for use until room is free of volatile fumes and odors.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46550, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46560 Coving in new construction. The nursing home must ensure:

(1) Kitchens, restrooms, laundry, utility rooms, and bathing areas have integral coves of continuous commercial grade sheet vinyl, bullnose ceramic tile or sealed bullnose quarry tile at least six inches in height; and

(2) All other wall junctions have either integral coving or top set base with toe.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46560, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46570 Walls in new construction. The nursing home must ensure:

(1) Wall finishes are easily cleanable;

(2) A water-resistant finish extends above the splash line in all rooms or areas subject to splash or spray, such as bathing facilities with tubs only, toilet rooms, janitors' closets, and can-wash areas; and

(3) Bathing facilities with showers have a water-resistant finish extending to the ceiling.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46570, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46580 Accessories in new construction. The nursing home must provide the following accessories with the necessary backing, if required, for mounting:

(1) Usable countertop area and mirror at each handwashing sink in toilet rooms and resident rooms;

(2) Towel or robe hooks at each handwashing sink in resident rooms and at each bathing facility;

(3) A robe hook at each bathing facility, toilet room and in examination room or therapy area, including outpatient therapy rooms;

(4) A securely mounted toilet paper holder properly located within easy reach of the user at each toilet fixture;

(5) Sanitary seat covers at each public and employee use toilet;

(6) Open front toilet seats on all toilets;

(7) Dispensers for paper towels and handwashing soap at each handwashing sink, and bathing facility;

(8) Sanitary napkin dispensers and disposers in public and employee women's toilet rooms; and

(9) Grab bars that are easily cleanable and resistant to corrosion and securely mounted.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46580, filed 2/24/00, effective 3/26/00.]

WAC 388-97-46590 Miscellaneous in new construction. The nursing home must ensure:

(1) Rooms and service areas are identified by visible and tactile signs, refer to WAC 388-97-35050(2) for possible exceptions; and

(2) Equipment and casework is designed, manufactured and installed for ease of proper cleaning and maintenance, and suitable for the functions of each area.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-46590, filed 2/24/00, effective 3/26/00.]

Heating, Ventilation, and Air Conditioning Systems in New Construction

WAC 388-97-470 Heating systems in new construction. The nursing home must ensure:

(1) The heating system is capable of maintaining a temperature of seventy-five degrees Fahrenheit for areas occupied by residents and seventy degrees Fahrenheit for nonresident areas;

(2) Resident rooms have individual temperature control, except in a dementia care unit controls may be covered, locked, or placed in an inconspicuous place;

(3) The following is insulated within the building:

(a) Pipes conducting hot water which are exposed to resident contact; and

(b) Air ducts and casings with outside surface temperatures below ambient dew point.

(4) Insulation on cold surfaces includes an exterior vapor barrier; and

(5) Electric resistant wall heat units are prohibited in new construction.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-470, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-470, filed 9/15/94, effective 10/16/94.]

WAC 388-97-47010 Cooling systems in new construction. The nursing home must have:

(1) A mechanical cooling system capable of maintaining a temperature of seventy-five degrees Fahrenheit for areas occupied by residents; and

(2) A cooling system that has mechanical refrigeration equipment to provide summer air conditioning to resident areas, food preparation areas, laundry, medication rooms, and therapy areas by either a central system with distribution ducts or piping, or packaged room or zonal air conditioners.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-47010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-47020 Ventilation systems in new construction. The nursing home must ensure:

(1) Ventilation of all rooms is designed to prevent objectionable odors, condensation, and direct drafts on the residents;

(2) All habitable space is mechanically ventilated including:

(a) Air-supply and air-exhaust systems;

(b) Installation of air-handling duct systems according to the requirements of the Uniform Mechanical Code and chapter 51-42 WAC;

(c) Corridors not used to supply air to, or exhaust air from, any room except that infiltration air from corridors may be used to ventilate bathrooms, toilet rooms, janitors' closets, and small electrical or telephone closets opening directly on corridors;

(d) Installation of supply registers and return air grilles at least three inches above the floor;

(e) Installation of exhaust grilles on or near the ceiling; and

(f) Outdoor air intakes located a minimum of twenty-five feet from the exhaust from any ventilating system, combustion equipment, or areas which may collect vehicular exhaust and other noxious fumes, and a minimum of ten feet from plumbing vents. The nursing home must locate the bottom of outdoor air intakes serving central systems a minimum of three feet above adjoining grade level or, if installed through the roof, three feet above the highest adjoining roof level.

TABLE 5
PRESSURE RELATIONSHIPS AND VENTILATION OF CERTAIN AREAS OF NURSING HOMES

FUNCTION AREA	Pressure Relationship To Adjacent Areas ^{1,2}	Minimum Air Changes of Outdoor Air Per Hour Supplied To Room	Minimum Total Air Changes Per Hour Supplied To Room	All Air Exhausted Directly To Outdoors	Air Recirculated Within Room Units
PATIENT CARE					
Isolation Room	N	2	12	Yes	No
Patient area corridor	±	Optional	2	Optional	Optional
Patient room	±	2	2	Optional	Optional
Toilet room	N	Optional	10	Yes	No

TABLE 5
PRESSURE RELATIONSHIPS AND VENTILATION OF CERTAIN AREAS OF NURSING HOMES

FUNCTION AREA	Pressure Relationship To Adjacent Areas ^{1,2}	Minimum Air Changes of Outdoor Air Per Hour Supplied To Room	Minimum Total Air Changes Per Hour Supplied To Room	All Air Exhausted Directly To Outdoors	Air Recirculated Within Room Units
DIAGNOSTIC AND TREATMENT					
Clean workroom or clean holding	P	2	4	Optional	Optional
Examination room	±	2	6	Optional	Optional
Occupational therapy ³	N	2	3	Optional	Optional
Physical therapy ³	N	2	3	Optional	Optional
Soiled workroom or soiled holding	N	2	10	Yes	No
STERILIZING AND SUPPLY					
Clean linen storage	P	Optional	2	Yes	No
Laundry, general ³	±	2	10	Yes	No
Linen and trash chute room	N	Optional	10	Yes	No
Soiled linen sorting and storage	N	Optional	10	Yes	No
Sterilizer equipment room	N	Optional	10	Yes	No
SERVICE					
Bathroom	N	Optional	10	Yes	No
Dietary day storage	±	Optional	2	Yes	No
Food preparation center ³	±	2	10	Yes	No
Janitor's closet	N	Optional	10	Yes	No
Warewashing room ³	N	Optional	10	Yes	No

^{1/} P=Positive N=Negative ±=Continuous directional control not required.

^{2/} Whether positive or negative, pressure must be a minimum of seventy cubic feet per minute (CFM).

^{3/} The volume of air may be reduced up to fifty percent in these areas during periods of nonuse. The soiled holding area of the general laundry must maintain its full ventilation capacity at all time.

(3) Minimum ventilation requirements. Meet the pressure relationship and ventilation rates per ASHRAE 95 HVAC Applications Chapter 7.11 Table 5 Pressure Relationships and Ventilation of Certain Areas of Nursing Homes. The nursing home must ensure:

(a) Exhaust hoods in food preparation areas comply with the Uniform Mechanical Code;

(b) All hoods over commercial type cooking ranges are equipped with fire extinguishing systems and heat actuated fan controls;

(c) Kitchen ventilation is adequate to provide comfortable working temperatures;

(d) Boiler rooms, elevator equipment rooms, laundry rooms, and any other heat-producing spaces are provided with sufficient outdoor air to maintain combustion rates of equipment and to limit temperatures at the ceiling to ninety-seven degrees Fahrenheit; and

(e) Individual toilet rooms and bathrooms are ventilated either by individual mechanical exhaust systems or by a central mechanical exhaust system.

(4) Individual exhaust systems.

(a) Where individual mechanical exhaust systems are used to exhaust individual toilet rooms or bathrooms, the individual ventilation fans are interconnected with room lighting to ensure ventilation while room is occupied. The ventilation fan must have a time delay shutoff to ensure that

the exhaust continues for a minimum of five minutes after the light switch is turned off; and

(b) The volume of air removed from the space by exhaust ventilation is replaced directly or indirectly by an equal amount of tempered/conditioned air.

(5) Central exhaust systems. The nursing home must ensure:

(a) All fans serving central exhaust systems are located to prevent a positive pressure in the duct passing through an occupied area; and

(b) Fire and smoke dampers are located and installed in accordance with the Uniform Building Code chapter 51-40 WAC.

(6) Air filters.

(a) All central ventilation or air-conditioning systems are equipped with filters having efficiencies of at least eighty percent if the system supplies air to resident rooms, therapy areas, food preparation areas, or laundry areas;

(b) Central ventilation or air conditioning systems means any system serving more than a single room used by residents or by any group of rooms serving the same utility function (i.e., the laundry);

(c) Filter efficiency is warranted by the manufacturer and is based on atmospheric dust spot efficiency per ASHRAE Standard 52-76;

(d) The filter bed is located upstream of the air-conditioning equipment, unless a prefilter is employed. In which

case, the prefilter is upstream of the equipment and the main filter bed may be located downstream; and

(e) The nursing home must ensure:

(i) Filter frames are durable and provide an airtight fit with the enclosing duct work. All joints between filter segments and enclosing duct work are gasketed or sealed;

(ii) All central air systems have a manometer installed across each filter bed with an alarm to signal high pressure differential; and

(iii) Humidifiers, if provided, are a steam type.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-47020, filed 2/24/00, effective 3/26/00.]

Plumbing and Fixtures in New Construction

WAC 388-97-480 Handwashing sinks in new construction. The nursing home must provide a handwashing sink in each toilet room and exam room.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-480, filed 2/24/00, effective 3/26/00; 94-19-041 (Order 3782), § 388-97-480, filed 9/15/94, effective 10/16/94.]

WAC 388-97-48010 Drinking fountains in new construction. Where drinking fountains are installed, the nursing home must ensure the fountains are of the inclined jet, sanitary type.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-48010, filed 2/24/00, effective 3/26/00.]

WAC 388-97-48020 Mixing valves or mixing faucets in new construction. The nursing home must provide each fixture, except toilet fixtures and special use fixtures, with hot and cold water through a mixing valve or mixing faucet.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-48020, filed 2/24/00, effective 3/26/00.]

WAC 388-97-48030 Spouts in new construction. The nursing home must ensure all lavatories and sinks in resident rooms, resident toilet rooms, and utility and medication areas have gooseneck spouts, without aerators in areas requiring infection control.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-48030, filed 2/24/00, effective 3/26/00.]

WAC 388-97-48040 Faucet controls in new construction. The nursing home must provide wrist blade, single-lever controls or their equivalent at all sinks and lavatories. The nursing home must:

(1) Provide at least four inch wrist blades and/or single-levers;

(2) Provide sufficient space for full open and closed operation; and

(3) Color-code and label faucet controls to indicate "hot" and "cold."

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-48040, filed 2/24/00, effective 3/26/00.]

[Title 388 WAC—p. 548]

SUBCHAPTER III NURSING HOME LICENSE

Initial License Application

WAC 388-97-550 Initial nursing home license. (1) A complete nursing home license application must be:

(a) Submitted at least sixty days prior to the proposed effective date of the license on forms designated by the department;

(b) Signed by the proposed licensee or the proposed licensee's authorized representative;

(c) Notarized; and

(d) Reviewed by the department in accordance with this chapter.

(2) All information requested on the license application must be provided. At minimum, the nursing home license application will require the following information:

(a) The name and address of the proposed licensee, and any partner, officer, director, managerial employee, or owner of five percent or more of the proposed licensee;

(b) The names of the administrator, director of nursing services, and, if applicable, the management company;

(c) The specific location and the mailing address of the facility for which a license is sought;

(d) The number of beds to be licensed; and

(e) The name and address of all nursing homes that the proposed licensee or any partner, officer, director, managerial employee, or owner of five percent or more of the proposed licensee has been affiliated with in the past ten years.

(3) The proposed licensee must be:

(a) The individual or entity responsible for the daily operation of the nursing home;

(b) Denied the license if any individual or entity named in the application is found by the department to be unqualified.

(4) For initial licensure of a new nursing home, the proposed licensee must submit the annual license fee with the initial license application. The nonrefundable nursing home license fee is two hundred seventy-five dollars per bed per year.

(5) If any information submitted in the initial license application changes before the license is issued, the proposed licensee must submit a revised application containing the changed information.

(6) If a license application is pending for more than six months, the proposed licensee must submit a revised application containing current information about the proposed licensee or any other individuals or entities named in the application.

[Statutory Authority: RCW 18.51.050. 02-20-058, § 388-97-550, filed 9/27/02, effective 10/28/02. Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-550, filed 2/24/00, effective 3/26/00.]

License Renewal

WAC 388-97-555 Nursing home license renewal. (1) All nursing home licenses must be renewed annually.

(2) License renewals must be:

(a) Submitted at least thirty days prior to the license's expiration date on forms designated by the department;

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(b) Signed by the current licensee or the current licensee's authorized representative;

(c) Notarized; and

(d) Reviewed by the department in accordance with this chapter.

(3) The current licensee must provide all information on the license renewal form or other information requested by the department.

(4) The application for a nursing home license renewal must be:

(a) Made by the individual or entity currently licensed and responsible for the daily operation of the nursing home;

(b) Denied if any individual or entity named in the renewal application is found by the department to be unqualified.

(5) The nursing home license renewal fee must be submitted at the time of renewal. The nonrefundable nursing home license renewal fee is two hundred seventy-five dollars per bed per year.

(6) In unusual circumstances, the department may issue an interim nursing home license for a period not to exceed three months. The current licensee must submit the prorated nursing home license fee for the period covered by the interim license. The annual date of license renewal does not change when an interim license is issued.

(7) A change of nursing home ownership does not change the date of license renewal and fee payment.

[Statutory Authority: RCW 18.51.050, 02-20-058, § 388-97-555, filed 9/27/02, effective 10/28/02. Statutory Authority: RCW 18.51.070 and 74.42.620, 00-06-028, § 388-97-555, filed 2/24/00, effective 3/26/00.]

Department Review of License Applications and Appeals

WAC 388-97-560 Department review of initial nursing home license applications. (1) All initial nursing home license applications must be reviewed by the department under this chapter.

(2) The department will not begin review of an incomplete license application.

(3) The proposed licensee must respond to any department request for additional information within five working days.

(4) When the application is determined to be complete, the department will consider the proposed licensee or any partner, officer, director, managerial employee, or owner of five percent or more of the proposed licensee, separately and jointly, in its review. The department will review:

(a) The information contained in the application;

(b) Survey and complaint investigation findings in every facility each individual and entity named in the application has been affiliated with during the past ten years;

(c) Compliance history;

(d) Financial assessments;

(e) Actions against the proposed licensee (i.e., revocation, suspension, refusal to renew, etc.);

(f) All criminal convictions, and relevant civil or administrative actions or findings including, but not limited to, findings under 42 C.F.R. § 488.335, disciplinary findings, and findings of abuse, neglect, exploitation, or abandonment; and

(g) Other relevant information.

(2007 Ed.)

(5) The department will notify the proposed licensee of the results of the review.

[Statutory Authority: RCW 18.51.070 and 74.42.620, 00-06-028, § 388-97-560, filed 2/24/00, effective 3/26/00.]

WAC 388-97-565 Department review of nursing home license renewals. (1) All renewal license applications must be reviewed by the department under this chapter.

(2) The department will not begin review of an incomplete license renewal application.

(3) The current licensee must respond to any department request for additional information within five working days.

(4) When the application is determined to be complete, the department will review:

(a) The information contained in the application;

(b) Actions against the license (i.e., revocation, suspension, refusal to renew, etc.);

(c) All criminal convictions, and relevant civil or administrative actions or findings including, but not limited to, findings under 42 C.F.R. § 488.335, disciplinary findings, and findings of abuse, neglect, exploitation, or abandonment; and

(d) Other relevant information.

(5) The department will notify the current licensee of the results of the review.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-565, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-565, filed 2/24/00, effective 3/26/00.]

WAC 388-97-570 Reasons for denial, suspension, modification, revocation of, or refusal to renew a nursing home license. (1) The department may deny, suspend, modify, revoke, or refuse to renew a nursing home license when the department finds the proposed or current licensee, or any partner, officer, director, managing employee, owner of five percent or more of the proposed or current licensee of the nursing home, owner of five percent or more of the assets of the nursing home, proposed or current administrator, or employee or individual providing nursing home care or services has:

(a) Failed or refused to comply with the:

(i) Requirements established by chapters 18.51, 74.42, or 74.46 RCW and regulations adopted under these chapters; or

(ii) Medicaid requirements of Title XIX of the Social Security Act and Medicaid regulations.

(b) A history of significant noncompliance with federal or state regulations in providing nursing home care;

(c) No credit history or a poor credit history;

(d) Engaged in the illegal use of drugs or the excessive use of alcohol or been convicted of "crimes relating to drugs" as defined in RCW 43.43.830;

(e) Unlawfully operated a nursing home, or long term care facility as defined in RCW 70.129.010, without a license or under a revoked or suspended license;

(f) Previously held a license to operate a hospital or any facility for the care of children or vulnerable adults, and that license has been revoked, or suspended, or the licensee did not seek renewal of the license following written notification of the licensing agency's initiation of revocation or suspension of the license;

(g) Obtained or attempted to obtain a license by fraudulent means or misrepresentation;

(h) Permitted, aided, or abetted the commission of any illegal act on the nursing home premises;

(i) Been convicted of a felony or other crime that would be prohibited under RCW 74.39A.050(8), if it reasonably relates to the competency of the individual to own or operate a nursing home;

(j) Failed to:

(i) Provide any authorization, documentation, or information the department requires in order to verify information contained in the application;

(ii) Meet financial obligations as the obligations fall due in the normal course of business;

(iii) Verify additional information the department determines relevant to the application;

(iv) Report abandonment, abuse, neglect or financial exploitation in violation of chapter 74.34 RCW; or in the case of a skilled nursing facility or nursing facilities, failure to report as required by 42 C.F.R. 483.13; or

(v) Pay a civil fine the department assesses under this chapter within ten days after assessment becomes final.

(k) Been certified pursuant to RCW 74.20A.320 as a person who is not in compliance with a child support order (license suspension only);

(l) Knowingly or with reason to know makes a false statement of a material fact in the application for a license or license renewal, in attached data, or in matters under department investigation;

(m) Refused to allow department representatives or agents to inspect required books, records, and files or portions of the nursing home premises;

(n) Willfully prevented, interfered with, or attempted to impede the work of authorized department representatives in the:

(i) Lawful enforcement of provisions under this chapter or chapters 18.51 or 74.42 RCW; or

(ii) Preservation of evidence of violations of provisions under this chapter or chapters 18.51 or 74.42 RCW.

(o) Retaliated against a resident or employee initiating or participating in proceedings specified under RCW 18.51.220; or

(p) Discriminated against Medicaid recipients as prohibited under RCW 74.42.055.

(2) In determining whether there is a history of significant noncompliance with federal or state regulations under subsection (1)(b), the department may, at a minimum, consider:

(a) Whether the violation resulted in a significant harm or a serious and immediate threat to the health, safety, or welfare of any resident;

(b) Whether the proposed or current licensee promptly investigated the circumstances surrounding any violation and took steps to correct and prevent a recurrence of a violation;

(c) The history of surveys and complaint investigation findings and any resulting enforcement actions;

(d) Repeated failure to comply with regulations;

(e) Inability to attain compliance with cited deficiencies within a reasonable period of time; and

(f) The number of violations relative to the number of facilities the proposed or current licensee, or any partner,

officer, director, managing employee, employee or individual providing nursing home care or services has been affiliated within the past ten years, or owner of five percent or more of the proposed or current licensee or of the assets of the nursing home.

(3) The department must deny, suspend, revoke, or refuse to renew a proposed or current licensee's nursing home license if the proposed or current licensee or any partner, officer, director, managing employee, owner of five percent or more of the proposed or current licensee of the nursing home or owner of five percent or more of the assets of the nursing home, proposed or current administrator, or employee or individual providing nursing home care or services has been:

(a) Convicted of a "crime against children or other persons" as defined under RCW 43.43.830;

(b) Convicted of a "crime relating to financial exploitation" as defined under RCW 43.43.830;

(c) Found by a court in a criminal proceeding or a protection proceeding under chapter 74.34 RCW, or any comparable state or federal law, to have abandoned, abused, neglected or financially exploited a vulnerable adult;

(d) Found in any final decision issued by a disciplinary board to have sexually or physically abused or exploited any minor or an individual with a developmental disability or to have abused, neglected, abandoned, or financially exploited any vulnerable adult;

(e) Found in any dependency action to have sexually assaulted or exploited any minor or to have physically abused any minor;

(f) Found by a court in a domestic relations proceeding under Title 26 RCW, or any comparable state or federal law, to have sexually abused or exploited any minor or to have physically abused any minor; or

(g) Found to have abused, neglected, abandoned or financially exploited or mistreated residents or misappropriated their property, and that finding has been entered on a nursing assistant registry.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-23-030, § 388-97-570, filed 11/12/02, effective 12/13/02; 02-14-063, § 388-97-570, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-570, filed 2/24/00, effective 3/26/00.]

WAC 388-97-575 Appeal of the department's licensing decision. A proposed or current licensee contesting a department licensing decision must file a written request for an administrative hearing within twenty days of receipt of the decision.

The appeals process and requirements are set forth in WAC 388-97-625.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-575, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-575, filed 2/24/00, effective 3/26/00.]

Management Agreements and Changes of Ownership

WAC 388-97-580 Management agreements. (1) The licensee is responsible for the daily operations of the nursing home.

(2) As used in this section:

(a) **"Management agreement,"** means a written, executed, agreement between the licensee and another individual or entity regarding the provision of certain services in a nursing home; and

(b) **"Manager"** refers to the individual or entity providing services under a management agreement.

(3) The licensee may not give the manager responsibilities that are so extensive that the licensee is relieved of responsibility for the daily operations and provisions of services of the facility. If the licensee does so, then the department must determine that a change of ownership has occurred.

(4) The proposed licensee or the current licensee must notify the residents and their representatives sixty days before entering into a management agreement.

(5) The department must receive a written management agreement, including an organizational chart showing the relationship between the proposed or current licensee, management company, and all related organizations:

(a) Sixty days before:

(i) The proposed change of ownership date;

(ii) The initial licensure date; or

(iii) The effective date of the management agreement; or

(b) Thirty days before the effective date of any amendment to an existing management agreement.

(6) Management agreements, at minimum must:

(a) Create a principal/agent relationship between the licensee and the manager;

(b) Describe the responsibilities of the licensee and manager, including items, services, and activities to be provided;

(c) Require the licensee's governing body, board of directors, or similar authority to appoint the facility administrator;

(d) Provide for maintenance and retention of all records as applicable according to rules and regulations;

(e) Allow unlimited access by the department to documentation and records according to applicable laws or regulations;

(f) Require the licensee to participate in monthly oversight meetings and quarterly on-site visits to the facility;

(g) Require the manager to immediately send copies of surveys and notices of noncompliance to the licensee;

(h) State that the licensee is responsible for ensuring all licenses, certifications, and accreditations are obtained and maintained;

(i) State that the manager and licensee will review the management agreement annually and notify the department of changes according to applicable regulations;

(j) Acknowledge that the licensee is the party responsible for meeting state and federal licensing and certification requirements;

(k) Require the licensee to maintain ultimate responsibility over personnel issues relating to the operation of the nursing home and care of the residents, including but not limited to, staffing plans, orientation, and training;

(l) Require that, even if day-to-day management of the trust funds are delegated, the licensee:

(i) Retains all fiduciary and custodial responsibility for funds that have been deposited with the nursing home by the resident; and

(ii) Is directly accountable to the residents for such funds.

(m) Provide that if any responsibilities for the day-to-day management of the resident trust fund are delegated to the manager, then the manager must:

(i) Provide the licensee with a monthly accounting of the resident funds; and

(ii) Meet all legal requirements related to holding, and accounting for, resident trust funds; and

(n) State that the manager will not represent itself or give the appearance it is the licensee.

(7) Upon receipt of a proposed management agreement, the department may require:

(a) The licensee or manager to provide additional information or clarification;

(b) Any changes necessary to:

(i) Bring the management agreement into compliance with this section; and

(ii) Ensure that the licensee has not been relieved of the responsibility for the daily operations of the facility; and

(c) More frequent contact between the licensee and manager under subsection (6)(f).

(8) The licensee and manager must act in accordance with the terms of the management agreements. If the department determines that they are not, then the department may take action deemed appropriate.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-580, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-580, filed 2/24/00, effective 3/26/00.]

WAC 388-97-585 Change of ownership. (1) A change of ownership occurs when there is a substitution, elimination, or withdrawal of the licensee or a substitution of control of the licensee. **"Control,"** as used in this section, means the possession, directly or indirectly, of the power to direct the management, operation, and policies of the licensee, whether through ownership, voting control, by agreement, by contract or otherwise. Events which constitute a change of ownership include, but are not limited to, the following:

(a) The form of legal organization of the licensee is changed (e.g., a sole proprietor forms a partnership or corporation);

(b) The licensee transfers ownership of the nursing home business enterprise to another party regardless of whether ownership of some or all of the real property and/or personal property assets of the facility is also transferred;

(c) Dissolution or consolidation of the entity;

(d) Merger unless the licensee survives the merger and there is not a change in control of the licensee;

(e) If, during any continuous twenty-four month period, fifty percent or more of the entity is transferred, whether by a single transaction or multiple transactions, to:

(i) A different party (e.g., new or former shareholders); or

(ii) An individual or entity that had less than a five percent ownership interest in the nursing home at the time of the first transaction; or

(f) Any other event or combination of events that the department determines results in a:

(i) Substitution, elimination, or withdrawal of the licensee; or

(ii) Substitution of control of the licensee responsible for the daily operational decisions of the nursing home.

(2) Ownership does not change when the following, without more, occur:

(a) A party contracts with the licensee to manage the nursing home enterprise in accordance with the requirements of WAC 388-97-580; or

(b) The real property or personal property assets of the nursing home are sold or leased, or a lease of the real property or personal property assets is terminated, as long as there is not a substitution or substitution of control of the licensee.

(3) When a change of ownership is contemplated, the current licensee must notify the department and all residents and their representatives at least sixty days prior to the proposed date of transfer. The notice must be in writing and contain the following information as specified in RCW 18.51.530:

(a) Name of the proposed licensee;

(b) Name of the managing entity;

(c) Names, addresses, and telephone numbers of department personnel to whom comments regarding the change may be directed;

(d) Names of all officers and the registered agent in the state of Washington if proposed licensee is a corporation; and

(e) Names of all general partners if proposed licensee is a partnership.

(4) The proposed licensee must comply with license application requirements. The operation or ownership of a nursing home must not be transferred until the proposed licensee has been issued a license to operate the nursing home.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-585, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-585, filed 2/24/00, effective 3/26/00.]

Licensed Bed Capacity, Relocation of Residents and License Relinquishment

WAC 388-97-590 Licensed bed capacity. A nursing home must not be licensed for a capacity that exceeds the number of beds permitted under:

(1) This chapter;

(2) Chapter 70.38 RCW and regulations thereunder; or

(3) Applicable local zoning, building or other such regulations.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-590, filed 2/24/00, effective 3/26/00.]

WAC 388-97-595 Relocation of residents. (1) In the event of license revocation or suspension, decertification, or other emergency closures the department must:

(a) Notify residents and, when appropriate, resident representatives of the action;

(b) Assist with residents' relocation and specify possible alternative living choices and locations; and

(c) The nursing home will assist the residents to the extent it is directed to do so by the department.

(2) When a resident's relocation occurs due to a nursing home's voluntary closure, or voluntary termination of its Medicare or Medicaid contract or both, the nursing home must:

(a) Notify the department and all residents and resident representatives in accordance with WAC 388-97-162; and

(b) Provide appropriate discharge planning and coordination for all residents including a plan to the department for safe and orderly transfer or discharge of residents from the nursing home.

(3) The department may provide residents assistance with relocation.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-595, filed 6/27/02, effective 7/28/02; 00-06-028, § 388-97-595, filed 2/24/00, effective 3/26/00.]

WAC 388-97-600 License relinquishment. (1) A nursing home licensee must voluntarily relinquish its license when:

(a) The nursing home ceases to do business as a nursing home; and

(b) Within twenty-four hours after the last resident is discharged from the facility.

(2) The license must be returned to the department.

(3) If a nursing home licensee fails to voluntarily relinquish its license, the department will revoke the license.

[Statutory Authority: RCW 18.51.070 and 74.42.620. 00-06-028, § 388-97-600, filed 2/24/00, effective 3/26/00.]

SUBCHAPTER IV NURSING HOME LICENSURE PROGRAM ADMINISTRATION

WAC 388-97-605 Inspections and deficiency citation report. (1) The department may inspect nursing homes at any time in order to determine compliance with the requirements of chapters 18.51 or 74.42 RCW and this chapter. Types of state inspections in nursing homes include preoccupancy, licensing, revisit, and complaint investigation. In the case of a Medicaid or Medicare contractor, or both, the department may also inspect Medicare and Medicaid certified nursing homes to determine compliance with the requirements of Title XVIII and/or XIX of the Social Security Act and federal Medicare and Medicaid regulations.

(2) The department will provide to the nursing home written documentation (notice) of the nursing home's deficiency(ies), the requirement that the deficiency(ies) violates, and the reasons for the determination of noncompliance with the requirements (RCW 18.51.091).

(3) The department may revisit the nursing home to confirm that corrections of deficiencies has been made. Revisits will be made:

(a) In accordance with RCW 74.39A.060 (5)(e);

(b) In the case of a Medicare or Medicaid contractor, or both, in accordance with the requirements of Title XVIII or XIX, or both of the Social Security Act and federal Medicare and Medicaid regulations; and

(c) At the department's discretion.

(4) The licensee or nursing home must:

(a) Ensure that department staff have access to the nursing home residents, staff and all resident records; and

(b) Not willfully interfere or fail to cooperate with department staff in the performance of official duties. Examples of willful interference or failure to cooperate include, but are not limited to, not allowing department staff to talk to res-

idents or staff in private or not allowing department staff access to resident records.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-605, filed 6/27/02, effective 7/28/02.]

WAC 388-97-610 Plan of correction. (1) The licensee or nursing home must, within ten calendar days of notification of the cited deficiencies prepare, sign, date and provide to the department a detailed written plan of correction. Such plan of correction will provide notification to the department of the date by which the nursing home will complete the correction of cited deficiencies. The plan of correction must be completed regardless of whether the licensee requests an informal department review in accordance in WAC 388-97-620.

(2) A plan of correction is not required for deficiencies at a severity level 1/isolated scope as described in WAC 388-97-640, unless specifically requested by the department.

(3) In the case of actual or imminent threat to resident health or safety/immediate jeopardy (severity level 4 as described in WAC 388-97-640), the department may require the licensee or nursing home to submit a document alleging that the imminent threat has been removed within a time frame specified by the department. The document must specify the steps the nursing home has taken or will take to correct the imminent harm. An allegation that the imminent harm has been removed does not substitute for the plan of correction as required by subsection (1) of this section but it will become a part of the completed plan of correction.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-610, filed 6/27/02, effective 7/28/02.]

WAC 388-97-615 Acceptable and unacceptable plans of correction. (1) A plan of correction must:

(a) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

(b) Address how the nursing home will identify other residents having the potential to be affected by the same deficient practice;

(c) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

(d) Indicate how the nursing home plans to monitor its performance to make sure that solutions are sustained, including how the plan of correction will be integrated into the nursing home's quality assurance system;

(e) Give the title of the person who is responsible for assuring lasting correction; and

(f) Give the date by which the correction will be made.

(2) The department will review the nursing home's plan of correction to determine whether it is acceptable.

(3) When deficiencies involve nursing home alterations, physical plant plan development, construction review, or other circumstances where extended time to complete correction may be required, the department's designated local aging and adult services administration (AASA) field office or other department designee may accept a plan of correction as evidence of substantial compliance under the following circumstances:

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(a) The plan of correction must include the steps that the nursing home needs to take, the time schedule for completion of the steps, and concrete evidence that the plan will be carried out as scheduled; and

(b) The nursing home must submit progress reports and/or updated plans to the department in accordance with a schedule specified by department.

(c) The department's acceptance of a plan of correction is solely at the department's discretion and does not rule out the imposition of optional remedies.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-615, filed 6/27/02, effective 7/28/02.]

WAC 388-97-620 Informal department review. (1) For Medicare or Medicaid certified nursing homes, the informal department review process described in this section is the only opportunity for the nursing home to dispute the federal deficiency citation report, unless a federal sanction is imposed.

(2) The nursing home licensee has the right to an informal department review of disputed state or federal citations, or both.

(3) A licensee must make a written request for an informal department review within ten calendar days of receipt of the department's written deficiency citation(s) report. The request must be directed to the department's designated local aging and adult services administration (AASA) office and must identify the deficiencies that are being disputed.

(4) At the informal department review, the licensee or nursing home may provide documentation and verbal explanations related to the disputed federal or state deficiencies, or both.

(5) When modifications or deletions are made to the disputed federal or state deficiency citations, or both, the licensee or nursing home must modify or delete the relevant portions of the plan of correction within five days of receipt of the modified or deleted deficiency(ies). The licensee or nursing home may request from the department a clean copy of the revised deficiency citation report.

(6) If the licensee or nursing home is unwilling to provide the modified plan of correction, the department may impose a per day civil fine for failure to return the modified deficiency citation report to the department in accordance with this subsection.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-620, filed 6/27/02, effective 7/28/02.]

WAC 388-97-625 Notice and appeal rights. (1) The notification and hearing rights in this section apply to any appealable action taken by the department under chapters 18.51, 74.42 and 74.39A RCW. Notification and appeals requirements for resident protection program findings are described in WAC 388-97-077.

(2) The following actions may be appealed:

(a) Imposition of a penalty under RCW 18.51.060 or 74.42.580;

(b) An action by the department such as a denial of a license under RCW 18.51.054, a license suspension under RCW 18.51.067 or a condition on a license under RCW 74.39A.050; or

(c) Deficiencies cited on the state survey report.

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(3) The appeal process will be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 18.51.065 and 74.42.580, chapter 388-02 WAC and this chapter. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision of this chapter will govern.

(4) The purpose of an administrative hearing will be to review actions taken by the department under chapters 18.51, 74.42 or 74.39A RCW, and under this chapter.

(5) The applicant, licensee or nursing home must file a request for an administrative hearing with the office of administrative hearings within twenty days of receipt of written notification of the department's action as defined in subsection (2) of this section. Further information about administrative hearings is available in chapter 388-02 WAC and at the office of administrative hearing (OAH) web site: www.oah.wa.gov.

(6) Orders of the department imposing a stop placement, license suspension, emergency closure emergency transfer of residents, temporary management or conditions on a license are effective immediately upon verbal or written notice and must remain in effect until they are rescinded by the department or through the state administrative appeals process.

(7) Deficiencies cited on the federal survey report may not be appealed. If a federal remedy is imposed, the Centers for Medicare and Medicaid Services will notify the nursing facility of appeal rights under the federal administrative appeals process.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-625, filed 6/27/02, effective 7/28/02.]

WAC 388-97-630 Remedies. Mandatory Remedies

(1) In accordance with RCW 18.51.060 (5)(a), the department must impose a stop placement order when the department determines that the nursing home is not in substantial compliance with applicable laws or regulations and the cited deficiency(ies):

- (a) Jeopardize the health and safety of the residents; or
- (b) Seriously limit the nursing home's capacity to provide adequate care.

(2) When required by RCW 18.51.060(3), the department must deny payment to a nursing home that is certified to provide Medicaid services for any Medicaid-eligible individual admitted to the nursing home. Nursing homes that are certified to provide Medicare services or both Medicare and Medicaid services may be subject to a federal denial of payment for new admissions, in accordance with federal law.

(3) The department must deny, suspend, revoke or refuse to renew a proposed or current licensee's nursing home license in accordance with WAC 388-97-570(3).

Optional Remedies

(4) When the department determines that a licensee has failed or refused to comply with the requirements under chapter 18.51, 74.39A or 74.42 RCW, or this chapter; or a Medicaid contractor has failed or refused to comply with Medicaid requirements of Title XIX of the Social Security Act or Medicaid regulations, the department may impose any or all of the following optional remedies:

- (a) Stop placement;
- (b) Immediate closure of a nursing home, emergency transfer of residents or both;
- (c) Civil fines;

- (d) Appoint temporary management;
- (e) Petition the court for appointment of a receiver in accordance with RCW 18.51.410;
- (f) License denial, revocation, suspension or nonrenewal;
- (g) Denial of payment for new Medicaid admissions;
- (h) Termination of the Medicaid provider agreement (contract);
- (i) Department on-site monitoring as defined under WAC 388-97-005; and
- (j) Reasonable conditions on a license as authorized by chapter 74.39A RCW. Examples of conditions on a license include but are not limited to training related to the deficiency(ies); consultation in order to write an acceptable plan of correction; demonstration of ability to meet financial obligations necessary to continue operation.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-630, filed 6/27/02, effective 7/28/02.]

WAC 388-97-635 Criteria for imposing optional remedies. (1) The criteria set forth in this section implement the requirements under RCW 18.51.060(8). The criteria do not replace the standards for imposition of mandatory remedies under RCW 18.51.060 (3) and (5), or for the imposition of mandatory remedies in accordance with WAC 388-97-630 (1), (2) and (3).

(2) The department must consider the imposition of one or more optional remedy(ies) when the nursing home has:

- (a) A history of being unable to sustain compliance;
- (b) One or more deficiencies on one inspection at severity level 2 or higher as described in WAC 388-97-640;
- (c) Been unable to provide an acceptable plan of correction after receiving assistance from the department about necessary revisions;
- (d) One or more deficiencies cited under general administration and/or nursing services;
- (e) One or more deficiencies related to retaliation against a resident or an employee for whistle blower activity under RCW 18.51.220, 74.34.180 or 74.39A.060 and WAC 388-97-203;
- (f) One or more deficiencies related to discrimination against a Medicare or Medicaid client under RCW 74.42.055, and Titles XVIII and XIX of the Social Security Act and Medicare and Medicaid regulations; or
- (g) Willfully interfered with the performance of official duties by a long-term care ombudsman.

(3) The department, in its sole discretion, may consider other relevant factors when determining what optional remedy or remedies to impose in particular circumstances.

(4) When the department imposes an optional remedy or remedies, the department will select more severe penalties for nursing homes that have deficiency(ies) that are:

- (a) Uncorrected upon revisit;
- (b) Recurring (repeated);
- (c) Pervasive; or
- (d) Present a threat to the health, safety, or welfare of the residents.

(5) The department will consider the severity and scope of cited deficiencies in accordance with WAC 388-97-640 when selecting optional remedy(ies). Such consideration will

not limit the department's discretion to impose a remedy for a deficiency at a low level severity and scope.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-635, filed 6/27/02, effective 7/28/02.]

WAC 388-97-640 Severity and scope of deficiencies.

(1) **"Severity of a deficiency"** means the seriousness of the deficiency. Factors the department will consider when determining the severity of a deficiency may include, but are not limited to:

(a) Whether harm to the resident has occurred, or could occur, including but not limited to a violation of resident's rights;

(b) The impact of the actual or potential harm on the resident; and

(c) The degree to which the nursing home failed to meet the resident's highest practicable physical, mental, and psychosocial well-being as defined in WAC 388-97-005.

(2) Severity levels

(a) Severity level 4—Imminent harm or immediate jeopardy

Level 4 means that a resident(s)' health or safety is imminently threatened or immediately jeopardized as a result of deficient nursing home practice. This level includes actual harm or potential harm, or both, to resident(s)' health or safety that has had or could have a severe negative outcome or critical impact on resident's well-being, including death or severe injury. Severity Level 4 requires immediate corrective action to protect the health and safety of resident(s).

(b) Severity level 3—Actual harm

Level 3 means that actual harm has occurred to resident(s) as the result of deficient nursing home practice.

(i) **"Serious harm"** is harm that results in a negative outcome that significantly compromises the resident(s)' ability to maintain and/or reach the highest practicable physical, mental and psychosocial well-being. Serious harm does not constitute imminent danger/immediate jeopardy (Severity Level 4).

(ii) **"Moderate harm"** is harm that results in a negative outcome that more than slightly but less than significantly compromises the resident(s)' ability to maintain and/or reach the highest practicable physical, mental and psychosocial well-being.

(iii) **"Minimal harm"** is harm that results in a negative outcome that to a small degree compromises the resident(s)' ability to maintain and/or reach the highest practicable physical, mental well-being.

(c) Severity level 2—Potential for harm

Level 2, **"potential for harm"** means that if the deficient nursing home practice is not corrected, resident(s) may suffer actual harm.

(d) Severity level 1—No harm or minimal impact

Level 1 means a deficient nursing home practice that does not compromise the resident(s)' ability to maintain or reach, or both, the highest practicable physical, mental and psychosocial well-being. Deficiencies at level 1 are those that have no direct or potential for no more than minimal impact on the resident. Examples include certain structure deficiencies, certain physical environment deficiencies and process deficiencies.

(3) **"Scope of a deficiency"** means the frequency, incidence, or extent of the occurrence of the deficiency.

(4) Scope categories

(a) **"Isolated or limited scope"** means a relatively few number of residents have been affected or have the potential to be affected, by the deficient nursing home practice.

(b) **"Moderate or pattern scope"** scope means more than an isolated and less than a widespread number of residents have been affected, or have the potential to be affected by the deficient nursing home practice.

(c) **"Widespread" or "systemic scope"** means most or all of the residents are affected or have the potential to be affected, by the deficient nursing home practice.

(5) Determination of scope will be made by the department in its sole discretion. Factors the department will consider may include:

(a) Size of the nursing home;

(b) Size of the sample;

(c) Number and location of affected residents;

(d) Whether the deficiency applies to all or a subset of the residents;

(e) Other factors relevant to the particular circumstances.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-640, filed 6/27/02, effective 7/28/02.]

WAC 388-97-645 Separate deficiencies—Separate remedies. (1) Each deficiency cited by the department for noncompliance with a statute or regulation is a separate deficiency subject to the assessment of a separate remedy.

(2) Each day upon which the same deficiency occurs is a separate deficiency subject to the assessment of a separate remedy.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-645, filed 6/27/02, effective 7/28/02.]

WAC 388-97-650 Stop placement. (1) The department must impose a stop placement order when required by RCW 18.51.060(5) and WAC 388-97-630(1) and may impose a stop placement order as an optional remedy in accordance with WAC 388-97-635. The department's stop placement order becomes effective upon verbal or written notice.

(2) The nursing home has the right to an informal department review to refute the federal or state deficiencies, or both, cited as the basis for the stop placement and must request such review in accordance with WAC 388-97-620(3).

(3) The department will not delay or suspend a stop placement order because the nursing home requests an administrative hearing or informal department review.

(4) The stop placement order must remain in effect until:

(a) The department terminates the stop placement order;

or

(b) The stop placement order is terminated by a final agency order following appeal conducted in accordance with chapter 34.05 RCW.

(5) The department must terminate the stop placement when:

(a) The nursing home states in writing that the deficiencies necessitating the stop placement action have been corrected; and

(b) Within fifteen working days of the nursing home's notification, department staff confirm by on-site revisit of the nursing home that:

(i) The deficiencies that necessitated the stop placement action have been corrected; and

(ii) The nursing home exhibits the capacity to maintain adequate care and services and correction of deficiencies.

(6) After lifting the stop placement, the department may continue to perform on site monitoring to verify that the nursing home has maintained correction of deficiencies.

(7) While a stop placement order is in effect, the department may approve a readmission to the nursing home from the hospital in accordance with RCW 18.51.060 (5)(b) and department guidelines for readmission decisions.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-23-030, § 388-97-650, filed 11/12/02, effective 12/13/02; 02-14-063, § 388-97-650, filed 6/27/02, effective 7/28/02.]

WAC 388-97-655 Amount of civil fine. (1) Except as otherwise provided in statute, the range for a:

(a) Per day civil fine is fifty dollars to three thousand dollars; and

(b) Per instance civil fine is one thousand to three thousand dollars.

(2) In the event of continued noncompliance, nothing in this section must prevent the department from increasing a civil fine up to the maximum amount allowed by law.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-655, filed 6/27/02, effective 7/28/02.]

WAC 388-97-660 Civil fine accrual and due dates and interest. (1) Accrual of a per day civil fine begins on the first date the department verifies that the nursing home has or had a specific deficiency. Accrual of the per day civil fine will end on the date the department determines the nursing home corrected the deficiency.

(2) A per instance fine may be assessed for a deficiency, regardless of whether or not the deficiency had been corrected by the time the department first identified it.

(3) Civil fine(s) are due twenty days after the nursing home is notified of the civil fine(s) if the nursing home does not request a hearing.

(4) If the nursing home requests a hearing, the civil fine(s) including interest, if any, is due twenty days after:

(a) A hearing decision ordering payment of the fine(s) becomes final in accordance with chapter 388-02 WAC;

(b) The appeal is withdrawn;

(c) A settlement agreement and order of dismissal is entered, unless otherwise specified in the agreement; or

(d) An order of dismissal is entered.

(5) Interest on the civil fine(s) begins to accrue at a rate of one percent per month, thirty days after the nursing home is notified of the fine, unless a settlement agreement includes

other provisions for payment of interest. If the amount of the civil fine is reduced following an appeal, interest on the reduced civil fine(s) accrues from thirty days after the nursing home was notified of the original civil fine(s).

(6) When a nursing home fails to pay a civil fine when due under this chapter, the department may:

(a) Withhold an amount equal to the fine plus interest, if any, from the nursing home's Medicaid payment;

(b) Impose an additional fine; or

(c) Suspend the nursing home license under WAC 388-97-570(1). Such license suspension must continue until the fine is paid.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-660, filed 6/27/02, effective 7/28/02.]

WAC 388-97-665 Civil penalty fund. (1) The department must deposit civil penalties collected under chapter 18.51 or 74.42 RCW into a special fund administered by the department to be applied to the protection of the health or property of residents of nursing homes found to be deficient.

(2) The funds must be administered by the department according to department procedures. Uses of the fund include, but are not limited to:

(a) Payment for the costs of relocation of residents to other facilities;

(b) Payment to maintain operation of a nursing home pending correction of deficiencies or closure; and

(c) Reimbursement of residents for personal funds or property lost when the resident's personal funds or property cannot be recovered from the nursing home or third party insurer.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-665, filed 6/27/02, effective 7/28/02.]

WAC 388-97-670 Temporary management. (1) When the department appoints a temporary manager, the department must order the licensee to:

(a) Cease operating the nursing home; and

(b) Immediately turn over to the temporary manager possession and control of the nursing home including, but not limited to, all patient care records, financial records, and other records necessary for continued operation of the nursing home while temporary management is in effect.

(2) The temporary manager will have authority to temporarily relocate some or all residents if the:

(a) Temporary manager determines the resident's health, security, or welfare is jeopardized; and

(b) Department concurs with the temporary manager's determination that relocation is necessary.

(3) The department's authority to order temporary management is discretionary in all cases.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-670, filed 6/27/02, effective 7/28/02.]

WAC 388-97-675 Receivership. (1) Receivership is authorized under RCW 18.51.400 through [18.51.]520 and the following regulations.

(2) After receivership is established, the department may recommend to the court that all residents be relocated and the nursing home closed when:

(a) Problems exist in the physical condition of the premises which cannot be corrected in an economically prudent manner; or

(b) The department determines the former licensee or owner:

(i) Is unwilling or unable to manage the nursing home in a manner ensuring residents' health, safety, and welfare; and

(ii) Has not entered into an enforceable agreement to sell the nursing home within three months of the court's decision to grant receivership.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-675, filed 6/27/02, effective 7/28/02.]

WAC 388-97-680 Temporary managers and receivers—Application. (1) The department may recruit individuals, partnerships, corporations and other entities interested in serving as a temporary manager or receiver of a nursing home.

(2) Individuals, partnerships, corporations, or other entities interested in being appointed as a temporary manager or receiver must complete and submit to the department the required application on department forms.

(3) Individuals, partnerships, corporations, or other entities with experience in providing long-term health care and a history of satisfactory nursing home operation may submit an application to the department at any time. Applicants will be subject to the criteria established for licensees found in WAC 388-97-570, except the department may waive the requirement that it have at least sixty days to review the application.

(4) The department must not appoint or recommend the appointment of a person (including partnership, corporation or other entity) to be a temporary manager or receiver if that person:

(a) Is the licensee, administrator, or partner, officer, director, managing employee, or owner of five percent or more of the licensee of the nursing home subject to temporary management or receivership;

(b) Is affiliated with the nursing home subject to temporary management or receivership; or

(c) Has owned or operated a nursing home ordered into temporary management or receivership in any state.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-680, filed 6/27/02, effective 7/28/02.]

WAC 388-97-685 Temporary managers and receivers—Considerations before appointment. (1) The department's authority to appoint a temporary manager or to recommend appointment of a specific individual or entity to act as receiver is discretionary in all cases.

(2) The department, in appointing a temporary manager or recommending appointment of a receiver, may consider one or more of the following factors:

(a) Potential temporary manager's or receiver's willingness to serve as a temporary manager or receiver for the nursing home in question;

(b) Amount and quality of the potential temporary manager's or receiver's experience in long-term care;

(c) Quality of care, as determined by prior survey reports, provided under the potential temporary manager's or the potential receiver's supervision, management or operation;

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(d) Potential temporary manager's or receiver's prior performance as a temporary manager or receiver;

(e) How soon the potential temporary manager or receiver is available to act as a temporary manager or receiver;

(f) Potential temporary manager's or receiver's familiarity and past compliance with Washington state and federal regulations applicable to nursing homes.

[Statutory Authority: RCW 18.51.070, 74.42.620, 02-14-063, § 388-97-685, filed 6/27/02, effective 7/28/02.]

WAC 388-97-690 Duties and powers of temporary manager and receiver. (1) The temporary manager or receiver must protect the health, security and welfare of the residents for the duration of the temporary management or receivership. The temporary manager or receiver must perform all acts reasonably necessary to ensure residents' needs are met. Such acts may include, but are not limited to:

(a) For receivers, the powers in RCW 18.51.490;

(b) Correcting cited deficiencies;

(c) Hiring, directing, and managing all consultants and employees and discharging them for just cause, discharging the administrator of the nursing home, recognizing collective bargaining agreement, and settling labor disputes;

(d) Receiving and expending in a prudent and business-like manner all current revenues of the home provided priority will be given to debts and expenditures directly related to providing care and meeting residents' needs;

(e) Making necessary purchases, repairs, and replacements, provided such expenditures in excess of five thousand dollars are approved by the department, or in the case of a receiver, approved by court;

(f) Entering into contracts necessary for the operation of the nursing home, provided that, the court must approve contracts extending beyond the period of receivership;

(g) Preparing all department-required reports;

(h) Overseeing facility closure, when appropriate;

(i) Planning required relocation with residents and residents' legal representative, family, or significant others in conjunction with home and community services division field staff;

(j) Meeting regularly with and informing staff, residents, and residents' families or significant others of:

(i) Plans for correcting the cited deficiencies;

(ii) Progress achieved in correction of deficiencies;

(iii) Plans for facility closure and relocation; and

(iv) Plans for continued operation of the nursing home, including training of staff.

(2) The temporary manager or receiver must make a detailed monthly accounting of all expenditures and liabilities to the department and to the owner of the nursing home, and to the court when required.

(3) The receiver must consult the court in cases of extraordinary or questionable debts incurred prior to the receiver's appointment and will not have the power to close the home or sell any of the nursing home's assets without prior court approval.

(4) The temporary manager or receiver must comply with all applicable state and federal laws and regulations. If the nursing home is certified and is providing care to Medicaid clients, the temporary manager or receiver must become

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the Medicaid contractor for the duration of the temporary management or receivership period.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-690, filed 6/27/02, effective 7/28/02.]

WAC 388-97-695 Termination of temporary management and receivership. (1) The department will terminate temporary management:

(a) After three months unless good cause is shown to continue the temporary management. Good cause for continuing the temporary management exists when returning the nursing home to its former licensee would subject residents to a threat to health, safety, or welfare;

(b) When all residents are transferred and the nursing home is closed;

(c) When deficiencies threatening residents' health, safety, or welfare are eliminated and the former licensee agrees to department-specified conditions regarding the continued facility operation; or

(d) When a new licensee assumes control of the nursing home.

(2) The department may appoint an alternate temporary manager:

(a) When the temporary manager is no longer willing to serve as a temporary manager;

(b) If a temporary manager is not making acceptable progress in correcting the nursing home deficiencies or in closing the nursing home; or

(c) If the department determines the temporary manager is not operating the nursing home in a financially responsible manner.

(3) The receivership will terminate in accordance with RCW 18.51.450 and 18.51.460.

(4) The department may recommend to the court an alternate receiver be appointed:

(a) When the receiver is no longer willing to serve as a receiver; or

(b) If a receiver is not making acceptable progress in correcting the deficiencies in the nursing home.

[Statutory Authority: RCW 18.51.070, 74.42.620. 02-14-063, § 388-97-695, filed 6/27/02, effective 7/28/02.]

Chapter 388-101 WAC CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS

WAC

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- 388-101-1145 Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW.
Reporting final findings. [Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-09-090 and 06-11-103, § 388-101-1145, filed 4/19/06 and 5/17/06, effective 10/1/06.] Repealed by 06-18-038, filed 8/29/06, effective 10/1/06. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW.
- 388-101-2310 What training is required before staff are qualified to perform delegated tasks? [05-05-077, recodified as § 388-101-2310, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-740, filed 10/26/01, effective 1/1/02.] Decodified by 05-07-138, filed 3/22/05, effective 3/22/05. Recodified as WAC 388-101-2410.
- 388-101-2320 Do nursing assistants need to comply with department of health requirements? [05-05-077, recodified as § 388-101-2320, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-750, filed 10/26/01, effective 1/1/02.] Decodified by 05-07-138, filed 3/22/05, effective 3/22/05. Recodified as WAC 388-101-2420.

PURPOSE

WAC 388-101-1010 What is the purpose of this chapter? (1) This chapter establishes standards for the department of social and health services (DSHS) to provide, or contract to provide, individualized community residential services to clients who:

- (a) Are eligible to receive services by the division of developmental disabilities (DDD); and
 - (b) Receive support from certified service providers.
- (2) Service providers support eligible clients to enable them to:
- (a) Enjoy all rights and privileges under the Constitution and laws of the United States and the state of Washington; and
 - (b) Participate in community life and have control of their environment to the greatest extent possible.
- (3) The authority for this chapter is Title 71A RCW.

[05-05-077, recodified as § 388-101-1010, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-010, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-010, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-010, filed 5/1/96, effective 6/1/96. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-010, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-010, filed 2/9/83.]

DEFINITIONS

WAC 388-101-1020 What definitions apply to this chapter? "Agency" refers to an entity interested in becoming a service provider that offers residential instruction and support services to clients.

"ADSA" refers to aging and disability services administration at DSHS. Residential care services and the division of developmental disabilities are divisions under aging and disability services.

"Certification" refers to the determination by RCS that an agency or service provider has satisfactorily complied with the requirements outlined in this chapter and in the department contract.

"Client" refers to a person who has a developmental disability and is eligible under RCW 71A.10.020. (For eligi-

bility criteria, see chapter 388-825 WAC and WAC 388-101-1210.)

"Client services" refers to instruction and support activities that benefit clients, as specified under WAC 388-101-1800 through 388-101-1860.

"Community protection services" (community protection intensive supported living services, or CP-ISLS) refers to intensive supported living services provided to clients who meet the criteria of "Individual with Community Protection Issues."

"Crisis diversion services (CDS)" refers to DDD-authorized crisis residential services and supports offered to clients on a temporary basis. These clients show a serious decline in mental functioning, making the client at risk for psychiatric hospitalization (see WAC 388-101-1200 and 388-101-1250 for details).

"Crisis service plan" refers to a document that identifies needs and services a client will receive while placed in crisis diversion services.

"DDD" refers to the division of developmental disabilities of aging and disability services administration (ADSA).

"DSHS" refers to the department of social and health services of Washington state.

"Exceptions" refers to residential care services' (RCS) approval of a written request for an exception to a rule in this chapter. (There are no exceptions to RCWs.)

"Group home" refers to residential services provided in a dwelling that is:

- (1) Owned, leased, or rented by an entity other than the client;
 - (2) Licensed by the applicable state authority; and
 - (3) Operated by a provider.
- (See WAC 388-101-1260 for further details.)

"Group training home" refers to a certified nonprofit residential facility that provides full-time care, treatment, training, and maintenance for clients, as defined under RCW 71A.22.020(2).

"HCBS" refers to home and community based services waivers. This is a Title XIX Medicaid waiver program that serves a specific number of individuals. This waiver is for particular home and community based services not covered under the Medicaid state plan. (See WAC 388-825-170 for more details.)

"IFP" refers to individual financial plan. (See WAC 388-101-2070.)

"IISP" refers to the individual instruction and support plan for clients. (See WAC 388-101-2010 through 388-101-2030.)

"Individual with community protection issues" refers to a client identified by DDD as needing one or more of the following criteria:

- (1) The person has been convicted of or charged with a crime of sexual violence as defined in chapter 71.09 RCW, including, but not limited to, rape, statutory rape, rape of a child, and child molestation;
- (2) The person has been convicted of or charged with acts directed towards strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization;

(3) The person has been convicted of or charged with a sexually violent offense and/or predatory act, and may constitute a future danger;

(4) The person has not been convicted and/or charged, but has a history of stalking, sexually violent, predatory, and/or opportunistic behavior which demonstrates a likelihood to commit a sexually violent and/or predatory act based on current behaviors that may escalate to violence;

(5) The person has committed one or more violent crimes, such as murder, attempted murder, arson, first degree assault, kidnapping, or use of a weapon to commit a crime.

"Initial assessment" refers to a written evaluation that identifies a client's needs upon entry into crisis diversion services.

"Instruction" refers to goal-oriented teaching that is designed for acquiring and enhancing skills.

"ISP" refers to the individual service plan for clients. (See WAC 388-101-1870 through 388-101-1900.)

"Nursing assistant" refers to a person who is registered or certified by department of health under chapter 18.88A RCW. A nursing assistant performs certain nursing care tasks that are delegated by a registered nurse for a specific client in authorized settings. (See chapter 246-841 WAC for more details.)

"POC" refers to the plan of care for clients based on the criteria of the home and community based waivers. (See WAC 388-101-1870 through 388-101-1900.)

"RCS" refers to residential care services of aging and disability services (ADSA).

"Regional support network (RSN)" refers to a county, combination of counties or other member entities under contract with DSHS mental health division (MHD). These RSNs administer all mental health service activities within their jurisdiction, using available resources. (See WAC 388-865-200 for details.)

"Reprisal" refers to any negative action taken as retaliation against an employee.

"Residential service" refers to client services offered by certified service providers.

"Secretary" refers to the secretary of the department of social and health services or the secretary's designee.

"Service provider" refers to an agency RCS has certified and DDD has contracted to provide residential services to clients. Also refers to state operated living alternative (SOLA) program.

"Severity" refers to the seriousness of an incident. This is determined by the extent to which a client's physical, mental, or psychosocial well-being is or may be compromised or threatened.

"SSP" (state supplemental payment) refers to DDD administered state paid cash assistance program for certain clients of DDD. (See chapter 388-827 WAC for details.)

"Support" refers to assistance as requested or needed by a client, based on their abilities, needs, and goals.

"Supported living" refers to residential services provided to clients living in their own homes, which are owned, rented, or leased by the clients or their legal representatives. (See WAC 388-101-1240 for more details.)

"Trust account" refers to a bank account containing two or more clients' funds where the service provider has the authority to make deposits and withdrawals.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1020, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1020, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-020, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-020, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-020, filed 10/26/01, effective 1/1/02; 99-19-104, recodified as § 388-820-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-020, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 86-08-003 (Order 2349), § 275-26-020, filed 3/20/86; 83-05-017 (Order 1945), § 275-26-020, filed 2/9/83.]

ABUSE REPORTING AND NEGLECT

WAC 388-101-1101 Abuse and neglect reporting requirements. (1) All administrators, owners, and staff are mandated reporters and must report instances of suspected abandonment, abuse, neglect, or financial exploitation of vulnerable adults as defined in, and accordance with chapter 74.34 RCW.

(2) Reports must be made to the centralized toll free telephone number for reporting abandonment, abuse, neglect or financial exploitation of vulnerable adults, provided by the department.

(3) Reports must be made to law enforcement agencies, as required under chapter 74.34 RCW.

(4) Service providers must have policies and procedures complying with state law that specify reporting requirements for client abandonment, abuse, neglect, and financial exploitation.

(5) Each administrator, owner, staff person, and volunteer must read and sign the policy about reporting requirements. The service provider must retain the signed policy for staff and volunteers.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1101, filed 8/29/06, effective 10/1/06.]

WAC 388-101-1106 Investigation of mandated reports. (1) The department will determine whether a report of client abandonment, abuse, neglect, or financial exploitation needs to be investigated, in accordance with established procedures.

(2) The department investigation will include an investigation of allegations about one or more of the following:

- (a) A service provider;
- (b) Anyone associated with a service provider; or
- (c) A client receiving services under this chapter.

(3) If, after completing an investigation under this chapter, the department concludes that it is more likely than not that the alleged perpetrator abandoned, abused, neglected, or financially exploited a client, the department will make an initial finding against the perpetrator.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1106, filed 8/29/06, effective 10/1/06.]

WAC 388-101-1111 Notice of an initial finding. (1) The department will notify the alleged perpetrator in writing within ten working days of making an initial finding of abandonment, abuse, neglect or financial exploitation of a client. The written notice will not include the identities of the alleged victim, reporter and witnesses.

(2) The department shall make a reasonable, good faith effort to determine the last known address of the alleged perpetrator.

(3) The time frame for notification can be extended beyond ten working days to include the time needed to translate the notification letter or make provisions for the safety of the alleged victim.

(4) Notice of the initial finding will be served as provided in chapter 388-02 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1111, filed 8/29/06, effective 10/1/06.]

WAC 388-101-1116 Reporting initial findings. (1) In a manner consistent with confidentiality requirements concerning the client, witnesses, and reporter, the department may provide notification of an initial finding to:

- (a) Other divisions within the department;
 - (b) The agency or program identified under RCW 74.34.068 with which the alleged perpetrator is associated as an employee, volunteer or contractor;
 - (c) Law enforcement; and
 - (d) Other investigative authorities consistent with chapter 74.34 RCW.
- (2) The notification will identify the finding as an initial finding.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1116, filed 8/29/06, effective 10/1/06.]

WAC 388-101-1121 Disputing an initial finding. (1) An alleged perpetrator of abandonment, abuse, neglect, or financial exploitation of a client may request an administrative hearing to challenge an initial finding made by the department.

(2) The request must be made in writing to the office of administrative hearings.

(3) The office of administrative hearings must receive the alleged perpetrator's written request for a hearing within thirty calendar days of the date the individual was served with notice of the initial finding.

(4) The written request for a hearing must include:

- (a) The full legal name, current address and phone number of the alleged perpetrator;
- (b) A brief explanation of why the alleged perpetrator disagrees with the initial finding;
- (c) A description of any assistance needed in the administrative appeal process by the alleged perpetrator, including a foreign or sign language interpreter or any accommodation for a disability; and
- (d) The alleged perpetrator's signature.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1121, filed 8/29/06, effective 10/1/06.]

WAC 388-101-1126 Disclosure of investigative and finding information. (1) The alleged perpetrator may only use confidential information provided by the department as needed to challenge initial findings through the appeal process.

(2) Confidential information such as the name and other personal identifying information of the reporter, witnesses, or the client will be redacted from documents unless otherwise

ordered by the administrative law judge consistent with chapter 74.34 RCW and other applicable state and federal laws.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1126, filed 8/29/06, effective 10/1/06.]

WAC 388-101-1131 Hearing procedures to dispute an initial finding. (1) Chapters 34.05 and 74.34 RCW, chapter 388-02 WAC, and the provisions of this chapter govern any appeal regarding an initial finding. In the event of a conflict between the provisions of this chapter and chapter 388-02 WAC, the provisions of this chapter shall prevail.

(2) The administrative law judge shall determine whether a preponderance of the evidence supports the initial finding that the alleged perpetrator abandoned, abused, neglected, or financially exploited a vulnerable adult, and shall issue an initial order.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1131, filed 8/29/06, effective 10/1/06.]

WAC 388-101-1136 Appeal of the administrative law judge's initial order on a finding. (1) If the alleged perpetrator or the department disagrees with the administrative law judge's decision, either party may challenge this decision by filing a petition for review with the department's board of appeals under chapter 34.05 RCW and chapter 388-02 WAC.

(2) If the department appeals the administrative law judge's decision, the department will not modify the finding in the department's records until a final hearing decision is issued.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1136, filed 8/29/06, effective 10/1/06.]

WAC 388-101-1141 Finalizing an initial finding. (1) An initial finding becomes a final finding when:

(a) The department gives the alleged perpetrator notice of the initial finding pursuant to WAC 388-101-1110 and the alleged perpetrator does not request an administrative hearing;

(b) The administrative law judge:

(i) Dismisses the hearing following withdrawal of the appeal or default; or

(ii) Issues an initial order upholding the finding and the alleged perpetrator fails to appeal the initial order to the department's board of appeals; or

(c) The board of appeals issues a final order upholding the finding.

(2) The final finding is permanent and will not be removed from the department's records unless:

(a) It is rescinded following judicial review; or

(b) The department decides to remove a single finding of neglect from its records based upon a written petition by the alleged perpetrator provided that at least one calendar year has passed since the finding was finalized and recorded.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1141, filed 8/29/06, effective 10/1/06.]

WAC 388-101-1146 Reporting final findings. The department will report a final finding of abandonment, abuse, neglect and financial exploitation within ten working days to the following:

- (1) The perpetrator;
- (2) The service provider that was associated with the perpetrator during the time of the incident;
- (3) The service provider that is currently associated with the perpetrator, if known;
- (4) The appropriate licensing authority; and
- (5) The department's registry of findings of abandonment, abuse, neglect and financial exploitation. The findings may be disclosed to the public upon request.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-1146, filed 8/29/06, effective 10/1/06.]

RESIDENTIAL SERVICES: GENERAL REQUIREMENTS

WAC 388-101-1180 What are residential services?

Residential services are instructions and supports provided to eligible clients by service providers to enable clients to live in their community. These may include:

- (1) Supported living services;
- (2) Group home services; or
- (3) Services provided in the group training home.

Residential services must follow the requirements outlined in this chapter. The client rights set forth in this chapter are the minimal rights guaranteed to all clients of certified residential services, and are not intended to diminish rights set forth in other state or federal laws that may contain additional rights.

[05-05-077, recodified as § 388-101-1180, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-030, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-030, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-030, filed 10/26/01, effective 1/1/02; 99-19-104, recodified as § 388-820-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-022, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-26-022, filed 2/5/90, effective 3/1/90. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-022, filed 2/9/83.]

WAC 388-101-1190 Who certifies residential services? Residential services are certified by RCS.

[05-05-077, recodified as § 388-101-1190, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-040, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-040, filed 10/26/01, effective 1/1/02; 99-19-104, recodified as § 388-820-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-050, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-050, filed 2/9/83.]

WAC 388-101-1200 Where are residential services provided? (1) Service providers may offer residential services in:

- (a) The client's own home;
- (b) Group homes; or
- (c) The group training home.

(2) Residential services must be located in a residential neighborhood within reasonable distance of necessary resources, unless a client chooses to live in a remote area. Resources include stores, banks, laundromats, churches, job opportunities, and other public services.

(2007 Ed.)

(a) **Exception:** Group homes certified prior to 1983 do not need to follow this requirement.

(b) **Exception:** Clients who receive community protection services may not need to follow this requirement.

[05-05-077, recodified as § 388-101-1200, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-050, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-050, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-060, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-060, filed 2/9/83.]

WAC 388-101-1205 Where are crisis diversion services provided? Crisis diversion services may be provided in either:

- (1) A single person dwelling that is maintained by the service provider; or
- (2) The client's own home.

[05-07-138, recodified as § 388-101-1205, filed 3/22/05, effective 3/22/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-056, filed 1/29/04, effective 2/29/04.]

WAC 388-101-1210 Who may receive residential services? Clients may receive residential services if they are at least eighteen years old and authorized by DDD to either:

- (1) Receive residential services outlined in this chapter; or
- (2) Have an agreement with the service provider to purchase residential services using SSP funds.

[05-05-077, recodified as § 388-101-1210, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-060, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-060, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-060, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-070, filed 8/9/91, effective 9/9/91. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-070, filed 2/9/83.]

WAC 388-101-1220 What physical and safety requirements exist for residential services? (1) Crisis diversion service providers who offer services in a client's own home are exempt from the physical and safety requirements described in this section.

For clients who receive more than forty hours of residential service per month.

(2) When clients receive more than forty hours of residential services per month, the service provider must ensure that the following physical and safety requirements are met for the client:

- (a) A safe and healthy environment;
- (b) Accessible telephone equipment;
- (c) An evacuation plan developed and practiced with the client;
- (d) An entrance and/or exit that does not rely solely upon windows, ladders, folding stairs, or trap doors;
- (e) A safe storage area for flammable and combustible materials;
- (f) Unblocked exits;
- (g) A working smoke detector, with a light-alarm for clients with hearing impairments, located close to sleeping rooms;

(h) A flashlight or a nonelectrical light source in working condition; and

(i) Basic first-aid supplies.

For clients who receive forty hours or less of residential service per month.

(3) When clients receive forty hours or less of residential services per month, at least once every six months, the service provider must ensure the following physical safety requirements are met:

(a) A safe and healthy environment;

(b) An entrance and/or exit that does not rely solely upon windows, ladders, folding stairs, or trap doors;

(c) A safe storage area for flammable and combustible materials;

(d) Unblocked exits; and

(e) A working smoke detector, with a light-alarm for clients with hearing impairments, located close to sleeping rooms.

(4) The following supports are also offered to clients who receive forty hours or less of residential services. These clients may choose not to participate in meeting these requirements. This choice must be documented by the service provider, as per WAC 388-101-1400. The supports offered include:

(a) Accessible telephone equipment;

(b) An evacuation plan developed and practiced with the client;

(c) A flashlight or a nonelectrical light source in working condition; and

(d) Basic first-aid supplies.

For all clients:

(5) The service provider must ensure that documentation is kept, showing that physical safety requirements are met. The client may independently document that these requirements are met as long as the client's IISP shows this involvement.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1220, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1220, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-070, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-070, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-070, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-072, filed 8/9/91, effective 9/9/91.]

WAC 388-101-1230 How must service providers assist clients in regulating water temperature? (1) Water temperature must be regulated by service providers for clients who receive services and supports from on-duty staff twenty-four hour a day.

(2) Service providers must assist clients so that the water temperature in their household is maintained below one hundred and twenty degrees Fahrenheit.

(3) Service providers must check the water temperature when the client first moves into the household and at least once every six months from then on. Note: The water temperature is best measured two hours after substantial hot water usage.

(4) The service provider must document compliance with this requirement.

[Title 388 WAC—p. 564]

[05-05-077, recodified as § 388-101-1230, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-076, filed 1/29/04, effective 2/29/04.]

WAC 388-101-1240 What are supported living services? (1) Supported living services are instruction and supports offered by service providers to clients who live in or are establishing their own homes. Homes must be owned, rented, or leased by the clients or their legal representatives.

(2) Clients who receive supported living services are responsible for paying for their daily living expenses, such as rent, utilities, and food, using their personal financial resources.

(3) The level of support is based on each client's instruction and support needs. Support may range from one hour per month to twenty-four hours per day of staff support per client.

[05-05-077, recodified as § 388-101-1240, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-080, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-080, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-074, filed 5/1/96, effective 6/1/96.]

WAC 388-101-1250 What are crisis diversion services? Crisis diversion services are DDD-authorized crisis residential services and supports offered to clients on a temporary basis. DDD may offer these services to clients who show a serious decline in mental functioning that puts them at risk of psychiatric hospitalization.

[05-05-077, recodified as § 388-101-1250, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-086, filed 1/29/04, effective 2/29/04.]

WAC 388-101-1260 What are group homes? (1) Group homes are residences that are licensed as either a boarding home or an adult family home by RCS, under chapters 388-78A and 388-76 WAC, respectively.

(2) Group homes must have a contract with DDD.

(3) The service provider must ensure that group homes comply with all applicable licensing regulations.

(4) Group homes provide residential services to two or more clients who are unrelated to the provider.

(5) Clients who live in group homes pay costs of room and board from their own financial resources. (See WAC 388-101-1420 for additional information.)

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1260, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1260, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-090, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-090, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-090, filed 10/26/01, effective 1/1/02; 99-19-104, recodified as § 388-820-090, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 18.88A and 71A.12 RCW. 96-10-076 (Order 3978), § 275-26-076, filed 5/1/96, effective 6/1/96.]

WAC 388-101-1400 When must a service provider document a client's refusal to participate in services? (1) A service provider must document a client's refusal to participate in:

(a) Physical and safety requirements, as outlined in WAC 388-101-1220(3); and

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(b) Health services under WAC 388-101-2140.

(2) Documentation must include the following:

(a) A description of events relating to the client's refusal to participate in these services;

(b) A plan to inform the client of the benefits of these services;

(c) A description of the service provider's efforts to give the services to the client; and

(d) Any health or safety concerns that the refusal may pose.

(3) The service provider must review this documentation with the client at least every six months. The client or client's guardian must sign the documentation after reviewing it.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1400, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1400, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-100, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-100, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-087, filed 8/9/91, effective 9/9/91.]

WAC 388-101-1410 May a service provider offer services to nonclients in the same household as clients? Service providers must notify DDD of their intent to offer services to nonclients who are in the same household with clients. DDD must approve any of these situations, considering the health, safety, and preference of the clients.

[05-05-077, recodified as § 388-101-1410, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-110, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-110, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapter 72.33 RCW. 83-05-017 (Order 1945), § 275-26-097, filed 2/9/83.]

WAC 388-101-1420 Who pays for a client's residential services? (1) DSHS must pay for contracted residential services provided to department-funded clients. Residential services are paid at the contracted rate.

(2) DSHS must require a client to share the cost of services when mandated by federal or state statute or regulation.

(3) Clients funded through SSP may purchase services through a separate agreement with the service provider.

(4) The service provider must inform DSHS when the client requires additional supports.

(a) The service provider must submit a written request with justification for additional service hours.

(b) DSHS may approve and provide payment for additional expenses or services.

(c) The service provider must retain a copy of department response.

(5) For a client who is receiving group home services and support:

(a) The client must pay for cost of care or services from earnings or other financial resources. Clients receiving SSI are responsible only for the cost of room and board.

(b) DSHS may pay for these services only after a client has used his or her own financial resources.

(c) When a client's guardian or legal representative controls the client's income, estate, or trust fund, he or she must reimburse the service provider as described in WAC 388-101-1420.

(2007 Ed.)

(6) Clients receiving supported living services must pay for their own housing, utilities, food, clothing, and other personal and incidental expenses from earnings and other financial resources.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1420, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1420, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-120, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-120, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-107, filed 8/9/91, effective 9/9/91.]

WAC 388-101-1430 When may a service provider receive initial set-up funds from DSHS? (1) DSHS may enter into a contractual agreement to reimburse the service provider for costs incurred to establish services. The costs must be based on a budget negotiated with DSHS.

(2) DSHS may reimburse service providers for client costs of establishing a residence.

(3) For reimbursement, the service provider must submit the billing documents required by DSHS.

[05-05-077, recodified as § 388-101-1430, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-130, filed 10/26/01, effective 1/1/02. 99-19-104, recodified as § 388-820-130, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.080. 91-17-005 (Order 3230), § 275-26-115, filed 8/9/91, effective 9/9/91.]

CERTIFICATION

WAC 388-101-1440 What are the different types of certification? There are three different types of certification that RCS approves for residential services:

- (1) Initial certification;
- (2) Regular certification; and
- (3) Provisional certification.

[05-05-077, recodified as § 388-101-1440, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-140, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-140, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1460 When may RCS grant initial certification to an agency? (1) Before RCS begins the certification process, the interested agency must submit a budget forecast, verification of financial stability, and staff coverage schedule to DDD.

(2) An interested agency must apply to RCS to be certified.

(3) RCS may grant initial certifications to agencies that meet the requirements outlined in this chapter.

[05-05-077, recodified as § 388-101-1460, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-150, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-150, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1470 How does an agency apply for initial certification? To apply for initial certification, an agency must go through the following application procedures.

- (1) DDD will review:
- (a) Verification of financial stability;

[Title 388 WAC—p. 565]

- (b) A budget forecast; and
- (c) A staff-coverage schedule.
- (2) After reviewing, DDD will send a letter of suggestion to RCS.
- (3) The interested agency will submit to RCS:
 - (a) A letter of intent;
 - (b) Relevant experience and qualifications of the agency;
 - (c) A minimum of two professional references;
 - (d) The administrator's resume;
 - (e) A list of the agency board of directors and affiliations, if applicable;
 - (f) Policies, principles and procedures regarding health and safety and;
 - (g) Methods on the prevention and reporting of abuse, neglect, exploitation and mistreatment to clients according to state law.

RCS may request additional information as needed to complete the application process.

- (4) Before applying to RCS, the interested agency will keep in their records the following:

- (a) A letter of intent;
- (b) A mission statement;
- (c) A statement of assurance stating that the service provider will not discriminate against a client or employee (see WAC 388-101-1630);
- (d) Verification of financial stability;
- (e) A budget forecast;
- (f) A staff coverage;
- (g) A staff in-service training plan;
- (h) The agency's policies and procedures;
- (i) Relevant experience and qualifications of the agency;
- (j) A minimum of two professional references;
- (k) A copy of the license if applying for a group home;
- (l) The administrator's resume; and
- (m) A list of the agency board of directors and affiliations, if applicable.
- (5) RCS must provide the county with a copy of the agency's letter of intent.
- (6) The county may submit written recommendations about the application to RCS within thirty calendar days after receiving the letter of intent. RCS reviews the county's recommendations.

- (7) An agency must comply within one hundred and eighty days of the certification's effective date with:

- (a) Relevant federal, state, and local laws and ordinances; and
- (b) RCS/DDD established requirements.

(8) After receiving all materials requested, a determination will be made on initial certification based on the information received. RCS notifies the agency in writing that all documentation has been received and determines if the agency meets the minimal requirements for initial certification.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1470, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1470, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-160, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-160, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1480 What happens after an agency receives initial certification? After an agency receives initial certification, DDD decides whether to grant a residential services contract with that agency.

(1) Under initial certification, agencies that receive a contract with DDD become service providers. Once a contract is in place, a service provider is approved for receiving client referrals and serving clients in a particular region for up to one hundred and eighty days. Service providers must have a separate contract for each region where they receive referrals and serve clients.

(2) If DDD does not contract with an agency, initial certification will be valid for up to a year for that agency.

[05-05-077, recodified as § 388-101-1480, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-170, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1490 May initial certification be extended for a service provider? If the initial certification expires before RCS conducts a formal review and evaluation of a service provider, RCS may extend the initial certification up to one hundred and eighty days.

[05-05-077, recodified as § 388-101-1490, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-180, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-180, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1500 How does a service provider receive regular certification? (1) RCS uses a formal review and evaluation process to determine whether a service provider has complied with certification requirements outlined in this chapter and the DSHS/DDD contract.

(2) The county may submit recommendations about a service provider to RCS.

(3) After determining that a service provider has complied with requirements, RCS may approve a service provider for regular certification.

(a) This certification allows a service provider to continue to receive referrals and provide instruction and support to clients.

(b) Regular certification may be granted to service providers for up to two years.

(4) Regular certification may be extended for a period up to one hundred and eighty days.

[05-05-077, recodified as § 388-101-1500, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-190, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-190, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1510 How often are reviews and evaluations done for service providers? (1) RCS must review and/or evaluate each service provider's services at least every two years.

(2) RCS may review a client's records and activities at any time to see if the service provider continues to address the clients' needs for instruction and support activities.

(3) DSHS may conduct additional evaluations or audits of any service provider at its discretion.

[05-05-077, recodified as § 388-101-1510, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12

RCW. 04-23-070, § 388-820-200, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-200, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1520 What occurs during review and evaluation? (1) Service providers are evaluated, using this chapter and the DSHS/DDD contract requirements.

(2) To gather information, evaluators use a sample of clients that the service provider supports. Ways to gather information for evaluation must include:

- (a) Observation of staff and client interactions;
 - (b) Interview of clients, legal representatives, and others with the client's consent; and
 - (c) Review of records.
- (3) Information may also be gathered by conducting:
- (a) Interviews with other entities contracted with DSHS; and

(b) Interviews with DSHS staff.

(4) The state-contracted evaluators discuss with the service provider their preliminary findings and request additional information and clarification.

(5) Evaluators conduct an exit conference to present the draft report to the service providers and DDD. The service provider's administrator or designee must be present at this exit conference. A copy of the draft report with preliminary findings are sent to RCS.

(a) The evaluation report will include the service provider's operation history.

(b) If the service provider has not complied with certification requirements or with its contract with DSHS/DDD, the evaluator will note the findings in the draft report.

(c) The service provider must draft a corrective action plan(s) with specific time frames and submit it to RCS for approval.

(d) At the conclusion of the exit conference, the service provider will receive a draft copy of the report including the corrective action plan(s) and the evaluator(s) will submit the draft copy to RCS.

(e) The final report, including corrective action plan(s), will be finalized by RCS and sent to the service provider.

[05-05-077, recodified as § 388-101-1520, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-210, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-210, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1530 May service providers disagree with evaluation findings? (1) If service providers disagree with evaluation findings, they must submit in writing documentation supporting their position within ten working days after the exit conference.

(2) After receiving the service provider's documentation, RCS must send written notification of its decision to the service provider within ten working days.

(3) The service provider's documentation and RCS' decision must become part of the final evaluation report.

(4) RCS must file a final report of the evaluation results and send a copy to the service provider. At this time, the evaluation report is considered to be a public document.

[05-05-077, recodified as § 388-101-1530, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-220, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-220, filed 10/26/01, effective 1/1/02.]

(2007 Ed.)

tory Authority: Title 71A RCW. 01-22-020, § 388-820-220, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1540 May a service provider receive provisional certification? (1) A service provider that does not comply with requirements of this chapter may receive provisional certification by RCS.

(2) Provisional certification may not exceed one hundred eighty days.

(3) At the end of provisional certification:

(a) If the service provider has complied with certification requirements, RCS may approve the service provider for regular certification.

(b) If the service provider has not complied with all certification requirements, RCS must revoke the service provider's certification and DSHS/DDD must terminate the contract.

[05-05-077, recodified as § 388-101-1540, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-230, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-230, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-230, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1550 When may RCS decertify a service provider? If a service provider does not comply with certification requirements, RCS may decertify a service provider under chapter 43.20A RCW. Upon decertification, DSHS/DDD must terminate the contract.

[05-05-077, recodified as § 388-101-1550, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-240, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-240, filed 10/26/01, effective 1/1/02.]

ADMINISTRATIVE REQUIREMENTS: GENERAL

WAC 388-101-1600 What are administrators of service providers required to do? RCS requires administrators of service providers to oversee all aspects of services delivered to clients, consistent with the DSHS/DDD contract. This includes:

(1) Overseeing all aspects of staff development, such as recruitment and staff training;

(2) Preparing and maintaining policies and procedures related to client services, personnel, and financial records; and

(3) Securely storing client, personnel, and financial records.

[05-05-077, recodified as § 388-101-1600, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-250, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-250, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1610 What type of administrative documents are service providers required to have? (1) Service providers must have these written statements:

(a) A mission statement;

(b) Program description;

(c) An organizational chart and description showing all supervisory relationships; and

(d) Definition of staff roles and responsibilities, including the person designated to act in the absence of the administrator.

(2) Service providers must also have these policies and procedures:

- (a) Admission criteria;
- (b) Client rights, including a client's right to file a complaint or suggestion without interference;
- (c) Client grievance procedures; and
- (d) Methods used for soliciting client input and feedback on services and support received.

(3) Service providers must have health and safety policies and procedures including:

- (a) Information on how to report suspected abuse, neglect, exploitation, and mistreatment;
- (b) Plans for responding to missing persons; client emergencies, including access to medical, mental health, and law enforcement resources; and natural or other disasters; and
- (c) Notification of client's guardian and/or relatives in case of emergency.

(4) In addition to other required documents, service providers must keep all documents, policies and procedures as required by the Centers for Medicare and Medicaid Services and any other applicable state or federal laws and have them readily available to DSHS.

[05-05-077, recodified as § 388-101-1610, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-260, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-260, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-260, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1620 What are the requirements for personnel policies? (1) Service providers must maintain current written personnel policies and procedures.

(2) Personnel policies and procedures must be available to all employees.

[05-05-077, recodified as § 388-101-1620, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-270, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1630 What nondiscrimination requirements must agencies and service providers meet?

(1) When employing staff or supporting clients, agencies and service providers must not discriminate against any person on the basis of:

- (a) Race;
- (b) Color;
- (c) Creed;
- (d) Religion;
- (e) National origin;
- (f) Age;
- (g) Gender;
- (h) Presence of any sensory, mental, or physical disability, including HIV/AIDS conditions;
- (i) Use of a trained dog guide or service animal by a person with a disability;
- (j) Marital status;
- (k) Disabled status or Vietnam Era veteran status;
- (l) Sexual orientation; and
- (m) Any other reasons prohibited by law.

[Title 388 WAC—p. 568]

(2) **Exception:** An employer may deny employment to a person if the decision is based upon a bona fide occupational qualification. (See chapter 49.60 RCW.)

[05-05-077, recodified as § 388-101-1630, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-280, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1640 What staffing requirements must service providers meet? (1) A service provider must have a designated administrator.

(2) Clients must have immediate access to staff, or the means to contact staff, at all times: Twenty-four hours a day, seven days a week.

(3) A service provider must provide adequate staff within contracted hours to administer the program and meet the needs of the clients.

(4) Each group home must maintain staffing that complies with:

(a) Boarding home or adult family home licensing requirements under chapter 388-78A or 388-76 WAC, respectively; and

(b) Contract requirements with the division of developmental disabilities.

[05-05-077, recodified as § 388-101-1640, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-290, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-290, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-290, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1650 May clients instruct and support other clients? (1) Clients must not be routinely involved in the unpaid instruction and support of other clients.

(2) Clients placed in crisis diversion services must not be involved in the instruction and support of other clients.

[05-05-077, recodified as § 388-101-1650, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-300, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-300, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1660 Who needs background checks?

(1) Service providers must obtain background checks from DSHS for all administrators, employees, volunteers and sub-contractors showing that there are no disqualifying records to prevent individuals from working with clients.

(2) Before administrators, employees, volunteers or sub-contractors may have unsupervised access to clients, the service provider must have a background check report from DSHS. This report must indicate that the individual has no disqualifying records that prevent him or her from working with clients.

(3) In certain situations, administrators, employees, volunteers, or subcontractors can only work with clients when they are directly observed by staff authorized to have unsupervised access to clients. These situations are:

(a) The service provider has not yet received a DSHS response for a background check request;

(b) DSHS has disqualified the individual based on background check information; or

(2007 Ed.)

(c) The individual is awaiting FBI clearance and does not have provisional clearance from their employer under WAC 388-06-0500 through 388-06-0540.

(4) Background checks must be renewed at least every thirty-six months for each administrator, employee, volunteer or subcontractor of a contracted service provider.

(5) Licensed boarding homes or licensed adult family homes must adhere to the current regulations set forth in this chapter and in the applicable licensing laws.

(6) Service providers must follow the requirements of RCW 43.43.830 and 74.15.030.

[05-05-077, recodified as § 388-101-1660, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-310, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-310, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-310, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1670 What are the minimum requirements for staff employed by service providers? Service provider staff must meet the following minimum requirements:

- (1) Pass background check as per WAC 388-101-1660;
- (2) Exhibit job-related competency and the ability to make independent judgments;
- (3) Have a high school diploma or GED equivalent, unless the employees were hired before September 1, 1991;
- (4) Be at least eighteen years of age when employed as a direct care staff, or at least twenty-one years of age when employed as an administrator; and
- (5) Treat clients with dignity and consideration, respecting the clients' civil and human rights at all times.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1670, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1670, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-320, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-320, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1680 What staff training is required? The service provider must give specific training to staff. Within the first six months, staff must receive a minimum of thirty-two total hours of training that meet the following requirements.

- (1) Before the employee works alone with clients, the service provider must explain the following to the employee:
 - (a) The current instruction and support plans of the clients with whom the employee works;
 - (b) Emergency procedures for clients;
 - (c) The state law on abuse and neglect; and
 - (d) Client confidentiality.
- (2) Within the first four weeks of employing a staff person, the service provider must provide training that includes:
 - (a) The service provider's mission statement;
 - (b) Policies and procedures; and
 - (c) On-the-job training.
- (3) Additional training within the first six months must include:
 - (a) First aid/CPR;
 - (b) Bloodborne pathogens with HIV/AIDS information; and
 - (c) Client services.

(2007 Ed.)

(4) Each employee must keep first aid/CPR certification and bloodborne pathogens training current.

(5) The service provider must document orientation and training activities.

(6) Group homes must also meet the training requirements mandated by the licensing requirements specified in chapter 388-78A WAC.

[05-05-077, recodified as § 388-101-16800, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-330, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-330, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-330, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1690 How often must performance reviews be conducted for staff of service providers? (1) Written performance reviews for staff of residential service providers must be conducted at least every twenty-four months and kept on file.

(2) If the service provider is a nonprofit organization, the organization's governing board, must give written performance reviews for administrators every twenty-four months.

(3) If the service provider is a for-profit organization, owners are not required to have performance reviews.

(4) If the service provider is a governmental agency, administrators are evaluated by their supervisor.

[05-05-077, recodified as § 388-101-1690, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-340, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-340, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1700 When must service providers have staff-coverage schedules approved by DDD? (1) DDD must approve staff-coverage schedules for those service providers who have on-duty staff twenty-four hours a day.

(2) The staff-coverage schedules must be approved at the following times:

- (a) Before certification review takes place;
 - (b) When household configuration changes affect staff coverage; or
 - (c) When additional staffing is requested.
- (3) Staff-coverage schedules may be requested by DDD at any time.
- (4) Each service provider must retain copies of the approved staff-coverage schedules.

[05-05-077, recodified as § 388-101-1700, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-350, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-350, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1710 What happens when a service provider's ownership changes? (1) A service provider must inform RCS and DDD in writing sixty days before a change of ownership occurs.

(2) On the effective date of a change of ownership, RCS must terminate the department's certification and DSHS/DDD must terminate the contract with the previous service provider.

[Title 388 WAC—p. 569]

(3) DDD must withhold final payment to the previous service provider until that service provider submits and DSHS accepts all reports and required documents.

(4) DDD is under no obligation to contract with the new owner entity.

[05-05-077, recodified as § 388-101-1710, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-360, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-360, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1720 When may a client's service provider change? A client's service provider may change when:

- (1) A client stops receiving residential services and supports from a service provider;
- (2) A service provider transfers ownership; or
- (3) The client chooses a different service provider.

[05-05-077, recodified as § 388-101-1720, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-370, filed 10/26/01, effective 1/1/02.]

ADMINISTRATIVE REQUIREMENTS: CLIENT RECORDS

WAC 388-101-1730 Are clients' records considered confidential? (1) The service provider and staff must consider all client record information privileged and confidential. Copies of client record information are available to:

- (a) DSHS, the client, and/or legal representative upon their request to the service provider; and
 - (b) The county developmental disabilities board with DDD approval, as allowed under RCW 71A.14.070.
- (2) Any other transfer or inspection of records must be authorized by a release of information form that:
- (a) Specifically gives information about the transfer or inspection; and
 - (b) Is signed by the client or guardian.
- (3) A signed release of information is valid for up to one year.

[05-05-077, recodified as § 388-101-1730, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-380, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1740 How long does a service provider need to keep client records? (1) While supporting a client, a service provider must keep a client's records from at least the past four years.

(2) After a client's participation with a service provider ends, the client's records must be kept by the service provider for at least six years.

[05-05-077, recodified as § 388-101-1740, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-390, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1750 What information do service providers need to keep in client records? (1) Crisis diversion service providers are exempt from the client record requirements specified in this section. Instead, they must follow requirements outlined in WAC 388-101-1760.

(2) Service providers must keep certain information in client records to fulfill DSHS requirements. The client's records must include, but not be limited to, the following:

(a) The client's name, address, and Social Security number.

(b) The name, address, and telephone number of the client's relative, guardian or legal representative.

(c) Copies of legal guardianship papers, if any.

(d) Client health records, including:

(i) The name, address, and telephone number of the client's physician, dentist, mental health service provider, and any other health care service provider;

(ii) Health care service providers' instructions about health care needed, including appointment dates and date of next appointment if appropriate;

(iii) Written documentation that the health care service providers' instructions have been followed; and

(iv) A record of major health events and surgeries when known.

(e) A copy of the client's most recent individual service plan or plan of care (ISP/POC).

(f) The client's individual instruction and support plan (IISP), including:

(i) Instruction and support activities for each client as a basis for review and evaluation of client's progress;

(ii) Semiannual review of the IISP;

(iii) Consultation with other service providers and other interested persons;

(iv) IISP revisions and changes; and

(v) Other activities relevant to the client that the client wants included.

(g) Progress notes and incident reports on clients.

(h) The client's financial records for funds managed by the service provider, including:

(i) Receipts, ledgers and records of the client's financial transactions; and

(ii) Client's related bankbooks, checkbooks, bank registers, tax records and bank statements.

(i) Burial plans and wills.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-1750, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-1750, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-400, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-400, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-400, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1760 What information do crisis diversion service providers need to keep in client records?

(1) All crisis diversion service providers must keep the following information in client records:

(a) The client's name, address, and Social Security number.

(b) The name, address, and telephone number of the client's relative, guardian or legal representative.

(c) Progress notes and incident reports on clients.

(2) Crisis diversion service providers other than those offering services in a client's own home have additional requirements. These service providers also must keep the following information in client records:

(a) An initial assessment;

(b) A crisis service plan;

(c) Copies of legal guardianship papers, if any;

(d) Client health records, including:

(i) The name, address, and telephone number of the client's physician, dentist, mental health service provider, and any other health care service provider;

(ii) Health care service providers' instructions about health care needed, including appointment dates and date of next appointment if appropriate;

(iii) Written documentation that the health care service providers' instructions have been followed; and

(iv) A record of major health events and surgeries when known.

[05-05-077, recodified as § 388-101-1760, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-405, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-405, filed 1/29/04, effective 2/29/04.]

WAC 388-101-1770 Do service providers need to keep client's property records? (1) Crisis diversion service providers who offer services in a client's own home are exempt from requirements in this section.

(2) The service provider must assist clients in maintaining current, written property records when the clients receive forty hours or more a month of services. The record consists of:

(a) A list of items with a value of at least twenty-five dollars that the client owns when moving into the program;

(b) A list of personal possessions with a value of seventy-five dollars or more per item once the client is receiving services;

(c) Description and identifying numbers, if any, of the property;

(d) The date the client purchased the items after moving into the program;

(e) The date and reason for addition or removal from the record; and

(f) The signature of the staff or client making the entry.

[05-05-077, recodified as § 388-101-1770, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-410, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-410, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1780 Are there requirements for record entries? (1) The service provider must note all record entries in ink.

(2) Entries must be made at the time of or immediately following the occurrence of the event recorded, in legible writing, and dated and signed by the person making the entry.

[05-05-077, recodified as § 388-101-1780, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-420, filed 10/26/01, effective 1/1/02.]

EMERGENCIES

WAC 388-101-1790 Who must service providers notify in emergencies? In emergencies, a service provider must:

(1) Notify the client's guardian or legal representative as soon as possible;

(2) Immediately report to DSHS about a serious incident or emergency; and

(2007 Ed.)

(3) Submit a written incident report to DSHS, as required by law or policy.

[05-05-077, recodified as § 388-101-1790, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-430, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-430, filed 10/26/01, effective 1/1/02.]

CLIENT SERVICES

WAC 388-101-1800 What are client services? Clients must receive instruction and support activities in one or more of these client services:

(1) Health and safety;

(2) Personal power and choice;

(3) Competence and self-reliance;

(4) Positive recognition by self and others;

(5) Positive relationships; and

(6) Integration in the physical and social life of the community.

[05-05-077, recodified as § 388-101-1800, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-450, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1810 What health and safety support may a service provider offer to a client? Service providers offer health and safety support to assist clients. This may include assisting clients to:

(1) Know when they need health services;

(2) Maintain good health;

(3) Learn about basic nutrition;

(4) Learn about human sexuality;

(5) Use health services, including mental health services;

(6) Manage and/or self-administer their medications;

(7) Deal with illness and injury;

(8) Apply first-aid procedures;

(9) Learn self-protection;

(10) Become aware of fire evacuation plans and burglary protection strategies; and

(11) Know emergency procedures, such as using 911 or a local emergency number.

[05-05-077, recodified as § 388-101-1810, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-460, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1820 What support may a service provider offer to a client to increase personal power and choices? Service providers support a client's personal power and choices. This may include assisting clients to:

(1) Secure housing and furnishings that reflect personal preferences, life style, and financial means;

(2) Express personal opinions and make decisions;

(3) Learn and exercise rights and responsibilities;

(4) Improve communication skills;

(5) Participate in a variety of activities of their choice, including new experiences;

(6) Exercise voter rights;

(7) Learn about and participate in self-advocacy and protection services; and

(8) Make career choices.

[05-05-077, recodified as § 388-101-1820, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-470, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1830 What support may a service provider offer to increase a client's competence and self-reliance? Service providers increase a client's competence and self-reliance. This may include assisting clients to:

- (1) Develop and achieve their goals;
- (2) Learn and use daily living skills, such as meal planning and preparation, grocery shopping, doing laundry, using household appliances, managing money, and using leisure time;
- (3) Identify situations where the client needs or desires assistance from others;
- (4) Complete or participate in all tasks within their abilities; and
- (5) Acquire and use adaptive devices and equipment, as needed.

[05-05-077, recodified as § 388-101-1830, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-480, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1840 How may service providers assist clients in gaining positive recognition? Service providers encourage a client's positive recognition. This may include assisting clients to:

- (1) Create positive self-esteem and feelings of self-worth;
- (2) Choose valued social roles;
- (3) Make choices that enhance their positive recognition by community members; and
- (4) Present themselves in ways that are typical of other people in their community.

[05-05-077, recodified as § 388-101-1840, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-490, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1850 What support may a service provider offer to increase the positive relationships in the client's life? Service providers encourage clients in developing, maintaining, and expanding positive relationships. This may include assisting clients to:

- (1) Improve their communication skills;
- (2) Experience opportunities to meet and interact with other people;
- (3) Initiate, build and sustain relationships;
- (4) Involve the client's guardian, chosen family members or representative in planning and making decisions that affect the client;
- (5) Resolve disagreements with peers, family, friends, staff, neighbors, and coworkers; and
- (6) Cope with the loss of a significant relationship, such as the death of a friend or family member, the end of a relationship, the loss of a job, or a change of staff.

[05-05-077, recodified as § 388-101-1850, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-500, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1860 How may a service provider assist clients with becoming integrated into their community? Service providers encourage clients to become inte-

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grated into the physical and social life of the community. Service providers may assist clients to:

- (1) Use community resources such as grocery store, bank, and social organizations;
- (2) Use available transportation;
- (3) Access educational and vocational opportunities; and
- (4) Participate on boards, committees, or other positions of influence or status.

[05-05-077, recodified as § 388-101-1860, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-510, filed 10/26/01, effective 1/1/02.]

CLIENT SERVICE PLANS

WAC 388-101-1870 What is an individual service plan/plan of care (ISP/POC) for clients? An individual service plan or plan of care (ISP/POC) is required for each client. The ISP/POC outlines the support needs and interests of the client. The plan identifies the responsibilities of the service provider and other entities in supporting the client. Examples of other entities are: Vocational provider, therapists, nurses, and advocates. (See RCW 71A.18.010.)

[05-05-077, recodified as § 388-101-1870, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-520, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-520, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1880 Who is responsible for completing and overseeing a client's ISP/POC? The client's DDD case resource manager is responsible for completing and overseeing a client's individual service plan or plan of care (ISP/POC).

[05-05-077, recodified as § 388-101-1880, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-530, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-530, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1890 Who may participate in creating a client's ISP/POC? (1) The case resource manager must have face-to-face contact with the client in developing the individual service plan or plan of care (ISP/POC).

(2) The case resource manager must also involve the client's guardian or legal representative and the service provider.

(3) In creating a client's individual service plan or plan of care (ISP/POC), under RCW 71A.18.010, the client and DDD case resource manager may involve:

- (a) Department staff; and
- (b) Other interested persons invited by the client.

[05-05-077, recodified as § 388-101-1890, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-540, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-540, filed 10/26/01, effective 1/1/02.]

WAC 388-101-1900 How often must the ISP/POC be reviewed? (1) An ISP/POC meeting must be held and a new ISP/POC developed with the client at least every twelve months, under RCW 71A.18.010. The meeting must be held in the client's home unless requested otherwise by the client.

(2007 Ed.)

(2) A client may request a review of the ISP/POC at any time.

[05-05-077, recodified as § 388-101-1900, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-550, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-550, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-550, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2000 What plans must crisis diversion service providers develop? Crisis diversion service providers must develop the following plans for each client they support:

(1) An initial assessment plan within forty-eight hours of placement; and

(2) A crisis service plan within seven days of placement.

[05-05-077, recodified as § 388-101-2000, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-555, filed 1/29/04, effective 2/29/04.]

WAC 388-101-2010 What is an individual instruction and support plan (IISP) for clients? (1) An individual instruction and support plan (IISP) outlines the specific goals for carrying out the residential services portion outlined in the individual service plan or plan of care (ISP/POC). The IISP also must describe the methods of instruction and/or support needed to reach the client's goal.

(2) The IISP must be based on the goals of the individual service plan or plan of care (ISP/POC), reflect the client's preferences, and have the client's agreement.

(3) The IISP identifies activities and opportunities that promote one or more of the following client services:

- (a) Health and safety;
- (b) Personal power and choice;
- (c) Positive recognition by self and others;
- (d) Integration in the physical and social life of the community;
- (e) Positive relationships; and
- (f) Competence and self-reliance.

[05-05-077, recodified as § 388-101-2010, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-560, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-560, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-560, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2020 Who may participate in developing the IISP for each client? (1) The service provider must develop with each client a written individual instruction and support plan (IISP).

(2) The client may involve other interested individuals in developing the IISP.

(3) The service provider must facilitate the individual instruction and support plan (IISP) in a manner that:

- (a) Is respectful and inclusive of the client;
- (b) Is appropriate to the age of the client or is preferred by the client;
- (c) Takes place or occurs in community settings; and
- (d) Results in opportunities for clients to experience positive change and personal growth.

[05-05-077, recodified as § 388-101-2020, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-570, filed 10/26/01, effective 1/1/02.]

(2007 Ed.)

WAC 388-101-2030 Who oversees the IISP for each client? (1) The service provider must oversee the progress made on each client's individual instruction and support plan (IISP).

(2) In overseeing each client's IISP, the service provider must:

(a) Consult with other service providers serving the client and other interested persons, as needed, to coordinate the IISP;

(b) Revise the IISP as goals are achieved, or as requested by the client and/or guardian; and

(c) Review and update the plan at least every six months.

[05-05-077, recodified as § 388-101-2030, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-580, filed 10/26/01, effective 1/1/02.]

CLIENT FUNDS

WAC 388-101-2040 May a service provider manage a client's funds? (1) A service provider may manage a client's funds after either:

(a) Obtaining written consent from the client, the client's guardian or legal representative; or

(b) Becoming the designated payee by the source of the client's unearned income.

Note: An example is a client receiving unearned income from the Social Security Administration.

(2) A client's funds are considered to be managed by a service provider when the service provider:

(a) Has signing authority and may disperse a client's funds; and/or

(b) May limit access to client funds by not allowing funds to be expended.

[05-05-077, recodified as § 388-101-2040, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-590, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2050 May a service provider hold bankbooks and bankcards for a client? Clients may ask a service provider to hold their bankbooks and bankcards while still having access to their own funds. This must be documented in the client's record and updated annually.

Note: In this situation, service providers are not necessarily considered managers of the client's funds.

[05-05-077, recodified as § 388-101-2050, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-600, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-600, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2060 May a service provider combine agency and client funds? A service provider may not combine client funds with any agency funds, such as agency operating funds.

[05-05-077, recodified as § 388-101-2060, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-610, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2070 Does the service provider need to develop an individual financial plan (IFP) for clients?

(1) A financial management plan is required only for those clients whose funds are managed by the service provider. The

client and service provider must develop this individual financial plan (IFP) together.

(2) The IFP must be reviewed at least every twelve months by the service provider and client.

(3) A copy of the IFP must be sent to:

(a) The guardian and/or legal representative; and

(b) The client's DDD case resource manager upon request.

[05-05-077, recodified as § 388-101-2070, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-620, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2080 What information must the IFP include? This plan must include all of the following items:

(1) The part of the client's funds and income that will be managed by the service provider;

(2) The part of client funds and income that will be managed by the client or legal representative;

(3) The type of accounts used;

(4) A budget process;

(5) Asset management, such as personal property, burial plan, retirement funds, stock, and vehicles;

(6) Cash management;

(7) Money management instruction and/or support;

(8) An explanation of which purchases require receipts;

(9) Contingency plan for expenditures if a client's resources exceed the home and community based services (HCBS) waiver limit; and

(10) A signature of the client and the client's guardian, if any.

[05-05-077, recodified as § 388-101-2080, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-630, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-630, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2090 How does a service provider manage client funds? (1) For client's funds that the service provider manages, the service provider must:

(a) Separately track each client's money even when several clients reside together;

(b) Keep the client's account current by maintaining a running balance;

(c) Reconcile the client's account to the bank statement on a monthly basis;

(d) Make deposits to the client's account within one week of receiving the client's money;

(e) Prevent the client's account from being overdrawn;

(f) Ensure that individual cash funds do not exceed seventy-five dollars per person unless specified differently in the individual's financial plan; and

(g) Retain receipts for purchases of over twenty-five dollars.

(2) When a client's service provider receives a check made out to the client, the service provider assisting the client must either:

(a) Get the client's signature and designation "for deposit only," and deposit the check in the client's account; or

(b) Get the client's "x" mark in the presence of another witness, cosign the check with the designation "for deposit only," and deposit the check in the client's account.

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(3) If the check for a client is made out to a payee other than the client, the payee signs the check.

(4) Clients must never sign a blank check.

(5) When clients use checks for purchases, they must sign checks at the time of purchase unless specified differently in their individual financial plan.

(6) The service provider must document the names of any staff who assist a client with financial transactions.

[05-05-077, recodified as § 388-101-2090, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-640, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2100 What documentation must service providers keep to protect a client's financial interests? Service providers must keep certain documentation for the part of funds they manage for clients. This protects clients' financial interests.

(1) Documentation for bank and cash accounts must include a monthly reconciliation and verification of the reconciliation. The reconciliation and/or verification must be completed by a person who did not make or assist in any financial transaction.

(2) Other documentation that a service provider must keep for client financial transactions include:

(a) Monthly bank statements and reconciliation;

(b) Checkbook registers and bankbooks;

(c) Deposit receipts;

(d) Receipts for purchases over twenty-five dollars;

(e) Any itemized subsidiary ledgers showing deposits, withdrawals, and interest payments to individual clients; and

(f) A control journal for trust accounts.

(3) Other documentation that a service provider must keep for client cash transactions include:

(a) A detailed ledger signed by the person who withdrew any of the client's money;

(b) Monthly reconciliation to the cash amount;

(c) Detailed accounting of the money received on behalf of the client, such as cash received from writing checks over the purchase amount, and a list of where the money was spent; and

(d) Receipts for purchases over twenty-five dollars where service provider staff withdrew the money.

(4) Service providers must notify DSHS when the client:

(a) Receives services under a home and community based services (HCBS) waiver; and

(b) Has an account that reaches three hundred dollars less than the maximum amount allowed by federal or state law.

Note: CAP-waiver is defined under WAC 388-825-170.

[05-05-077, recodified as § 388-101-2100, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-650, filed 11/15/04, effective 12/16/04. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-650, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-650, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2110 How are a client's funds transferred when they are managed by a service provider? When a service provider manages a client's funds, transferring those funds must follow specific procedures.

(2007 Ed.)

(1) When a client transfers from one service provider to another, the previous service provider must transfer client funds within thirty days. To transfer funds, the previous service provider must:

(a) Give the client, the client's guardian, and/or the legal representative a written accounting of all known client funds;

(b) When applicable, give the new service provider a written accounting of all transferred client funds;

(c) Obtain a written receipt from the client, client's guardian and/or legal representative for all transferred funds; and

(d) When applicable, obtain the new service provider's written receipt for the transferred funds.

(2) When a client becomes incapacitated or a client's whereabouts are unknown, the client's service provider must transfer the client's funds within one hundred and eighty days to the client's legal guardian, to DSHS, or to the requesting governmental entity.

(3) When a client dies, the service provider must transfer the client's funds within ninety days to:

(a) The client's guardian;

(b) The legal representative;

(c) The requesting governmental entity; or

(d) DSHS if the client does not have a legal heir.

[05-05-077, recodified as § 388-101-2110, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-660, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2120 How does a service provider handle loans to a client? (1) A service provider may loan money to a client from the service provider's funds and collect the debt from the client by installments.

(2) The client's service provider must **not**:

(a) Charge a client interest for money loaned; or

(b) Borrow funds from the client.

(3) A service provider must retain a signed agreement with the client.

(4) Documentation must be kept for:

(a) The amount loaned;

(b) Payments; and

(c) The balance owed.

[05-05-077, recodified as § 388-101-2120, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-670, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2130 When must a service provider pay a client? A service provider must pay a client when:

(1) A service provider or staff has stolen, misplaced, or mismanaged client funds.

(2) There are service charges incurred on a trust account that the service provider operates for a client.

(3) A client performs work for the service provider.

(a) The service provider must pay the client at least the current minimum wage.

(b) Clients who work for a service provider must be paid according to federal and state law requirements.

[05-05-077, recodified as § 388-101-2130, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-680, filed 10/26/01, effective 1/1/02.]

(2007 Ed.)

CLIENT HEALTH SERVICES

WAC 388-101-2140 What must service providers do to support a client's health? (1) The service provider must give necessary assistance to the client in:

(a) Accessing health, mental health, and dental services; and

(b) Medication management, administration and assistance.

(2) For clients who receive an average of thirty hours or more of service per month or are placed in the diversion services, the service provider must:

(a) Maintain health records;

(b) Assist the client in arranging appointments with health professionals;

(c) Monitor medical treatment prescribed by health professionals;

(d) Communicate directly with health professionals when needed; and

(e) Ensure that the client receives an annual physical and dental examination unless the appropriate medical professional gives a written exception. Crisis diversion service providers are exempt from this requirement.

[05-05-077, recodified as § 388-101-2140, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030 and chapter 71A.12 RCW. 04-04-043, § 388-820-690, filed 1/29/04, effective 2/29/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-690, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2150 May a client refuse health care services? A client may refuse to participate in health care services. Service providers must document these situations, according to WAC 388-101-1400.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-2150, filed 5/3/05, effective 6/3/05. 05-05-077, recodified as § 388-101-2150, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-700, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2160 When may client funds be used for health services? (1) Client funds for health services may be used when no other funding is available.

(2) A service provider must document all denials from:

(a) DSHS' medical assistance administration; and/or

(b) Private insurance companies or other carriers of primary medical insurance.

(3) The written documentation must be given to the client's DDD case resource manager and kept in the client's files.

[05-05-077, recodified as § 388-101-2160, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-710, filed 10/26/01, effective 1/1/02.]

CLIENT TRANSPORTATION

WAC 388-101-2300 Client transportation. (1) The service provider must provide transportation or ensure that clients have a way to get to:

(a) Emergency medical care;

(b) Medical appointments; and

(c) Therapies.

(2) Within available resources, the service provider must provide necessary assistance with transportation to and from:

- (a) Work, school or other publicly funded services;
- (b) Leisure or recreation activities;
- (c) Client-requested activities; and
- (d) ISP/POC- or IISP-related activities.

(3) A vehicle that the service provider uses to transport clients must be:

- (a) In safe operating condition; and
- (b) Insured as required by chapters 46.29 and 46.30 RCW.

(4) Service providers, employees, and subcontractors who transport clients must have a valid driver's license as required by chapter 46.20 RCW.

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 06-18-038, § 388-101-2300, filed 8/29/06, effective 10/1/06. 05-05-077, recodified as § 388-101-2300, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-720, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-720, filed 10/26/01, effective 1/1/02.]

DISPUTE RIGHTS

WAC 388-101-2330 May an agency or service provider contest a RCS decision? (1) An agency or service provider may contest a RCS decision about certification within twenty-eight days of being notified of the decision.

(2) Within this twenty-eight day period, the agency or service provider must request in writing that the RCS director or designee review the decision. The agency or service provider must:

- (a) Sign the request;
- (b) Identify the challenged decision and the date it was made;
- (c) State specifically the issues and regulations involved and the grounds for the service provider's disagreement; and
- (d) Include with the request copies of any supporting documentation for the service provider's position.

[05-05-077, recodified as § 388-101-2330, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-880, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-880, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2340 When does an administrative review conference occur? (1) After receiving the agency or service provider's timely written request to review a decision, RCS has twenty-eight days to contact the service provider to schedule an administrative review conference at a mutually convenient time.

(2) **Exception:** The agency or service provider and RCS may agree in writing to a specific later date for the conference.

[05-05-077, recodified as § 388-101-2340, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-890, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-890, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2350 May an administrative review conference be conducted by telephone? (1) The administra-

tive review conference between RCS and an agency or service provider may be conducted by telephone.

(2) **Exception:** If either RCS, or the agency or service provider requests in writing that the conference be held in person, the conference may not be conducted by telephone.

[05-05-077, recodified as § 388-101-2350, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-900, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-900, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2360 What happens during the administrative review conference? (1) The agency or service provider requesting an administrative review conference and appropriate RCS representatives must attend the conference.

(2) The agency or service provider must bring to the conference, or give to RCS before the conference, any supporting documentation for the service provider's position.

(3) The parties must clarify and attempt to resolve the issues at the conference.

(4) If additional documentation is needed to resolve issues, a second session of the conference must be scheduled. The second conference must be scheduled no later than twenty-eight days after the initial session unless both parties agree in writing to a specific later date.

(5) The director or designee of RCS must give a written decision to the service provider after the end of the conference.

[05-05-077, recodified as § 388-101-2360, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-910, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-910, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2370 May an agency or service provider contest the decision from the administrative review conference? At the administrative review conference, an agency or service provider may contest a decision made by the director or designee of RCS. To contest a decision, the agency or service provider may request a hearing. The hearing procedure follows the requirements under chapter 388-02 WAC.

[05-05-077, recodified as § 388-101-2370, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-920, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-920, filed 10/26/01, effective 1/1/02.]

REQUESTS FOR EXCEPTIONS

WAC 388-101-2380 Does RCS make exceptions to the requirements in this chapter? RCS may grant service providers exceptions to the requirements specified in this chapter as long as the following conditions are met:

(1) The service provider must submit a written request for an exception to the DDD regional administrator of the region where the contract is held.

(2) DDD must evaluate requests for exceptions, considering:

- (a) The health and safety of the clients;
- (b) The quality of the services;

- (c) Supervision; and
- (d) The impact on client services.

(3) DDD must send a copy of the requests that have significant impacts on client services to the client(s) involved. DDD must then give the client an opportunity to comment before an exception is granted.

(4) DDD will send their recommendations of the exceptions of the requirements to RCS within twenty working days.

(5) The RCS director or designee will approve or deny the request in writing within ten working days after receiving the recommendation from DDD.

(6) Any exception granted must be in line with the legislative intent of Title 71A RCW.

(7) Service providers must retain a copy of each RCS-approved exception.

(8) Service providers do not have hearing rights when they receive a denial from RCS for an exception to the rules in this chapter.

[05-05-077, recodified as § 388-101-2380, filed 2/15/05, effective 2/15/05. Statutory Authority: RCW 71A.12.030, 71A.12.080, and chapter 71A.12 RCW. 04-23-070, § 388-820-930, filed 11/15/04, effective 12/16/04. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-930, filed 10/26/01, effective 1/1/02.]

NURSE DELEGATION

WAC 388-101-2400 Who may delegate nursing care tasks? (1) Any registered nurse (RN) may delegate specified nursing care tasks to staff who become qualified nursing assistants. Qualified nursing assistants may perform nursing care tasks only for the client who is specified by the RN to receive care.

(2) One nursing assistant must not transfer delegated authority to perform nursing care tasks to another nursing assistant.

[05-07-138, recodified as § 388-101-2400, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-730, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2410 What training is required before staff are qualified to perform delegated tasks? (1) Before performing delegated tasks, staff must:

- (a) Be registered or certified as a nursing assistant (NAR or NAC, respectively);
- (b) Complete nurse delegation core training approved by DSHS and receive a certificate; and
- (c) Receive client-specific training from the delegating registered nurse.

(2) In addition, registered nursing assistants must complete thirty-two hours of staff training required by WAC 388-101-1680 before doing nursing care tasks. Certified nursing assistants may perform delegated tasks before completing the required thirty-two hours of staff training.

(3) After the staff member completes the required training, the service provider must keep:

- (a) Written instructions provided by the delegating registered nurse; and
- (b) A copy of the current registration or certification for each employee.

(2007 Ed.)

[Statutory Authority: RCW 71A.12.030, 71A.12.080, and Title 71A RCW. 05-10-086, § 388-101-2410, filed 5/3/05, effective 6/3/05. 05-07-138, recodified as § 388-101-2410, filed 3/22/05, effective 3/22/05. 05-05-077, recodified as § 388-101-2310, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-740, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2420 Do nursing assistants need to comply with department of health requirements? Nursing assistants must comply with department of health (DOH) requirements under chapter 246-840 WAC.

[05-07-138, recodified as § 388-101-2420, filed 3/22/05, effective 3/22/05. 05-05-077, recodified as § 388-101-2320, filed 2/15/05, effective 2/15/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-750, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2430 Who is authorized to provide consent for a client's receiving health care? (1) Before nursing assistants perform nursing care tasks for a client, the registered nurse must obtain consent from the client or person authorized to give consent.

(2) Under RCW 7.70.065, if a client is unable to give consent or is incapacitated, certain people are authorized to provide consent for a client's receiving health care. These people must be one of the following in this priority order:

- (a) The legal guardian, if any;
 - (b) An individual who holds a durable power of attorney for health care decisions;
 - (c) The client's spouse;
 - (d) The client's children who are at least eighteen years of age;
 - (e) The client's parents; and
 - (f) The client's adult siblings.
- (3) Proof of consent must be kept in the client's files.

[05-07-138, recodified as § 388-101-2430, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-760, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2440 What rights do nursing assistants have concerning the delegation of nursing care tasks? Nursing assistants have certain rights when nursing care tasks are delegated by the registered nurse.

- (1) The nursing assistant:
 - (a) May consent or refuse to consent to perform a delegated nursing care task; and
 - (b) Must not receive employer reprisal for refusing to accept the delegation of a nursing care task if the refusal is based on client safety issues.

(2) The service provider must post the toll-free telephone number (1-800-562-6078), established by DSHS' aging and adult services administration, for complaints about the delegation of nursing tasks to nursing assistants. This phone number is on DSHS forms: 13-678B, 13-680 and 13-681.

[05-07-138, recodified as § 388-101-2440, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-770, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2450 Are nursing assistants liable for errors while doing nursing care tasks? If nursing assistants are following written directions from the delegating nurse, they are not liable for errors in doing nursing care tasks.

[Title 388 WAC—p. 577]

[05-07-138, recodified as § 388-101-2450, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-780, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2460 What happens if unqualified staff do a nursing task? (1) DSHS must impose a civil fine on any service provider who knowingly performs or permits an employee to perform a nursing task without proper delegation. (See chapter 18.88A RCW and chapter 246-840 WAC.) The minimum amount of this fine is two hundred fifty dollars. The maximum fine allowed is one thousand dollars.

- (2) When assessing civil fines, DSHS must consider:
- (a) Severity of occurrence;
 - (b) Frequency of occurrence; and
 - (c) Other relevant factors relating to the occurrence.

[05-07-138, recodified as § 388-101-2460, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-790, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2470 What technical assistance may service providers get from DSHS for nurse delegation requirements? (1) DSHS must offer technical assistance to service providers for purposes of education and assistance to help service providers comply with nurse delegation requirements and protocols.

(2) The DSHS technical assistance program must include:

- (a) Technical assistance visits where DSHS informs the service provider of violation of law or service provider rules;
- (b) Information about how to get technical assistance;
- (c) Printed information;
- (d) Information and assistance by phone;
- (e) Training meetings;
- (f) Other appropriate methods to provide technical assistance; and
- (g) A list of organizations that provide technical assistance.

[05-07-138, recodified as § 388-101-2470, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-800, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2480 What happens when DSHS finds a service provider in violation of nurse delegation requirements? (1) Before imposing a civil fine, DSHS may take the following steps after discovering that a service provider is in violation of rules:

- (a) Notify the service provider in writing about the concerns;
- (b) Give the service provider an opportunity to explain circumstances or present additional information that may clarify concerns; and
- (c) Request the service provider to provide additional information, if necessary.

(2) DSHS must inform the service provider in writing about the outcome of findings and any required actions.

[05-07-138, recodified as § 388-101-2480, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-810, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2490 May a service provider have a chance to correct violations before being fined? The service provider must be given a reasonable period of time to

correct violations of nurse delegation requirements before any civil penalty is imposed.

[05-07-138, recodified as § 388-101-2490, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-820, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2500 May civil fines be imposed during technical assistance visits? A civil fine may be issued during a technical assistance visit if:

- (1) The service provider has previously been found out of compliance for the same statute or rule; or
- (2) The service provider's violation is likely to place a person in danger of death or bodily harm.

[05-07-138, recodified as § 388-101-2500, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-830, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2510 How does DSHS impose a civil fine? DSHS gives a service provider written notice of any civil fines. This notice must:

- (1) State the amount and reasons for the fine and the applicable law under which the fine is imposed; and
- (2) Inform the service provider of the right to request a hearing.

[05-07-138, recodified as § 388-101-2510, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-840, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2520 When is payment due for a civil fine? (1) A civil fine becomes due twenty-eight days after the receipt of the written notice of the fine.

(2) **Exception:** If a service provider requests a hearing under chapter 34.05 RCW and RCW 43.20A.215, DSHS must stop the fine while waiting for a final decision on the matter.

[05-07-138, recodified as § 388-101-2520, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-850, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2530 May a service provider disagree with DSHS findings of a violation? (1) When a service provider disagrees with DSHS' finding of a violation under this chapter, the service provider has the right to have the violation reviewed under the department's dispute resolution process.

(2) No service provider may discriminate or retaliate in any manner against a person who makes a complaint or has cooperated in the complaint investigation.

[05-07-138, recodified as § 388-101-2530, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-860, filed 10/26/01, effective 1/1/02.]

WAC 388-101-2540 May a service provider contest a civil fine? (1) A service provider may contest DSHS' decision to impose a civil fine.

(2) Within twenty-eight days of receiving the decision, the service provider must file a written application for a hearing, showing proof of receipt with the Board of Appeals, P.O. Box 42489, Olympia, WA 98504-2489. The application must include:

- (a) The grounds for contesting the department decision;
and
(b) A copy of the contested department decision.
(3) Hearings are governed by chapter 34.05 RCW and RCW 43.20A.215, and chapter 388-02 WAC. If any provision in this section conflicts with chapter 388-02 WAC, the provision in this section governs.

[05-07-138, recodified as § 388-101-2540, filed 3/22/05, effective 3/22/05. Statutory Authority: Title 71A RCW. 01-22-020, § 388-820-870, filed 10/26/01, effective 1/1/02.]

Chapter 388-105 WAC

MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICES

WAC

- 388-105-0005 The daily Medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and that reside in adult family homes (AFH) and boarding homes contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services.
- 388-105-0035 Requirements for a capital add-on rate for licensed boarding homes contracted to provide assisted living (AL) services.
- 388-105-0045 Bed or unit hold—Medicaid resident discharged for a hospital or nursing home stay from an adult family home (AFH) or a boarding home contracted to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living services (AL).

388-105-0020

388-105-0025

388-105-0030

388-105-0040

and/or has unmet care needs? [Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0015, filed 6/29/01, effective 7/30/01.] Repealed by 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

How does the department determine at which care level the Medicaid resident will be placed? [Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0020, filed 6/29/01, effective 7/30/01.] Repealed by 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

How many ADL values and unmet care need points correspond to the four care levels? [Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0025, filed 6/29/01, effective 7/30/01.] Repealed by 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

What are the daily Medicaid payment rates for contracted assisted living facilities (AL) not receiving a capital rate add-on? [Statutory Authority: RCW 74.39A.030, 2003 c 231. 04-09-092, § 388-105-0030, filed 4/20/04, effective 5/21/04. Statutory Authority: 2002 c 371. 02-22-058, § 388-105-0030, filed 10/31/02, effective 12/1/02.] Repealed by 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

What are the daily capital add-on rates for assisted living facilities (AL) and the AL daily payment rates with a capital add-on rate? [Statutory Authority: RCW 74.39A.030, 2003 c 231. 04-09-092, § 388-105-0040, filed 4/20/04, effective 5/21/04. Statutory Authority: 2002 c 371. 02-22-058, § 388-105-0040, filed 10/31/02, effective 12/1/02.] Repealed by 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 388-105-0010 What are care levels? [Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0010, filed 6/29/01, effective 7/30/01.] Repealed by 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.
- 388-105-0015 How does the department determine whether the Medicaid resident needs assistance in completing ADLs

WAC 388-105-0005 The daily Medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and that reside in adult family homes (AFH) and boarding homes contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services. For contracted AFH and boarding homes contracted to provide AL, ARC, and EARC services, the department pays the following daily rates for care of a Medicaid resident:

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE KING COUNTY					
CARE CLASSIFICATION	AL Without Capital	AL With Capital	ARC	EARC	AFH
	Add-on	Add-on			
A Low (1)	\$65.30	\$70.41	\$46.18	\$46.18	\$46.82
A Med (2)	\$70.71	\$75.82	\$52.40	\$52.40	\$53.13
A High (3)	\$79.34	\$84.45	\$66.92	\$66.92	\$59.45
B Low (4)	\$65.30	\$70.41	\$46.18	\$46.18	\$46.82
B Med (5)	\$72.87	\$77.98	\$58.62	\$58.62	\$59.45
B High (6)	\$86.88	\$91.99	\$75.23	\$75.23	\$67.85
C Low (7)	\$70.71	\$75.82	\$52.40	\$52.40	\$53.13
C Med (8)	\$79.34	\$84.45	\$66.92	\$66.92	\$67.85
C High (9)	\$98.77	\$103.88	\$87.68	\$87.68	\$88.89
D Low (10)	\$72.87	\$77.98	\$58.62	\$58.62	\$67.85
D Med (11)	\$79.34	\$84.45	\$66.92	\$66.92	\$76.28
D High (12)	\$98.77	\$103.88	\$87.68	\$87.68	\$88.89

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE METROPOLITAN COUNTIES*					
CARE CLASSIFICATION	AL Without Capital	AL With Capital	ARC	EARC	AFH
	Add-on	Add-on			
A Low (1)	\$59.90	\$64.54	\$46.18	\$46.18	\$46.82
A Med (2)	\$63.15	\$67.79	\$50.32	\$50.32	\$51.03

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE METROPOLITAN COUNTIES*					
CARE CLASSIFICATION	AL Without Capital	AL With Capital	ARC	EARC	AFH
	Add-on	Add-on			
A High (3)	\$77.18	\$81.82	\$63.81	\$63.81	\$56.28
B Low (4)	\$59.90	\$64.54	\$46.18	\$46.18	\$46.82
B Med (5)	\$68.54	\$73.18	\$55.51	\$55.51	\$56.28
B High (6)	\$84.73	\$89.37	\$71.08	\$71.08	\$64.70
C Low (7)	\$63.15	\$67.79	\$50.32	\$50.32	\$51.03
C Med (8)	\$77.18	\$81.82	\$63.81	\$63.81	\$64.70
C High (9)	\$95.52	\$100.16	\$81.45	\$81.45	\$82.59
D Low (10)	\$68.54	\$73.18	\$55.51	\$55.51	\$64.70
D Med (11)	\$77.18	\$81.82	\$63.81	\$63.81	\$72.06
D High (12)	\$95.52	\$100.16	\$81.45	\$81.45	\$82.59

*Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima counties.

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE NONMETROPOLITAN COUNTIES**					
CARE CLASSIFICATION	AL Without Capital	AL With Capital	ARC	EARC	AFH
	Add-on	Add-on			
A Low (1)	\$58.83	\$63.77	\$46.18	\$46.18	\$46.82
A Med (2)	\$63.15	\$68.09	\$49.29	\$49.29	\$49.98
A High (3)	\$77.18	\$82.12	\$62.78	\$62.78	\$55.24
B Low (4)	\$58.83	\$63.77	\$46.18	\$46.18	\$46.82
B Med (5)	\$68.54	\$73.48	\$54.48	\$54.48	\$55.24
B High (6)	\$84.73	\$89.67	\$69.00	\$69.00	\$63.66
C Low (7)	\$63.15	\$68.09	\$49.29	\$49.29	\$49.98
C Med (8)	\$77.18	\$82.12	\$62.78	\$62.78	\$63.66
C High (9)	\$95.52	\$100.46	\$78.34	\$78.34	\$79.44
D Low (10)	\$68.54	\$73.48	\$54.48	\$54.48	\$63.66
D Med (11)	\$77.18	\$82.12	\$62.78	\$62.78	\$69.96
D High (12)	\$95.52	\$100.46	\$78.34	\$78.34	\$79.44

** Nonmetropolitan counties: Adams, Asotin, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Garfield, Grant, Grays Harbor, Jefferson, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Orielle, San Juan, Skagit, Skamania, Stevens, Wahkiakum, Walla Walla and Whitman.

[Statutory Authority: Chapter 74.39A RCW, RCW 18.20.290, 2006 c 372, 260, and 64. 06-19-017, § 388-105-0005, filed 9/8/06, effective 10/9/06. Statutory Authority: Chapter 74.39A RCW. 06-07-013, § 388-105-0005, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.39A.030, 2003 c 231. 04-09-092, § 388-105-0005, filed 4/20/04, effective 5/21/04. Statutory Authority: 2002 c 371. 02-22-058, § 388-105-0005, filed 10/31/02, effective 12/1/02. Statutory Authority: 2001 c 7 § 206. 01-21-077, § 388-105-0005, filed 10/18/01, effective 11/18/01. Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0005, filed 6/29/01, effective 7/30/01.]

WAC 388-105-0035 Requirements for a capital add-on rate for licensed boarding homes contracted to provide assisted living (AL) services. (1) To the extent funds are appropriated to pay a capital add-on rate to AL contractors, beginning July 1, 2006 and every July 1 thereafter, the department will pay a capital add-on rate to AL contractors that have a Medicaid occupancy percentage that equals or exceeds sixty percent as determined in accordance with subsection (2) and (3) of this section. The department will pay the capital add-on rate to those AL contractors meeting the sixty percent Medicaid occupancy percentage for a full fiscal year i.e., July 1 through June 30.

(2) The department will determine an AL contractor's Medicaid occupancy percentage by dividing its Medicaid resident days from the last six months of the calendar year preceding the applicable July 1 rate effective date by the product of the weighted average for all its licensed boarding home beds irrespective of use times the calendar days (one hundred eighty-four) for the same six-month period.

(3) For the purposes of this section, Medicaid resident days include those clients enrolled in Medicaid managed long-term care programs, including but not limited to the program for all inclusive care (PACE) and Medicaid/Medicare integration project (MMIP).

[Statutory Authority: Chapter 74.39A RCW, RCW 18.20.290, 2006 c 372, 260, and 64. 06-19-017, § 388-105-0035, filed 9/8/06, effective 10/9/06. Statutory Authority: Chapter 74.39A RCW. 06-07-012, § 388-105-0035, filed 3/3/06, effective 4/3/06. Statutory Authority: 2002 c 371. 02-22-058, § 388-105-0035, filed 10/31/02, effective 12/1/02.]

WAC 388-105-0045 Bed or unit hold—Medicaid resident discharged for a hospital or nursing home stay from an adult family home (AFH) or a boarding home contracted to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living services (AL). (1) When an AFH, ARC, EARC, or AL contracts to provide services under chapter 74.39A RCW, the AFH,

ARC, EARC, and AL contractor must hold a Medicaid eligible resident's bed or unit when:

(a) Short-term care is needed in a nursing home or hospital;

(b) The resident is likely to return to the AFH, ARC, EARC, or AL; and

(c) Payment is made under subsection (3) of this section.

(2)(a) When the department pays the contractor to hold the Medicaid resident's bed or unit during the resident's short-term nursing home or hospital stay, the contractor must hold the bed or unit for up to twenty days. If during the twenty day bed hold period, a department case manager determines that the Medicaid resident's hospital or nursing home stay is not short term and the Medicaid resident is unlikely to return to the AFH, ARC, EARC or AL facility, the department will cease paying for the bed hold the day the case manager notifies the contractor of his/her decision.

(b) A Medicaid resident's discharge from an AFH, ARC, EARC, or an AL facility for a short term stay in a nursing home or hospital must be longer than twenty-four hours before subsection (3) of WAC 388-105-0045 applies.

(3) The department will compensate the contractor for holding the bed or unit for the:

(a) First through seventh day at seventy percent of the Medicaid daily rate paid for care of the resident before the hospital or nursing home stay; and

(b) Eighth through the twentieth day, at eleven dollars a day.

(4) The AFH, ARC, EARC, or AL facility may seek third-party payment to hold a bed or unit for twenty-one days or longer. The third-party payment shall not exceed the Medicaid daily rate paid to the facility for the resident. If third-party payment is not available and the returning Medicaid resident continues to meet the admission criteria under chapter 388-71 and/or 388-106 WAC, then the Medicaid resident may return to the first available and appropriate bed or unit.

(5) The department's social worker or case manager determines whether the:

(a) Stay in a nursing home or hospital will be short-term; and

(b) Resident is likely to return to the AFH, ARC, EARC, or AL facility.

(6) When the resident's stay in the hospital or nursing home exceeds twenty days or the department's social worker or case manager determines that the Medicaid resident's stay in the nursing home or hospital is not short-term and the resident is unlikely to return to the AFH, ARC, EARC, or AL facility, then only subsection (4) of this section applies to any private contractual arrangements that the contractor may make with a third party in regard to the discharged resident's unit or bed.

[Statutory Authority: Chapter 74.39A RCW, RCW 18.20.290, 2006 c 372, 260, and 64. 06-19-017, § 388-105-0045, filed 9/8/06, effective 10/9/06. Statutory Authority: Chapter 74.39A RCW. 06-07-013, § 388-105-0045, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.39A.030, 2003 c 231. 04-09-092, § 388-105-0045, filed 4/20/04, effective 5/21/04.]

388-106-0213 How are my needs assessed if I am a child applying for

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WAC

388-106-0005
388-106-0010

388-106-0015

388-106-0020

388-106-0025

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388-106-0047

COMPREHENSIVE ASSESSMENT REPORTING EVALUATION (CARE) ASSESSMENT

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388-106-0055

388-106-0060

388-106-0065

388-106-0070

388-106-0075

388-106-0080

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388-106-0210

Chapter 388-106 WAC

LONG-TERM CARE SERVICES

SCOPE AND DEFINITIONS

What is the purpose and scope of this chapter?
What definitions apply to this chapter?

APPLYING FOR SERVICES

What long-term care services does the department provide?
Under the MPC, COPES, MNRW, MNIW, and chore programs, what services are not covered?
How do I apply for long-term care services?
Where can I receive services?
May I receive personal care services through any of the long-term care programs when I am out of the state of Washington?
Who can provide long-term care services?
When will the department authorize my long-term care services?
When can the department terminate or deny long-term care services to me?

CARE CLASSIFICATION

How is the amount of long-term care services I can receive in my own home or in a residential facility determined?
What criteria does the CARE tool use to place me in one of the classification groups?
How does the CARE tool measure cognitive performance?
How does the CARE tool measure clinical complexity?
How does the CARE tool measure mood and behaviors?
How does the CARE tool measure activities of daily living (ADLs)?
How does the CARE tool evaluate me for the exceptional care classification of in-home care?
How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, and ADLs as determined under WAC 388-106-0105 to place me in a classification group for residential facilities?
What is the payment rate that the department will pay the provider if I receive personal care services in a residential facility?
How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110, to place me in a classification group for in-home care?
How does the department determine the number of hours I may receive for in-home care?
What are the maximum hours that I can receive for in-home services?
What may change the maximum number of hours that I can receive for in-home personal care services?
What may change the maximum payment rate that will be paid for residential personal care services provided to me?

MEDICAID PERSONAL CARE (MPC)

What services may I receive under Medicaid personal care (MPC)?
Am I eligible for MPC-funded services?
MPC services?

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388-106-0220	How do I remain eligible for MPC?	388-106-0815	Am I eligible for adult day health?
388-106-0225	How do I pay for MPC?		
388-106-0230	Can I be employed and receive MPC?		GAU-FUNDED RESIDENTIAL CARE
388-106-0235	Are there waiting lists for MPC?	388-106-0900	What services may I receive under GAU-funded residential care?
COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM (COPES)		388-106-0905	Am I eligible to receive GAU-funded residential care services?
388-106-0300	What services may I receive under community options program entry system (COPES) when I live in my own home?		RESIDENTIAL CARE DISCHARGE ALLOWANCE
388-106-0305	What services may I receive under COPES if I live in a residential facility?	388-106-0950	What services may I receive under the residential care discharge allowance?
388-106-0310	Am I eligible for COPES-funded services?	388-106-0955	Am I eligible for residential care discharge allowance?
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388-106-0325	How do I pay for COPES services?	388-106-1000	What is the intent of WAC 388-106-1000 through 388-106-1055?
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388-106-0350	What are nursing facility care services?	388-106-1025	Who can provide my PDN services?
388-106-0355	Am I eligible for nursing facility care services?	388-106-1030	Are there limitations or other requirements for PDN?
388-106-0360	How do I pay for nursing facility care services?	388-106-1035	What requirements must a home health agency meet in order to provide and get paid for my PDN?
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388-106-0600	What services may I receive under chore?	388-106-1220	How are respite care providers reimbursed for their services?
388-106-0610	Am I eligible for chore-funded services?	388-106-1225	Are participants required to pay for the cost of their services?
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388-106-0700	What services may I receive under PACE?		NEW FREEDOM CONSUMER DIRECTED SERVICES (NFCDS)
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388-106-1420	How do I remain eligible for New Freedom consumer directed services (NFCDS)?
388-106-1425	How do I pay for New Freedom consumer directed services (NFCDS)?
388-106-1430	Can I be employed and receive New Freedom consumer directed services (NFCDS)?
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388-106-1450	Is the individual budget intended to fully meet all of my needs?
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SCOPE AND DEFINITIONS

WAC 388-106-0005 What is the purpose and scope of this chapter? This chapter applies to applicants and recipients of long-term care services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0005, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0010 What definitions apply to this chapter? "Ability to make self understood" means how you make yourself understood to those closest to you; express or communicate requests, needs, opinions, urgent problems and social conversations, whether in speech, writing, sign language, symbols, or a combination of these including use of a communication board or keyboard:

- (a) Understood: You express ideas clearly;
- (b) Usually understood: You have difficulty finding the right words or finishing thoughts, resulting in delayed responses, or you require some prompting to make self understood;
- (c) Sometimes understood: You have limited ability, but are able to express concrete requests regarding at least basic needs (e.g. food, drink, sleep, toilet);
- (d) Rarely/never understood. At best, understanding is limited to caregiver's interpretation of client specific sounds or body language (e.g. indicated presence of pain or need to toilet.)

"Activities of daily living (ADL)" means the following:

- (a) Bathing: How you take a full-body bath/shower, sponge bath, and transfer in/out of tub/shower.
- (b) Bed mobility: How you move to and from a lying position, turn side to side, and position your body while in bed, in a recliner, or other type of furniture.
- (c) Body care: How you perform with passive range of motion, applications of dressings and ointments or lotions to the body and pedicure to trim toenails and apply lotion to feet. In adult family homes, contracted assisted living, enhanced adult residential care, and enhanced adult residential care-specialized dementia care facilities, dressing changes using clean technique and topical ointments must be

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performed by a licensed nurse or through nurse delegation in accordance with chapter 246-840 WAC. Body care excludes:

(i) Foot care if you are diabetic or have poor circulation; or

(ii) Changing bandages or dressings when sterile procedures are required.

(d) Dressing: How you put on, fasten, and take off all items of clothing, including donning/removing prosthesis.

(e) Eating: How you eat and drink, regardless of skill. Eating includes any method of receiving nutrition, e.g., by mouth, tube or through a vein.

(f) Locomotion in room and immediate living environment: How you move between locations in your room and immediate living environment. If you are in a wheelchair, locomotion includes how self-sufficient you are once in your wheelchair.

(g) Locomotion outside of immediate living environment including outdoors: How you move to and return from more distant areas. If you are living in a boarding home or nursing facility (NF), this includes areas set aside for dining, activities, etc. If you are living in your own home or in an adult family home, locomotion outside immediate living environment including outdoors, includes how you move to and return from a patio or porch, backyard, to the mailbox, to see the next-door neighbor, etc.

(h) Walk in room, hallway and rest of immediate living environment: How you walk between locations in your room and immediate living environment.

(i) Medication management: Describes the amount of assistance, if any, required to receive medications, over the counter preparations or herbal supplements.

(j) Toilet use: How you use the toilet room, commode, bedpan, or urinal, transfer on/off toilet, cleanse, change pad, manage ostomy or catheter, and adjust clothes.

(k) Transfer: How you move between surfaces, i.e., to/from bed, chair, wheelchair, standing position. Transfer does not include how you move to/from the bath, toilet, or vehicle.

(l) Personal hygiene: How you maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands (including nail care), and perineum (menses care). Personal hygiene does not include hygiene in baths and showers.

"Aged person" means a person sixty-five years of age or older.

"Agency provider" means a licensed home care agency or a licensed home health agency having a contract to provide long-term care personal care services to you in your own home.

"Application" means a written request for medical assistance or long-term care services submitted to the department by the applicant, the applicant's authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant must submit the request on a form prescribed by the department.

"Assessment details" means a summary of information that the department entered into the CARE assessment describing your needs.

"Assessment or reassessment" means an inventory and evaluation of abilities and needs based on an in-person inter-

view in your own home or your place of residence, using CARE.

"Assistance available" means the amount of informal support available if the need is partially met. The department determines the amount of the assistance available using one of four categories:

- (a) Less than one-fourth of the time;
- (b) One-fourth to one-half of the time;
- (c) Over one-half of the time to three-fourths of the time;

or

- (d) Over three-fourths but not all of the time.

"Assistance with body care" means you need assistance with:

- (a) Application of ointment or lotions;
- (b) Trimming of toenails;
- (c) Dry bandage changes; or
- (d) Passive range of motion treatment.

"Assistance with medication management" means you need assistance managing your medications. You are scored as:

(a) Independent if you remember to take medications as prescribed and manage your medications without assistance.

(b) Assistance required if you need assistance from a nonlicensed provider to facilitate your self-administration of a prescribed, over the counter, or herbal medication, as defined in chapter 246-888 WAC. Assistance required includes reminding or coaching you, handing you the medication container, opening the container, using an enabler to assist you in getting the medication into your mouth, alteration of a medication for self-administration, and placing the medication in your hand. This does not include assistance with intravenous or injectable medications. You must be aware that you are taking medications.

(c) Self-directed medication assistance/administration if you are a person with a functional disability who is capable of and who chooses to self-direct your medication assistance/administration.

(d) Must be administered if you must have medications placed in your mouth or applied or instilled to your skin or mucus membrane. Administration must either be performed by a licensed professional or delegated by a registered nurse to a qualified caregiver (per chapter 246-840 WAC). Intravenous or injectable medications may never be delegated. Administration may also be performed by a family member or unpaid caregiver if facility licensing regulations allow.

"Authorization" means an official approval of a departmental action, for example, a determination of client eligibility for service or payment for a client's long-term care services.

"Blind person" means a person determined blind as described under WAC 388-511-1105 by the division of disability determination services of the medical assistance administration.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-475-0100 and chapter 388-513 WAC.

"Client" means an applicant for service or a person currently receiving services from the department.

"Current" means a behavior occurred within seven days of the CARE assessment date, including the day of the

assessment. Behaviors that the department designates as current must include information about:

(a) Whether the behavior is easily altered or not easily altered; and

(b) The frequency of the behavior.

"Decision making" means your ability and actual performance in making everyday decisions about tasks or activities of daily living. The department determines whether you are:

(a) Independent: Decisions about your daily routine are consistent and organized; reflecting your lifestyle, choices, culture, and values.

(b) Modified independence/difficulty in new situations: You have an organized daily routine, are able to make decisions in familiar situations, but experience some difficulty in decision making when faced with new tasks or situations.

(c) Moderately impaired/poor decisions; unaware of consequences: Your decisions are poor and you require reminders, cues and supervision in planning, organizing and correcting daily routines. You attempt to make decisions, although poorly.

(d) Severely impaired/no or few decisions: Decision making is severely impaired; you never/rarely make decisions.

"Department" means the state department of social and health services, aging and disability services administration or its designee.

"Designee" means area agency on aging.

"Difficulty" means how difficult it is or would be for you to perform an instrumental activity of daily living (IADL). This is assessed as:

(a) No difficulty in performing the activity;

(b) Some difficulty in performing the activity (e.g., you need some help, are very slow, or fatigue easily); or

(c) Great difficulty in performing the activity (e.g., little or no involvement in the activity is possible).

"Disabling condition" means you have a medical condition which prevents you from self performance of personal care tasks without assistance.

"Estate recovery" means the department's process of recouping the cost of Medicaid and long-term care benefit payments from the estate of the deceased client. See chapter 388-527 WAC.

"Home health agency" means a licensed:

(a) Agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence and reimbursed through the use of the client's medical identification card; or

(b) Home health agency, certified or not certified under Medicare, contracted and authorized to provide:

(i) Private duty nursing; or

(ii) Skilled nursing services under an approved Medicaid waiver program.

"Income" means income as defined under WAC 388-500-0005.

"Individual provider" means a person employed by you to provide personal care services in your own home. See WAC 388-71-0500 through 388-71-05909.

"Disability" is described under WAC 388-511-1105.

"Informal support" means a person or resource that is available to provide assistance without home and community program funding. The person or resource providing the informal support must be age 18 or older.

"Institution" means medical facilities, nursing facilities, and institutions for the mentally retarded. It does not include correctional institutions. See medical institutions in WAC 388-500-0005.

"Instrumental activities of daily living (IADL)" means routine activities performed around the home or in the community and includes the following:

(a) Meal preparation: How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food, utensils, and cleaning up after meals). NOTE: The department will not authorize this IADL to plan meals or clean up after meals. You must need assistance with actual meal preparation.

(b) Ordinary housework: How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry).

(c) Essential shopping: How shopping is completed to meet your health and nutritional needs (e.g., selecting items). Shopping is limited to brief, occasional trips in the local area to shop for food, medical necessities and household items required specifically for your health, maintenance or well-being. This includes shopping with or for you.

(d) Wood supply: How wood is supplied (e.g., splitting, stacking, or carrying wood) when you use wood as the sole source of fuel for heating and/or cooking.

(e) Travel to medical services: How you travel by vehicle to a physician's office or clinic in the local area to obtain medical diagnosis or treatment-includes driving vehicle yourself, traveling as a passenger in a car, bus, or taxi.

(f) Managing finances: How bills are paid, checkbook is balanced, household expenses are managed. The department cannot pay for any assistance with managing finances.

(g) Telephone use: How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).

"Long-term care services" means the services administered directly or through contract by the aging and disability services administration and identified in WAC 388-106-0015.

"Medicaid" is defined under WAC 388-500-0005.

"Medically necessary" is defined under WAC 388-500-0005.

"Medically needy (MN)" means the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"New Freedom consumer directed services (NFCDS)" means a mix of services and supports to meet needs identified in the participant's assessment and identified in a New Freedom spending plan, within the limits of the individual budget, that provide participants with flexibility to plan, select, and direct the purchase of goods and services to meet identified needs. Participants have a meaningful leadership role in:

(a) The design, delivery and evaluation of services and supports;

(b) Exercising control of decisions and resources, making their own decisions about health and well being;

(c) Determining how to meet their own needs;

(d) Determining how and by whom these needs should be met; and

(e) Monitoring the quality of services received.

"New Freedom consumer directed services (NFCDS) participant" means a participant who is an applicant for or currently receiving services under the NFCDS waiver.

"New Freedom spending plan (NFSP)" means the plan developed by the participant, within the limits of an individual budget, that details the participant's choices to purchase specific NFCDS and provides required federal Medicaid documentation.

"Own home" means your present or intended place of residence:

(a) In a building that you rent and the rental is not contingent upon the purchase of personal care services as defined in this section;

(b) In a building that you own;

(c) In a relative's established residence; or

(d) In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services as defined in this section.

"Past" means the behavior occurred from eight days to five years of the assessment date. For behaviors indicated as past, the department determines whether the behavior is addressed with current interventions or whether no interventions are in place.

"Personal aide" is defined in RCW 74.39.007.

"Personal care services" means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations. Assistance is evaluated with the use of assistive devices.

"Physician" is defined under WAC 388-500-0005.

"Plan of care" means assessment details and service summary generated by CARE.

"Provider or provider of service" means an institution, agency, or person:

(a) Having a signed department contract to provide long-term care client services; and

(b) Qualified and eligible to receive department payment.

"Residential facility" means a licensed adult family home under department contract or licensed boarding home under department contract to provide assisted living, adult residential care or enhanced adult residential care.

"Self performance for ADLs" means what you actually did in the last seven days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period and does not include support provided as defined in WAC 388-106-0010. Your self performance level is scored as:

(a) Independent if you received no help or oversight, or if you needed help or oversight only once or twice;

(b) Supervision if you received oversight (monitoring or standby), encouragement, or cueing three or more times;

(c) Limited assistance if you were highly involved in the activity and given physical help in guided maneuvering of limbs or other nonweight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;

(d) Extensive assistance if you performed part of the activity, but on three or more occasions, you needed weight bearing support or you received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means you needed physical help with part of the activity (other than transfer);

(e) Total dependence if you received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by you in all aspects of the ADL; or

(f) Activity did not occur if you or others did not perform an ADL over the last seven days before your assessment. The activity may not have occurred because:

- (i) You were not able (e.g., walking, if paralyzed);
- (ii) No provider was available to assist; or
- (iii) You declined assistance with the task.

"Self performance for IADLs" means what you actually did in the last thirty days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the thirty-day period. Your self performance is scored as:

(a) Independent if you received no help, set-up help, or supervision;

(b) Set-up help/arrangements only if on some occasions you did your own set-up/arrangement and at other times you received help from another person;

(c) Limited assistance if on some occasions you did not need any assistance but at other times in the last thirty days you required some assistance;

(d) Extensive assistance if you were involved in performing the activity, but required cueing/supervision or partial assistance at all times;

(e) Total dependence if you needed the activity fully performed by others; or

(f) Activity did not occur if you or others did not perform the activity in the last thirty days before the assessment.

"Service summary" is CARE information which includes: Contacts (e.g. emergency contact), services the client is eligible for, number of hours or residential rates, personal care needs, the list of formal and informal providers and what tasks they will provide, a provider schedule, referral needs/information, and dates and agreement to the services.

"SSI-related" is defined under WAC 388-475-0050.

"Status" means the amount of informal support available. The department determines whether the ADL or IADL is:

(a) Met, which means the ADL or IADL will be fully provided by an informal support;

(b) Unmet, which means an informal support will not be available to provide assistance with the identified ADL or IADL;

(c) Partially met, which means an informal support will be available to provide some assistance, but not all, with the identified ADL or IADL; or

(d) Client declines, which means you do not want assistance with the task.

"Supplemental Security Income (SSI)" means the federal program as described under WAC 388-500-0005.

"Support provided" means the highest level of support provided (to you) by others in the last seven days before the assessment, even if that level of support occurred only once.

(a) No set-up or physical help provided by others;

(b) Set-up help only provided, which is the type of help characterized by providing you with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);

(c) One-person physical assist provided;

(d) Two- or more person physical assist provided; or

(e) Activity did not occur during entire seven-day period.

"You/your" means the client.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-0010, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0010, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0010, filed 5/17/05, effective 6/17/05.]

APPLYING FOR SERVICES

WAC 388-106-0015 What long-term care services does the department provide? The department provides long-term care services through programs that are designed to help you remain in the community. These programs offer an alternative to nursing home care (which is described in WAC 388-106-0350 through 388-106-0360). You may receive services from any of the following:

(1) **Medicaid personal care (MPC)** is a Medicaid state plan program authorized under RCW 74.09.520. Clients eligible for this program may receive personal care in their own home or in a residential facility.

(2) **Community options program entry system (COPES)** is a Medicaid waiver program authorized under RCW 74.39A.030. Clients eligible for this program may receive personal care in their own home or in a residential facility.

(3) **Medically needy residential waiver (MNRW)** is a Medicaid waiver program authorized under RCW 74.39.041. Clients eligible for this program may receive personal care in a residential facility.

(4) **Medically needy in-home waiver (MNIW)** is a Medicaid waiver program authorized under RCW 74.09.700. Clients eligible for this program may receive personal care in their own home.

(5) **Chore** is a state-only funded program authorized under RCW 74.39A.110. Grandfathered clients may receive assistance with personal care in their own home.

(6) **Volunteer chore** is a state-funded program that provides volunteer assistance with household tasks to eligible clients.

(7) **Program of all-inclusive care for the elderly (PACE)** is a Medicaid/Medicare managed care program authorized under 42 CFR 460.2. Clients eligible for this program may receive personal care and medical services in their own home, in residential facilities, and in adult day health centers.

(8) **Adult day health** is a supervised daytime program providing skilled nursing and rehabilitative therapy services in addition to core services outlined in WAC 388-106-0800.

(9) **Adult day care** is a supervised daytime program providing core services, as defined under WAC 388-106-0800.

(10) **GAU-funded residential care** is a state-funded program authorized under WAC 388-400-0025. Clients eligible for this program may receive personal care services in an adult family home or an adult residential care facility.

(11) **Residential care discharge allowance** is a service that helps eligible clients to establish or resume living in their own home.

(12) **Private duty nursing** is a Medicaid service that provides an alternative to institutionalization in a hospital or nursing facility setting. Clients eligible for this program may receive at least four continuous hours of skilled nursing care on a day to day basis in their own home.

(13) **Senior Citizens Services Act (SCSA)** is a program authorized under chapter 74.38 RCW. Clients eligible for this program may receive community-based services as defined in RCW 74.38.040.

(14) **Respite program** is a program authorized under RCW 74.41.040 and WAC 388-106-1200. This program provides relief care for unpaid family or other caregivers of adults with a functional disability.

(15) **Programs for persons with developmental disabilities** are discussed in chapter 388-823 through 388-853 WAC.

(16) **Nursing facility.**

(17) **Medicare/Medicaid integration project (MMIP)** is a DSHS prepaid managed care program, authorized under 42 CFR Part 438, that integrates medical and long-term care services for clients who are sixty-five years of age or older and eligible for Medicare (Parts A and B) and Medicaid.

(18) **New Freedom consumer directed services (NFCDS)** is a Medicaid waiver program authorized under RCW 74.39A.030.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, 06-16-035, § 388-106-0015, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0015, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438.05-19-045, § 388-106-0015, filed 9/15/05, effective 10/16/05. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0015, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0020 Under the MPC, COPES, MNRW, MNIW, and chore programs, what services are not covered? The following types of services are not covered under MPC, COPES, MNRW, MNIW, and chore:

(1) Child care.

(2) Individual providers and agency providers must not provide sterile procedures, administration of medications, or other tasks requiring a licensed health professional unless these tasks are provided through nursing delegation, self-directed care or provided by a family member.

(3) Services provided over the telephone.

(4) Services to assist other household members not eligible for services.

(5) Development of social, behavioral, recreational, communication, or other types of community living skills.

(6) Nursing care.

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(7) Pet care.

(8) Assistance with managing finances.

(9) Respite.

(10) Yard care.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0020, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0025 How do I apply for long-term care services? To apply for long-term care services, you must request an assessment from the department and submit a Medicaid application.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0025, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0030 Where can I receive services?

You may receive services:

(1) In your own home.

(2) In a residential facility, which includes licensed:

(a) Adult family homes, as defined in RCW 70.128.010.

(b) Boarding homes. Types of licensed and contracted boarding homes include:

(i) Assisted living facilities, as defined in WAC 388-110-020;

(ii) Enhanced adult residential care facilities, as defined in WAC 388-110-020;

(iii) Enhanced adult residential care facilities-specialized dementia care, as defined in WAC 388-110-020; and

(iv) Adult residential care facilities, as defined in WAC 388-110-020.

(3) In a nursing home, as defined in WAC 388-97-005.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0030, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0035 May I receive personal care services through any of the long-term care programs when I am out of the state of Washington? (1) You may receive personal care assistance through any long-term care programs in WAC 388-106-0015 subsections (1) through (5) when temporarily traveling out of state for less than thirty days, as long as your:

(a) Individual provider is contracted with the state of Washington;

(b) Travel plans are coordinated with your case manager prior to departure;

(c) Services are authorized on your plan of care prior to departure; and

(d) Services are strictly for your personal care and do not include your provider's travel time, expenses.

(2) You may not receive personal care services outside of the United States.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0035, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0035, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0040 Who can provide long-term care services? The following types of providers can provide long-term care services:

(1) Individual providers (IPs), who provide services to clients in their own home. IPs must meet the requirements outlined in WAC 388-71-0500 through 388-71-05909.

[Title 388 WAC—p. 587]

(2) Home care agencies, who provide services to clients in their own home. Home care agencies must be licensed under chapter 70.127 RCW and chapter 246-336 WAC and contracted with area agency on aging.

(3) Residential providers, which include licensed adult family homes and boarding homes, who contract with the department to provide assisted living, adult residential care, and enhanced adult residential care services (which may also include specialized dementia care).

(4) Providers who have contracted with the department to perform other services.

(5) In the case of New Freedom consumer directed services (NFCDS), providers meeting NFCDS HCBS waiver requirements contracting with a department approved provider of fiscal management services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-0040, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0040, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0045 When will the department authorize my long-term care services? The department will authorize long-term care services when you:

- (1) Are assessed using CARE;
- (2) Are found financially and functionally eligible for services including, if applicable, the determination of the amount of participation toward the cost of your care and/or the amount of room and board that you must pay;
- (3) Have given consent for services and approved your plan of care; and
- (4) Have chosen a provider(s), qualified for payment.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0045, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0047 When can the department terminate or deny long-term care services to me? (1) The department will deny or terminate long-term care services if you are not eligible for long-term care services pursuant to WAC 388-106-0210, 388-106-0310, 388-106-0410, 388-106-0510, or 388-106-0610.

(2) The department may deny or terminate long-term care services to you if, after exhaustion of standard case management activities and the approaches delineated in the department's challenging cases protocol, which must include an attempt to reasonably accommodate your disability or disabilities, any of the following conditions exist:

- (a) After a department representative reviews with you your rights and responsibilities as a client of the department, per WAC 388-106-1300 and 388-106-1303, you refuse to accept those long-term care services identified in your plan of care that are vital to your health, welfare or safety;
- (b) You choose to receive services in your own home and you or others in your home demonstrate behaviors that are substantially likely to cause serious harm to you or your care provider;
- (c) You choose to receive services in your own home and hazardous conditions in or immediately around your home jeopardize the health, safety, or welfare of you or your provider. Hazardous conditions include but are not limited to the following:
 - (i) Threatening, uncontrolled animals (e.g., dogs);

- (ii) The manufacture, sale, or use of illegal drugs;
- (iii) The presence of hazardous materials (e.g., exposed sewage, evidence of a methamphetamine lab).

[Statutory Authority: RCW 74.08.090, 74.09.520, 42 C.F.R. 441.302(a); Social Security Act section 1915c waiver rules, 42 C.F.R. 440.180. 06-16-070, § 388-106-0047, filed 7/28/06, effective 8/28/06.]

COMPREHENSIVE ASSESSMENT REPORTING EVALUATION (CARE) ASSESSMENT

WAC 388-106-0050 What is an assessment? (1) An assessment is an in-person interview in your home or your place of residence that is conducted by the department to inventory and evaluate your ability to care for yourself. The department will assess you at least annually or more often when there are significant changes to your ability to care for yourself.

(2) Between assessments, the department may modify your current assessment without an in-person interview in your home or place of residence. The reasons that the department may modify your current assessment without conducting an in-person interview in your home or place of residence include but are not limited to the following:

- (a) Errors made by department staff in coding the information from your in-person interview;
- (b) New information requested by department staff at the time of your assessment and received after completion of the in-person interview (e.g. medical diagnosis);
- (c) Changes in the level of informal support available to you; or
- (d) Clarification of the coding selected.

(3) When the department modifies your current assessment, it will notify you using a Planned Action Notice of the modification regardless of whether the modification results in a change to your benefits. You will also receive a new service summary and assessment details.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0050, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0050, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0055 What is the purpose of an assessment? The purpose of an assessment is to:

- (1) Determine eligibility for long-term care programs;
- (2) Identify your strengths, limitations, and preferences;
- (3) Evaluate your living situation and environment;
- (4) Evaluate your physical health, functional and cognitive abilities;
- (5) Determine availability of informal supports and other nondepartment paid resources;
- (6) Determine need for intervention;
- (7) Determine need for case management activities;
- (8) Determine your classification group that will set your payment rate for residential care or number of hours of in-home care;
- (9) Determine need for referrals; and
- (10) Develop a plan of care, as defined in WAC 388-106-0010.
- (11) In the case of New Freedom consumer directed services, the purpose of an assessment is to determine functional

eligibility and for the participant to develop the New Freedom spending plan, as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-0055, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0055, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0060 Who must perform the assessment? The assessment must be performed by the department.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0060, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0065 What is the process for conducting an assessment? The department:

(1) Will assess you using a department-prescribed assessment tool, titled the comprehensive assessment reporting evaluation (CARE).

(2) May request the assessment be conducted in private. However, you have the right to request that third parties be present.

(3) Has the right to end the assessment if behaviors by any party are impeding the assessment process. If an assessment is terminated, the department will reschedule.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0065, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0065, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0070 Will I be assessed in CARE? You will be assessed in CARE if you are applying for or receiving COPES, MNIW, MNRW, MPC, chore, respite, adult day health, GAU-funded residential care, PACE, or Private Duty Nursing. You may not be assessed by forms previously used by the department once you have been assessed under CARE.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0070, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0075 How is my need for personal care services assessed in CARE? To assess your need for personal care services, the department gathers information from you, your caregivers, family members, and other sources. The department will assess your ability to perform:

(1) Activities of daily living (ADL) using self performance, support provided, status and assistance available, as defined in WAC 388-106-0010. Also, the department determines your need for "assistance with body care" and "assistance with medication management," as defined in WAC 388-106-0010; and

(2) Instrumental activities of daily living (IADL) using self performance, difficulty, status and assistance available, as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0075, filed 5/17/05, effective 6/17/05.]

CARE CLASSIFICATION

WAC 388-106-0080 How is the amount of long-term care services I can receive in my own home or in a residential facility determined? The amount of long-term care services you can receive in your own home or in a residential facility is determined through a classification system. Twelve

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classifications apply to clients served in residential and in-home settings. Two additional exceptional care groups apply to clients served in in-home settings. The department has assigned each classification a residential facility rate or a base number of hours you can receive in your own home.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0080, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0085 What criteria does the CARE tool use to place me in one of the classification groups? The department uses CARE to assess your characteristics. Based on this assessment, the CARE tool uses the following criteria to place you in one of the classification groups:

- (1) Cognitive performance.
- (2) Clinical complexity.
- (3) Mood/behaviors symptoms.
- (4) Activities of daily living (ADLs).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0085, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0090 How does the CARE tool measure cognitive performance? (1) The CARE tool uses a tool called the cognitive performance scale (CPS) to evaluate your cognitive impairment. The CPS results in a score that ranges from zero (intact) to six (very severe impairment). Your CPS score is based on:

- (a) Whether you are comatose.
- (b) Your ability to make decisions, as defined in WAC 388-106-0010 "Decision making."
- (c) Your ability to make yourself understood, as defined in WAC 388-106-0010 "Ability to make self understood."
- (d) Whether you have short-term memory problem (e.g. can you remember recent events?) or whether you have delayed recall; and
- (e) Whether you score as total dependence for self performance in eating, as defined in WAC 388-106-0010 "Self performance of ADLs."

(2) You will receive a CPS score of:

(a) **Zero** when you do not have problems with decision-making ability, making yourself understood, or recent memory.

(b) **One** when you meet one of the following:

(i) Your decision-making ability is scored as modified independence or moderately impaired;

(ii) Your ability to make yourself understood is usually, sometimes, or rarely/never understood; or

(iii) You have a recent memory problem.

(c) **Two** when you meet two of the following:

(i) Your decision-making ability is scored as modified independence or moderately impaired;

(ii) Your ability to make yourself understood is usually, sometimes, or rarely/never understood; and/or

(iii) You have a short-term memory problem or delayed recall.

(d) **Three** when you meet at least two of the criteria listed in subsection (2)(b) of this section and one of the following applies:

(i) Your decision making is moderately impaired; or

(ii) Your ability to make yourself understood is sometimes or rarely/never understood.

(e) **Four** when both of the following criteria applies:

(i) Your decision making is moderately impaired; and
 (ii) Your ability to make yourself understood is sometimes or rarely/never understood.

(f) **Five** when your ability to make decisions is scored as severely impaired.

(g) **Six** when one of the following applies:

(i) Your ability to make decisions is severely impaired and you require total dependence in eating; or

(ii) You are comatose.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0090, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0095 How does the CARE tool measure clinical complexity? The CARE tool places you in the clinically complex classification group only when you have one or more of the following criteria and corresponding ADL scores:

Condition	AND an ADL Score of
ALS (Lou Gehrig's Disease)	>14
Aphasia (expressive and/or receptive)	>=2
Cerebral Palsy	>14
Diabetes Mellitus (insulin dependent)	>14
Diabetes Mellitus (noninsulin dependent)	>14
Emphysema & Shortness of Breath (at rest or exertion) or dizziness/vertigo	>10
COPD & Shortness of Breath (at rest or exertion) or dizziness/vertigo	>10
Explicit terminal prognosis	>14
Hemiplegia	>14
Multiple Sclerosis	>14
Parkinson Disease	>14
Pathological bone fracture	>14
Quadriplegia	>14
Rheumatoid Arthritis	>14
You have one or more of the following skin problems: ■ Pressure ulcers, with areas of persistent skin redness; ■ Pressure ulcers with partial loss of skin layers; ■ Pressure ulcers, with a full thickness lost; ■ Skin desensitized to pain/pressure; ■ Open lesions; and/or ■ Stasis ulcers. AND You require one of the following types of assistance: ■ Ulcer care; ■ Pressure relieving device; ■ Turning/reposition program; ■ Application of dressing; or ■ Wound/skin care.	>=2
You have a burn(s) and you need one of the following: ■ Application of dressing; or ■ Wound/skin care	>=2
You have one or more of the following problems: ■ You are frequently incontinent (bladder); ■ You are incontinent all or most of the time (bladder); ■ You are frequently incontinent (bowel); or ■ You are incontinent all or most of the time (bowel). AND One of the following applies: ■ The status of your individual management of bowel bladder supplies is "Uses, has leakage, needs assistance"; ■ The status of your individual management of bowel bladder supplies is "Does not use, has leakage"; or ■ You use any scheduled toileting plan.	>10
You have a current swallowing problem, and you are not independent in eating.	>10

Condition	AND an ADL Score of
You have Edema.	>14
You have Pain daily.	>14
You need and receive a Bowel program.	>10
You need Dialysis.	>10
You require IV nutritional support or tube feedings; and Your total calories received per IV or tube was at least 25%; and Your fluid intake is greater than 2 cups.	>=2
You need Hospice care.	>14
You need Injections.	>14
You need Intravenous medications.	>10
You need management of IV lines.	>10
You need Ostomy care.	>=2
You need Oxygen therapy.	>10
You need Radiation.	>10
You need and receive Passive range of motion.	>10
You need and receive Walking training.	>10
You need Suction treatment.	>=2
You need Tracheostomy care.	>10
You need a Ventilator/respirator	>10
Key: >means greater than. >= means greater than or equal to.	

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0095, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0100 How does the CARE tool measure mood and behaviors? (1) When you do not meet the criteria for the clinically complex classification group, or the criteria for exceptional care, or for in-home only have a cognitive performance scale score of five or six, the mood and behavior criteria listed in subsection (3) below determines your classification group.

(2) For each behavior that the CARE tool has documented, the department will determine a status as "current" or "past" as defined in WAC 388-106-0010.

(3) CARE places you in the mood and behavior classification group only if you have one or more of the behavior/moods that also meets the listed status, frequency, and alterability as identified in the following chart. No other moods or behaviors documented by CARE will qualify you for the mood and behavior classification.

Behavior/Mood	AND Status, Frequency & Alterability
Assaultive	Current
Combative during personal care	Current
Combative during personal care	In past and addressed with current interventions
Crying tearfulness	Current, frequency 4 or more days per week
Delusions	In past, addressed with current interventions
Depression score >=14	N/A
Disrobes in public	Current and not easily altered
Easily irritable/agitated	Current and not easily altered
Eats nonedible substances	Current
Eats nonedible substances	In past, addressed with current interventions
Hallucinations	Current
Hiding items	In past, addressed with current interventions
Hoarding/collecting	In past, addressed with current interventions
Mental health therapy/program	Need
Repetitive complaints/questions	Current, daily
Repetitive complaints/questions	In past, addressed with current interventions

Behavior/Mood	AND Status, Frequency & Alterability
Repetitive movement/pacing	Current, daily
Resistive to care	Current
Resistive to care	In past, addressed with current interventions
Sexual acting out	Current
Sexual acting out	In past, addressed with current interventions
Spitting	Current and not easily altered
Spitting	In past, addressed with current interventions
Breaks/throws items	Current
Unsafe smoking	Current and not easily altered
Up at night and requires intervention	Current
Wanders exit seeking	Current
Wanders exit seeking	In past, addressed with current interventions
Wanders not exit seeking	Current
Wanders not exit seeking	In past, addressed with current interventions
Yelling/screaming Key: > means greater than. >= means greater than or equal to.	Current, frequency 4 or more days per week

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0100, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0105 How does the CARE tool measure activities of daily living (ADLs)? (1) CARE determines an ADL score ranging from zero to twenty-eight for each of the following ADLs.

- (a) Personal hygiene;
- (b) Bed mobility;
- (c) Transfers;
- (d) Eating;
- (e) Toilet use;
- (f) Dressing;
- (g) Locomotion in room;
- (h) Locomotion outside room; and
- (i) Walk in room.

(2) The department through the CARE tool determines the ADL score by using the definitions in WAC 388-106-0010 under "Self-performance for ADLs." The CARE tool assigns the following points to the level of self performance for each of the ADLs listed in subsection (1) of this section. For the locomotion in room, locomotion outside of room and walk in room, the department uses the highest score of the three in determining the total ADL score.

ADL Scoring Chart	
If Self Performance is:	Score Equals
Independent	0
Supervision	1
Limited assistance	2
Extensive assistance	3
Total dependence	4
Did not occur/no provider	4
Did not occur/client not able	4
Did not occur/client declined	0

(3) Although assessed by CARE, the department does not score bathing and medication management to determine classification groups.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0105, filed 5/17/05, effective 6/17/05.]

(2007 Ed.)

WAC 388-106-0110 How does the CARE tool evaluate me for the exceptional care classification of in-home care? CARE places you in the exceptional care classifications for the in-home setting when the following criteria are met in either diagram 1 or 2:

Diagram 1
You have one of the following diagnoses: <ul style="list-style-type: none"> ■ Quadriplegia; ■ Paraplegia; ■ ALS (Amyotrophic Lateral Sclerosis); ■ Parkinson's Disease; ■ Multiple Sclerosis; ■ Comatose; ■ Muscular Dystrophy; ■ Cerebral Palsy; ■ Post Polio Syndrome; or ■ TBI (traumatic brain injury).
AND
You have an ADL score of greater than or equal to 22.
AND
You need a Turning/repositioning program.
AND
You require at least one of the following: <ul style="list-style-type: none"> ■ External catheter; ■ Intermittent catheter; ■ Indwelling catheter care; ■ Bowel program; or ■ Ostomy care
AND
You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care: <ul style="list-style-type: none"> ■ Active range of motion (AROM); or ■ Passive range of motion (PROM).

Diagram 2
You have an ADL score of greater than or equal to 22.
AND
You need a Turning/repositioning program.
AND
You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care: <ul style="list-style-type: none"> ■ Active range of motion (AROM); or ■ Passive range of motion (PROM).
AND
All of the following apply: <ul style="list-style-type: none"> ■ You require IV nutrition support or tube feeding; ■ Your total calories received per IV or tube was greater than 50%; and ■ Your fluid intake is greater than 2 cups.
AND
You need assistance with one of the following, provided by an individual provider, agency provider, a private duty nurse, or through self-directed care: <ul style="list-style-type: none"> ■ Dialysis; or ■ Ventilator/respirator.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0110, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0115 How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, and ADLs as determined under WAC 388-106-0105 to place me in a classification group for residential facilities? The CARE tool uses the criteria of

cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, and ADLs as determined under WAC 388-106-0105 to place you into one of the following twelve residential classification groups:

Classification	ADL Score	Group
Group D Cognitive performance score = 4-6 and Clinically complex = yes and Mood/behavior = yes or no	ADL Score 18-28 ADL Score 13-17 ADL Score 2-12	D High (12) D Med (11) D Low (10)
Group C Cognitive performance score = 0-3 and Clinically complex = yes and Mood/behavior = yes or no	ADL Score 18-28 ADL Score 9-17 ADL Score 2-8	C High (9) C Med (8) C Low (7)
Group B Mood & behavior = Yes and Clinically complex = no and Cognitive performance score = 0-6	ADL Score 15-28 ADL Score 5-14 ADL Score 0-4	B High (6) B Med (5) B Low (4)
Group A Mood & behavior = No and Clinically complex = No and Cognitive performance score = 0-6	ADL Score 10-28 ADL Score 5-9 ADL Score 0-4	A High (3) A Med (2) A Low (1)

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0115, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0120 What is the payment rate that the department will pay the provider if I receive personal care services in a residential facility? The department publishes rates and/or adopts rules to establish how much the department pays toward the cost of your care in a residential facility. The department assigns payment rates to the CARE classification groups. Payment for care in a residential facility corresponds to the payment rate assigned to the classification group in which the CARE tool has placed you.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0120, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0125 How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110, to place me in a classification group for in-home care? CARE uses the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following fourteen in-home groups.

Classification	ADL Score	Group	Base Hours of Group
Group E Exceptional care = yes and Mood and behavior = yes or no and Cognitive performance score = 0-6	ADL Score 26-28 ADL Score 22-25	E High (14) E Med (13)	420 350

Classification	ADL Score	Group	Base Hours of Group
Group D Cognitive performance score = 4-6 and Clinically complex = yes and Mood and behavior = yes or no OR Cognitive performance score = 5-6 and Clinically complex = no and Mood and behavior = yes or no	ADL Score 18-28	D High (12)	240
	ADL Score 13-17	D Med (11)	190
	ADL Score 2-12	D Low (10)	145
Group C Cognitive performance score = 0-3 and Clinically complex = yes and Mood and behavior = yes or no	ADL Score 18-28	C High (9)	180
	ADL Score 9-17	C Med (8)	140
	ADL Score 2-8	C Low (7)	83
Group B Mood and behavior = yes and Clinically complex = no and Cognitive performance score = 0-4	ADL Score 15-28	B High (6)	155
	ADL Score 5-14	B Med (5)	90
	ADL Score 0-4	B Low (4)	52
Group A Mood and behavior = no and Clinically complex = no and Cognitive performance score = 0-4	ADL Score 10-28	A High (3)	78
	ADL Score 5-9	A Med (2)	62
	ADL Score 0-4	A Low (1)	29

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0125, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0130 How does the department determine the number of hours I may receive for in-home care? (1) The department assigns a base number of hours to each classification group as described in WAC 388-106-0125.

(2) The department will deduct from the base hours to account for your informal supports, as defined in WAC 388-106-0010, as follows:

(a) The CARE tool determines the adjustment for informal supports by determining the amount of assistance available to meet your needs, assigns it a numeric percentage, and reduces the base hours assigned to the classification group by the numeric percentage. The department has assigned the following numeric values for the amount of assistance available for each ADL and IADL:

Meds	Self Performance	Status	Assistance Available	Value Percentage
Self administration of medications	Rules for all codes apply except independent is not counted	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3

Unscheduled ADLs	Self Performance	Status	Assistance Available	Value Percentage
Bed mobility, transfer, walk in room, eating, toilet use	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
>3/4 time	.3			
Scheduled ADLs	Self Performance	Status	Assistance Available	Value Percentage
Dressing, personal hygiene, bathing	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.75
			1/4 to 1/2 time	.55
			1/2 to 3/4 time	.35
>3/4 time	.15			
IADLs	Self Performance	Status	Assistance Available	Value Percentage
Meal preparation, Ordinary housework, Essential shopping*	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.3
			1/4 to 1/2 time	.2
			1/2 to 3/4 time	.1
>3/4 time	.05			
IADLs	Self Performance	Status	Assistance Available	Value Percentage
Travel to medical	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
>3/4 time	.3			
Key: > means greater than < means less than *Results in 5% deduction for each IADL from the base hours. Remaining hours may be used for completion of household and personal care tasks.				

(b) To determine the amount of reduction for informal support, the value percentage is divided by the number of qualifying ADLs and IADLs needs. The result is value A. Value A is then subtracted from one. This is value B. Value B is divided by three. This is value C. Value A and Value C are summed. This is value D. Value D is multiplied by the "base hours" assigned to your classification group and the result is base in-home care hours reduced for informal supports.

(3) Also, the department will adjust in-home base hours for the following shared living circumstances:

(a) If there is more than one client living in the same household, the status under subsection (2)(a) of this section must be met or partially met for the following IADLs:

- (i) Meal preparation,
- (ii) Housekeeping,
- (iii) Shopping, and
- (iv) Wood supply.

(b) If you and your paid provider live in the same household, the status under subsection (2)(a) of this section must be met for the following IADLs:

- (i) Meal preparation,
- (ii) Housekeeping,
- (iii) Shopping, and
- (iv) Wood supply.

(c) When there is more than one client living in the same household and your paid provider lives in your household, the status under subsection (2)(a) of this section must be met for the following IADLs:

- (i) Meal preparation,
- (ii) Housekeeping,
- (iii) Shopping, and
- (iv) Wood supply.

(4) After deductions are made to your base hours, as described in subsections (2) and (3), the department may add on hours based on your living environment:

Condition	Status	Assistance Available	Add On Hours
Offsite laundry facilities, which means the client does not have facilities in own home and the caregiver is not available to perform any other personal or household tasks while laundry is done.	Unmet	N/A	8
Client is >45 minutes from essential services (which means he/she lives more than 45 minutes one-way from a full-service market).	Unmet	N/A	5
	Met	N/A	0
	Partially met	<1/4 time	5
		between 1/4 to 1/2 time	4
		between 1/2 to 3/4 time	2
		>3/4 time	2
Wood supply used as sole source of heat.	Unmet	N/A	8
	Met	N/A	0
	Declines	N/A	0
	Partially met	<1/4 time	8
		between 1/4 to 1/2 time	6
		between 1/2 to 3/4 time	4
		>3/4 time	2

(5) In the case of New Freedom consumer directed services (NFCDS), the department determines hours as described in WAC 388-106-1450.

(6) The result of actions under subsections (2), (3), and (4) is the maximum number of hours that can be used to develop your plan of care. The department must take into account cost effectiveness, client health and safety, and program limits in determining how hours can be used to meet your identified needs. In the case of New Freedom consumer directed services (NFCDS), a New Freedom spending plan (NFSP) is developed in place of a plan of care.

(7) You and your case manager will work to determine what services you choose to receive if you are eligible. The hours may be used to authorize:

(a) Personal care services from a home care agency provider and/or an individual provider.

(b) Home delivered meals (i.e. a half hour from the available hours for each meal authorized).

(c) Adult day care (i.e. a half hour from the available hours for each hour of day care authorized).

(d) A home health aide if you are eligible per WAC 388-106-0300 or 388-106-0500.

(e) A private duty nurse (PDN) if you are eligible per WAC 388-71-0910 and 388-71-0915 or WAC 388-551-3000 (i.e. one hour from the available hours for each hour of PDN authorized).

(f) The purchase of New Freedom consumer directed services (NFCDS).

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-0130, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0130, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0130, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0135 What are the maximum hours that I can receive for in-home services? The maximum hours that you may receive is the base hours assigned to your classification group and adjusted per WAC 388-106-0130. For chore program clients, the maximum personal care hours per month the department will pay is one hundred sixteen.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0135, filed 5/17/05, effective 6/17/05.]

(2007 Ed.)

WAC 388-106-0140 What may change the maximum number of hours that I can receive for in-home personal care services? The maximum number of in-home personal care hours you can receive may change:

(1) When you have a change in any of the criteria listed in WAC 388-106-0125 and/or 388-106-0130; or

(2) Because you meet the criteria in WAC 388-440-0001, an exception to rule is approved by the department for in-home personal care hours in excess of the amount determined to be available to you by the CARE tool.

[Statutory Authority: RCW 74.08.090, 74.09.520, chapters 74.39 and 74.39A RCW. 07-01-046, § 388-106-0140, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0140, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0145 What may change the maximum payment rate that will be paid for residential personal care services provided to me? The maximum payment rate that will be paid for residential personal care services provided to you may change:

(1) When you have a change in any of the criteria listed in WAC 388-106-0115 and/or 388-106-0120; or

(2) Because you meet the criteria in WAC 388-440-0001, an exception to rule is approved by the department for a payment rate for your residential personal care services in excess of the rate determined to be applicable to you by the CARE tool.

[Statutory Authority: RCW 74.08.090, 74.09.520, chapters 74.39 and 74.39A RCW. 07-01-046, § 388-106-0145, filed 12/14/06, effective 1/14/07.]

MEDICAID PERSONAL CARE (MPC)

WAC 388-106-0200 What services may I receive under Medicaid personal care (MPC)? You may be eligible to receive only the following services under Medicaid personal care (MPC):

(1) Personal care services, as defined in WAC 388-106-0010, in your own home and, as applicable, assistance with personal care tasks while you are out of the home accessing community resources or working.

(2) Personal care services in one of the following residential care facilities:

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(a) Adult family homes; or

(b) A licensed boarding home that has contracted with the department to provide adult residential care services.

(3) Nursing services, if you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager:

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In none-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource;

(e) File review; and/or

(f) Evaluation of health-related care needs affecting service planning and delivery.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0200, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0200, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0210 Am I eligible for MPC-funded services? You are eligible for MPC-funded services when the department assesses your needs and determines that you meet all of the following criteria:

(1) You are certified as noninstitutional categorically needy, as defined in WAC 388-500-0005. Categorically needy medical institutional programs described in chapter 388-513 WAC do not meet this criteria.

(2) You are functionally eligible which means one of the following applies:

(a) You have an unmet or partially met need with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in:		
	Self Performance is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Dressing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup

Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup
Medication Management	Assistance Required	N/A
Personal Hygiene	Supervision	N/A
Body care which includes: Application of ointment or lotions; Toenails trimmed; Dry bandage changes; or Passive range of motion treatment.	Need	N/A
Your need for assistance in any of the activities listed in subsection (a) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

; or

(b) You have an unmet or partially met need or the activity did not occur (because you were unable or no provider was available) with at least one or more of the following:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	Supervision	One person physical assist
Toileting	Extensive Assistance	One person physical assist
Bathing	Limited Assistance	One person physical assist
Dressing	Extensive Assistance	One person physical assist
Transfer	Extensive Assistance	One person physical assist
Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A

Personal Hygiene	Extensive Assistance	One person physical assist
Body care which includes: Application of ointment or lotions; Toenails trimmed; Dry bandage changes; or Passive range of motion treatment.	Need	N/A
Your need for assistance in any of the activities listed in subsection (b) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose determining your functional eligibility.		

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0210, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0213 How are my needs assessed if I am a child applying for MPC services? If you are a child applying for MPC services, the department will complete a CARE assessment and:

(1) Consider and document the role of your legally responsible natural/step/adoptive parent(s).

(2) Code your needs as met based on the guidelines outlined in the following table:

		Activities of Daily Living (ADLs)																	
Ages		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
■ = Code status as Met																			
Medication Management																			
Independent, supervision, limited, extensive, or total		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Locomotion in Room ^{Note}																			
Independent, supervision, limited or extensive		■	■	■	■														
Total		■	■																
Locomotion Outside Room ^{Note}																			
Independent or supervision		■	■	■	■	■	■												
Limited or extensive		■	■	■	■														
Total		■	■																
Walk in Room ^{Note}																			
Independent, supervision, limited or extensive		■	■	■	■														
Total		■	■																
Bed Mobility																			
Independent, supervision, limited or extensive		■	■	■															
Total		■	■																
Transfers																			
Independent, supervision, limited, extensive or total		■	■	■															
& under 30 pounds (Total & over 30 pounds = no age limit)																			
Toilet Use																			
Support provided for nighttime wetting only (independent, supervision, limited, extensive)		■	■	■	■	■	■	■	■										
Independent, supervision, limited, extensive		■	■	■	■	■	■												
Total		■	■	■	■														
Eating																			
Independent, supervision, limited, extensive, or total		■	■	■															
Bathing																			
Independent or supervision		■	■	■	■	■	■	■	■	■	■	■	■						
Physical assistance all/part		■	■	■	■	■	■	■	■										
Total		■	■	■	■	■													
Dressing																			
Independent or supervision		■	■	■	■	■	■	■	■	■	■	■	■						
Limited or extensive		■	■	■	■	■	■	■	■										
Total		■	■	■	■	■													
Personal Hygiene																			
Independent or supervision		■	■	■	■	■	■	■	■	■	■	■	■						
Limited or extensive		■	■	■	■	■	■	■	■										
Total		■	■	■	■	■													

		Instrumental Activities of Daily Living																	
Ages		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
■ = Code status as Met																			
Telephone																			
Independent, supervision, limited, extensive, or total		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Transportation																			
Independent, supervision, limited, extensive, or total		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Shopping																			
Independent, supervision, limited, extensive, or total		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Wood Supply																			
Independent, supervision, limited, extensive, or total		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Housework																			
Independent, supervision, limited, extensive, or total		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Finances																			
Independent, supervision, limited, extensive, or total		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Meal Preparation																			
Independent, supervision, limited, extensive, or total		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■

NOTE: If the activity did not occur, the department codes self performance as total and status as met.

		Ages																	
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Additional guidelines based on age																			
Any foot care needs																			
Status Need met		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Any skin care (other than feet)																			
Status Need met		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Speech/Hearing																			
Score comprehension as understood		■	■	■															
MMSE can be administered = no		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Memory																			
Short term memory ok		■	■	■	■	■	■	■	■	■	■	■	■						
Long term memory ok		■	■	■	■	■	■	■	■	■	■	■	■						
Depression																			
Select interview = unable to obtain		■	■	■	■	■	■	■	■	■	■	■	■						
Decision making																			
Rate how client makes decisions = independent		■	■	■	■	■	■	■	■	■	■	■	■						
Bladder/Bowel																			
Support provided for nighttime wetting only - Individual management =		■	■	■	■	■	■	■	■	■	■	■	■						
Does not need/use																			
Support provided for daytime wetting - Individual Management = Does not need/use		■	■	■	■	■	■												
Treatment																			
Passive range of motion		■	■	■	■														

(3) In addition, determine that the status and assistance available are met or partially met over three-fourths of the time, when you are living with your legally responsible natural/step/adoptive parent(s).

(4) Will not code mental health therapy, behaviors, or depression if you are in foster care.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0213, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0213, filed 5/17/05, effective 6/17/05.]

are significant changes in your functional or financial cir-

[Title 388 WAC—p. 598]

WAC 388-106-0215 When do MPC services start?

Your eligibility for MPC begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0215, filed 2/6/06, effective 3/9/06.]

WAC 388-106-0220 How do I remain eligible for MPC?

(1) In order to remain eligible for MPC, you must be in need of services in accordance with WAC 388-106-0210 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there cumstances.

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(2) When eligibility statutes, regulations, and/or rules for MPC change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your MPC services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0220, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0225 How do I pay for MPC? (1) If you live in your own home, you do not participate toward the cost of your personal care services.

(2) If you live in a residential facility and are:

(a) An SSI beneficiary who receives only SSI income, you only pay for board and room. You are allowed to keep a personal needs allowance of at least thirty-eight dollars and eighty-four cents per month;

(b) An SSI beneficiary who receives SSI and SSA benefits, you only pay for board and room. You are allowed to keep a personal needs allowance of at least fifty-eight dollars and eighty-four cents per month;

(c) An SSI-related person under WAC 388-511-1105, you may be required to participate towards the cost of your personal care services in addition to your board and room if your financial eligibility is based on the facility's state contracted rate. You will receive a personal allowance of fifty-eight dollars and eighty-four cents;

(d) A GA-X client in a residential care facility, you are allowed to keep a personal allowance of only thirty-eight dollars and eighty-four cents per month. The remainder of your grant must be paid to the facility.

(3) The department pays the residential care facility from the first day of service through the:

(a) Last day of service when the Medicaid resident dies in the facility; or

(b) Day of service before the day the Medicaid resident is discharged.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0225, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0230 Can I be employed and receive MPC? You can be employed and receive MPC services if you remain medicaid eligible under the noninstitutional categorically needy program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0230, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0235 Are there waiting lists for MPC? There are no waiting lists for MPC. Instead of waiting lists, the department may revise rules to reduce caseload size, hours, rates, or payments in order to stay within the legislative appropriation.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0235, filed 5/17/05, effective 6/17/05.]

COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM (COPES)

WAC 388-106-0300 What services may I receive under community options program entry system (COPES) when I live in my own home? When you live in

your own home, you may be eligible to receive only the following services under COPES:

(1) Personal care services as defined in WAC 388-106-0010 in your own home and, as applicable, while you are out of the home accessing community resources or working.

(2) Adult day care if you meet the eligibility requirements under WAC 388-106-0805.

(3) Environmental modifications, if the minor physical adaptations to your home:

(a) Are necessary to ensure your health, welfare and safety;

(b) Enable you to function with greater independence in the home;

(c) Directly benefit you medically or remedially;

(d) Meet applicable state or local codes; and

(e) Are not adaptations or improvements, which are of general utility or add to the total square footage.

(4) Home delivered meals, providing nutritional balanced meals, limited to one meal per day, if:

(a) You are homebound and live in your own home;

(b) You are unable to prepare the meal;

(c) You don't have a caregiver (paid or unpaid) available to prepare this meal; and

(d) Receiving this meal is more cost-effective than having a paid caregiver.

(5) Home health aide service tasks in your own home, if the service tasks:

(a) Include assistance with ambulation, exercise, self-administered medications and hands-on personal care;

(b) Are beyond the amount, duration or scope of Medicaid reimbursed home health services as described in WAC 388-551-2120 and are in addition to those available services;

(c) Are health-related. Note: Incidental services such as meal preparation may be performed in conjunction with a health-related task as long as it is not the sole purpose of the aide's visit; and

(d) Do not replace Medicare home health services.

(6) Personal emergency response system (PERS), if the service is necessary to enable you to secure help in the event of an emergency and if you:

(a) Live alone in your own home; or

(b) Are alone, in your own home, for significant parts of the day and have no regular provider for extended periods of time.

(7) Skilled nursing, if the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse; and

(b) Beyond the amount, duration or scope of Medicaid-reimbursed home health services as provided under WAC 388-551-2100.

(8) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, if the items are:

(a) Medically necessary under WAC 388-500-0005;

(b) Necessary for: Life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live;

(c) Directly medically or remedially beneficial to you; and

(d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under Medicaid and/or Medicare.

(9) Training needs identified in CARE or in a professional evaluation, which meet a therapeutic goal such as:

- (a) Adjusting to a serious impairment;
- (b) Managing personal care needs; or
- (c) Developing necessary skills to deal with care providers.

(10) Transportation services, when the service:

- (a) Provides access to community services and resources to meet your therapeutic goal;
- (b) Is not diverting in nature; and
- (c) Is in addition to and does not replace the Medicaid-brokered transportation or transportation services available in the community.

(11) Nurse delegation services, when:

(a) You are receiving personal care from a registered or certified nursing assistant who has completed nurse delegation core training;

(b) Your medical condition is considered stable and predictable by the delegating nurse; and

(c) Services are provided in compliance with WAC 246-840-930.

(12) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager.

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In non-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource.

(e) File review; and/or

(f) Evaluation of health-related care needs affecting service plan and delivery.

(13) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to set up your own home. Services:

(a) May include: Safety deposits, utility set-up fees or deposits, health and safety assurances such as pest eradication, allergen control or one-time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution; and

(b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0300, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0300, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0305 What services may I receive under COPES if I live in a residential facility? If you live in one of the following residential facilities: A licensed boarding home contracted with the department to provide assisted living, enhanced adult residential care, enhanced adult residential care-specialized dementia care or an adult family home, you may be eligible to receive only the following services under COPES:

(1) Personal care services as defined under WAC 388-106-0010.

(2) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, when the items are:

(a) Medically necessary under WAC 388-500-0005; and

(b) Necessary: For life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live; and

(c) Directly medically or remedially beneficial to you; and

(d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under Medicaid and/or Medicare; and

(e) In addition to and do not replace the services required by the department's contract with a residential facility.

(3) Training needs identified in CARE or in a professional evaluation, that are in addition to and do not replace the services required by the department's contract with the residential facility and that meet a therapeutic goal such as:

(a) Adjusting to a serious impairment;

(b) Managing personal care needs; or

(c) Developing necessary skills to deal with care providers.

(4) Transportation services, when the service:

(a) Provides access to community services and resources to meet a therapeutic goal;

(b) Is not diverting in nature;

(c) Is in addition to and does not replace the Medicaid-brokered transportation or transportation services available in the community; and

(d) Does not replace the services required by DSHS contract in residential facilities.

(5) Skilled nursing, when the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse;

(b) Beyond the amount, duration or scope of Medicaid-reimbursed home health services as provided under WAC 388-551-2100; and

(c) In addition to and does not replace the services required by the department's contract with the residential facility (e.g. intermittent nursing services as described in WAC 388-78A-2310).

(6) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager.

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In none-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource.

(e) File review; and/or

(f) Evaluation of health-related care needs affecting service plan and delivery.

(7) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to live in a residential facility. Services:

(a) May include: Safety deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution.

(b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0305, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0305, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0310 Am I eligible for COPES-funded services? You are eligible for COPES-funded services if you meet all of the following criteria. The department must assess your needs in CARE and determine that:

(1) You are age:

(a) Eighteen or older and blind or have a disability, as defined in WAC 388-511-1105; or

(b) Sixty-five or older.

(2) You meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC 388-515-1505, community options program entry system (COPES).

(3) You:

(a) Are not eligible for Medicaid personal care services (MPC); or

(b) Are eligible for MPC services, but the department determines that the amount, duration, or scope of your needs is beyond what MPC can provide.

(4) Your CARE assessment shows you need the level of care provided in a nursing facility (or will likely need the level of care within thirty days unless COPES services are provided) which is defined in WAC 388-106-0355(1).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0310, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0315 When do COPES services start? Your eligibility for COPES begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0315, filed 5/17/05, effective 6/17/05.]

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WAC 388-106-0320 How do I remain eligible for COPES? (1) In order to remain eligible for COPES, you must be in need of services in accordance with WAC 388-106-0310 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for COPES change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your COPES services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0320, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0325 How do I pay for COPES services? Depending on your income and resources, you may be required to pay participation toward the cost of your care, as outlined in WAC 388-515-1505. If you have nonexempt income that exceeds the cost of COPES services, you may retain the difference. If you are receiving services in:

(1) Your own home, you are allowed to keep some of your income for a maintenance allowance.

(2) In a residential facility, you must use your income to pay for your room and board and services. You are allowed to keep some of your income for personal needs allowance (PNA). The department determines the amount of PNA that you may keep. The department pays the facility for the difference between what you pay and the department-set rate for the facility. The department pays the residential care facility from the first day of service through the:

(a) Last day of service when the Medicaid resident dies in the facility; or

(b) Day of service before the day the Medicaid resident is discharged.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0325, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0330 Can I be employed and receive COPES? You can be employed and receive COPES, per WAC 388-515-1505.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0330, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0335 Are there waiting lists for COPES? The department will create a waiting list in accordance with caseload limits determined by legislative funding. Wait listed clients will gain access in the following manner:

(1) Nursing home residents wanting COPES waiver services will be ranked first on the wait list by date of application for services;

(2) Then clients living in the community with a higher level of need, as determined by the CARE assessment, will be ranked higher on the wait list over clients with a lower level of need; and

(3) When two or more clients in the community have equal need levels, the client with the earlier application for services will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0335, filed 5/17/05, effective 6/17/05.]

NURSING FACILITY CARE SERVICES

WAC 388-106-0350 What are nursing facility care services? You may receive care in a nursing facility, as outlined in chapter 388-97 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0350, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0355 Am I eligible for nursing facility care services? You are eligible for nursing facility care if the department:

(1) Assesses you in CARE and determines that you meet the functional criteria for nursing facility level of care which means one of the following applies:

(a) You require care provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis;

(b) You have an unmet or partially met need with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup
Medication Management	Assistance Required	N/A
Your need for assistance in any activities listed in subsection (b) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose in determining your functional eligibility.		

(c) You have an unmet or partially met need with at least two of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	Supervision	One person physical assist
Toileting	Extensive Assistance	One person physical assist
Bathing	Limited Assistance	One person physical assist

Transfer	Extensive Assistance	One person physical assist
Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A
Your need for assistance in any of the activities listed in subsection (c) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

or:

(d) You have a cognitive impairment and require supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	Supervision	One person physical assist
Toileting	Extensive Assistance	One person physical assist
Bathing	Limited Assistance	One person physical assist
Transfer	Extensive Assistance	One person physical assist
Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A
Your need for assistance in any of the activities listed in subsection (d) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(2) Determines that you meet the financial eligibility requirements set through WAC 388-513-1315.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0355, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0360 How do I pay for nursing facility care services? (1) If you are Medicaid eligible and the nursing facility admits you without a request for assessment from the department, the nursing facility will not:

(a) Be reimbursed by the department; or
(b) Be allowed to collect payment, including a deposit or minimum stay fee, from you or your family/representative for any care provided before the date of request for assessment.

(2) If you are eligible for Medicaid-funding nursing facility care, the department pays for your services beginning on the date:

(a) Of the request for a department assessment; or
(b) Nursing facility care actually begins, whichever is later.

(3) If you become financially eligible for Medicaid after you have been admitted, the department pays for your nursing facility care beginning on the date of:

(a) Request for assessment or financial application, whichever is earlier;
(b) Nursing facility placement; or
(c) When you are determined financially eligible, whichever is later.

(4) Exception: Payment back to the request date is limited to three months prior to the month that the financial application is received.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0360, filed 5/17/05, effective 6/17/05.]

MEDICALLY NEEDY RESIDENTIAL WAIVER

WAC 388-106-0400 What services may I receive under medically needy residential waiver (MNRW)? You may be eligible to receive only the following MNRW services in one of the following residential facilities: A licensed boarding home contracted with the department to provide assisted living, enhanced residential care, enhanced adult residential care-specialized dementia care or an adult family home:

(1) Personal care services as defined in WAC 388-106-0010.

(2) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, when the items are:

(a) Medically necessary under WAC 388-500-0005; and
(b) Necessary: For life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live;

(c) Directly medically or remedially beneficial to you;
(d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under Medicaid and/or Medicare; and

(e) In addition to and do not replace the services required by the department's contract with the residential facility.

(3) Training needs identified in CARE or in a professional evaluation that are in addition to and do not replace

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services required by the department's contract with the residential facility and that meet a therapeutic goal such as:

(a) Adjusting to a serious impairment;
(b) Managing personal care needs; or
(c) Developing necessary skills to deal with care providers.

(4) Transportation services, when the service:

(a) Provides access to community services and resources provided to meet a therapeutic goal;

(b) Is not diverting in nature;

(c) Is in addition to and does not replace the Medicaid-brokered transportation or transportation services available in the community; and

(d) Does not replace the services required by the department's contract with a residential facility.

(5) Skilled nursing, when the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse;

(b) Beyond the amount, duration or scope of Medicaid-reimbursed home health services as provided under WAC 388-551-2120; and

(c) In addition to and does not replace the services required by the department's contract with the residential facility (e.g. intermittent nursing services as described in WAC 388-78A-2310).

(6) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any additional collateral contact information obtained by your case manager.

(a) Nursing assessment/reassessment;

(b) Instruction to care providers and clients;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, only in the event of an emergency. A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In none-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource.

(e) File review; and/or

(f) Evaluation of health-related care needs affecting service plan and delivery.

(7) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to live in a residential facility. Services:

(a) May include: Safety deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution.

(b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.-020, 06-05-022, § 388-106-0400, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0400, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0410 Am I eligible for MNRW-funded services? You are eligible for MNRW-funded services if you choose to receive services in a residential facility and you meet all of the following criteria. The department must assess your needs, using CARE, and determine that:

- (1) You are age:
 - (a) Eighteen or older and blind or have a disability, as defined in WAC 388-511-1105; or
 - (b) Sixty-five or older.
- (2) You meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC 388-515-1540.
- (3) You are not eligible for Medicaid personal care services (MPC) or COPES.
- (4) Your CARE assessment shows you need the level of care provided in a nursing facility (or will likely need the level of care within thirty days unless MNRW services are provided) which is defined in WAC 388-106-0355(1).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0410, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0415 When do MNRW services start? Your eligibility for MNRW begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0415, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0420 How do I remain eligible for MNRW? (1) In order to remain eligible for MNRW, you must be in need of services in accordance with WAC 388-106-0410 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for MNRW change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your MNRW services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0420, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0425 How do I pay for MNRW services? (1) You must use your income to pay for your room and board and services. The amount you pay is determined in WAC 388-515-1540. You are allowed to keep some of your income for personal needs allowance (PNA). The department pays the facility for the difference between what you pay and the department-set rate for the facility. The department pays the residential care facility from the first day of service through the:

- (a) Last day of service when the Medicaid resident dies in the facility; or
- (b) Day of service before the day the Medicaid resident is discharged.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0425, filed 5/17/05, effective 6/17/05.]

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WAC 388-106-0430 Can I be employed and receive MNRW? You may be employed and receive MNRW per WAC 388-515-1540.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0430, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0435 Are there waiting lists for MNRW? The department will create a waiting list in accordance with caseload limits determined by legislative funding. Wait listed clients will gain access in the following manner:

- (1) Nursing home residents wanting MN waiver services will be ranked first on the wait list by date of application for services;
- (2) Then clients living in the community with a higher level of need, as determined by the department's CARE assessment, will be ranked higher on the wait list over clients with lower level of need; and
- (3) When two or more clients in the community have equal need levels, the client with the earlier application for services will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0435, filed 5/17/05, effective 6/17/05.]

MEDICALLY NEEDY IN-HOME WAIVER

WAC 388-106-0500 What services may I receive under medically needy in-home waiver (MNIW)? You may be eligible to receive only the following medically needy in-home waiver (MNIW) services in your own home:

(1) Personal care services as defined in WAC 388-106-0010 in your own home and, as applicable, while you are out of the home accessing community resources or working.

(2) Adult day care if you meet the eligibility requirements under WAC 388-106-0805.

(3) Environmental modifications, if the minor physical adaptations to your home:

(a) Are necessary to ensure your health, welfare and safety;

(b) Enable you to function with greater independence in the home;

(c) Directly benefit you medically or remedially;

(d) Meet applicable state or local codes; and

(e) Are not adaptations or improvements, which are of general utility or add to the total square footage.

(4) Home delivered meals, providing nutritional balanced meals, limited to one meal per day, if:

(a) You are homebound and live in your own home;

(b) You are unable to prepare the meal;

(c) You don't have a caregiver (paid or unpaid) available to prepare this meal; and

(d) Receiving this meal is more cost-effective than having a paid caregiver.

(5) Home health aide service, if the service tasks:

(a) Include assistance with ambulation, exercise, self-administered medications and hands on personal care;

(b) Are beyond the amount, duration or scope of Medicaid reimbursed home health services (WAC 388-551-2120) and are in addition to those available services;

(c) Are health-related. Note: Incidental services such as meal preparation may be performed in conjunction with a

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health-related task as long as it is not the sole purpose of the aide's visit; and

(d) Do not replace Medicare home health services.

(6) Personal emergency response system (PERS), if the service is necessary to enable you to secure help in the event of an emergency and if you:

(a) Live alone in your own home; or

(b) Are alone, in your own home, for significant parts of the day and have no regular provider for extended periods of time.

(7) Skilled nursing, if the service is:

(a) Provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse; and

(b) Beyond the amount, duration or scope of Medicaid-reimbursed home health services as provided under WAC 388-551-2120.

(8) Specialized durable and nondurable medical equipment and supplies under WAC 388-543-1000, if the items are:

(a) Medically necessary under WAC 388-500-0005;

(b) Necessary: For life support; to increase your ability to perform activities of daily living; or to perceive, control, or communicate with the environment in which you live;

(c) Directly medically or remedially beneficial to you; and

(d) In addition to and do not replace any medical equipment and/or supplies otherwise provided under Medicaid and/or Medicare.

(9) Training needs identified in CARE or in a professional evaluation, which meet a therapeutic goal such as:

(a) Adjusting to a serious impairment;

(b) Managing personal care needs; or

(c) Developing necessary skills to deal with care providers.

(10) Transportation services if you live in your own home, when the service:

(a) Provides access to community services and resources to meet a therapeutic goal;

(b) Is not diverting in nature;

(c) Is in addition to and does not replace the Medicaid-brokered transportation or transportation services available in the community.

(11) Nurse delegation services when:

(a) You are receiving personal care from a registered or certified nursing assistant who has completed nurse delegation core training;

(b) Your medical condition is considered stable and predictable by the delegating nurse; and

(c) Services are provided in compliance with WAC 246-840-930.

(12) Nursing services, when you are not already receiving this type of service from another resource. A registered nurse may visit you and perform any of the following activities. The frequency and scope of the nursing services is based on your individual need as determined by your CARE assessment and any collateral contact information obtained by your case manager.

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

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(d) Skilled treatment, only in the event of an emergency.

A skilled treatment is care that would require authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, for example, medication administration or wound care such as debridement. In none-emergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, a home health agency or other appropriate resource;

(e) File review; and/or

(f) Evaluation of health-related care needs affecting service planning and delivery.

(13) Community transition services, if you are being discharged from the nursing facility or hospital and if services are necessary for you to set up your own home. Services:

(a) May include: Safety deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution.

(b) Do not include rent, recreational or diverting items such as TV, cable or VCRs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-0500, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0500, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0510 Am I eligible for MNIW-funded services? You are eligible for MNIW-funded services if you choose to receive services in your own home and you meet all of the following criteria. The department must assess your needs in CARE and determine that:

(1) You are age:

(a) Eighteen or older and blind or have a disability, as defined in WAC 388-511-1105; or

(b) Sixty-five or older.

(2) You meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC 388-515-1505;

(3) You are not eligible for Medicaid personal care services (MPC) or COPES;

(4) Your CARE assessment shows you need the level of care provided in a nursing facility (or will likely need the level of care within thirty days unless MNIW services are provided) which is defined in WAC 388-106-0355(1).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0510, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0515 When do MNIW services start? Your eligibility for MNIW begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0515, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0520 How do I remain eligible for MNIW? (1) In order to remain eligible for MNIW, you must be in need of services in accordance with WAC 388-106-0510 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for MNIW change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your MNIW services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0520, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0525 How do I pay for MNIW? The amount you pay is determined in WAC 388-515-1550.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0525, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0530 Can I be employed and receive MNIW? You can be employed and receive MNIW, per WAC 388-515-1550.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0530, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0535 Are there waiting lists for MNIW? The department will create a waiting list in accordance with caseload limits determined by legislative funding. Wait listed clients will gain access in the following manner:

(1) Nursing home residents wanting MN waiver services will be ranked first on the wait list by date of application for services;

(2) Then clients living in the community with a higher level of need as determined by the department's CARE assessment will be ranked higher on the wait list over clients with lower level of need; and

(3) When two or more clients in the community have equal need levels, the client with the earlier application for services will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0535, filed 5/17/05, effective 6/17/05.]

CHORE

WAC 388-106-0600 What services may I receive under chore? You may receive personal care services in your own home and, as applicable, assistance with personal care tasks while you are out of the home accessing community resources or working.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0600, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0610 Am I eligible for chore-funded services? To be eligible for chore-funded services you must meet all of the following criteria:

(1) Be grandfathered on the chore program before August 1, 2001 and have continued to receive chore without a break in service.

(2) Not be eligible for MPC or COPES.

(3) Be eighteen years of age or older.

(4) Have an unmet or partially met need with at least one of the following activities of daily living, as defined in WAC 388-106-0010.

[Title 388 WAC—p. 606]

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Dressing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup
Medication Management	Assistance Required	N/A
Personal Hygiene	Supervision	N/A
Body care which includes: Application of ointment or lotions; Toenails trimmed; Dry bandage changes; or Passive range of motion treatment.	Need	N/A
Your need for assistance in any of the activities listed in this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.		

(5) Have net household income (as described in WAC 388-450-0005 and 388-450-0040) not exceeding:

(a) The sum of the cost of your chore services; and

(b) One-hundred percent of the federal poverty level (FPL) adjusted for family size.

(6) Have resources, as described in chapter 388-470 WAC, which do not exceed ten thousand dollars for a one-person family or fifteen thousand dollars for a two-person family. (Note: One thousand dollars for each additional family member may be added to these limits.); and

(7) Not transfer assets on or after November 1, 1995 for less than fair market value, as described in WAC 388-513-1365.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0610, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0615 When do chore services start? Your eligibility for chore services begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0615, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0620 How do I remain eligible for chore? (1) In order to remain eligible for chore, you must be

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in need of services in accordance with WAC 388-106-0610 as determined through a CARE assessment. The assessment in CARE must be at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for chore change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your chore services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0620, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0625 How do I pay for chore? You may retain an amount equal to one hundred percent of the federal poverty level, adjusted for family size, as the home maintenance allowance and pay the difference between the FPL and your nonexempt income. Exempt income includes:

- (1) Income listed in WAC 388-513-1340;
- (2) Spousal income allocated and actually paid as participation in the cost of the spouse's community options program entry system (COPES) services;
- (3) Amounts paid for medical expenses not subject to third party payment;
- (4) Health insurance premiums, coinsurance or deductible charges; and
- (5) If applicable, those work expense deductions listed in WAC 388-106-0630(2).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0625, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0630 Can I be employed and receive chore? If you are not Medicaid eligible due to your earned income and resources and are receiving chore personal care services:

- (1) You may be required to pay participation, per WAC 388-106-0625, for any earned income above one hundred percent of the federal poverty level.
- (2) The department will exempt fifty percent of your earned income after work expense deductions. Work expense deductions are:
 - (a) Personal work expenses in the form of self-employment taxes (FICA); and income taxes when paid;
 - (b) Payroll deductions required by law or as a condition of employment in the amounts actually withheld;
 - (c) The necessary cost of transportation to and from the place of employment by the most economical means, except rental cars;
 - (d) Expenses necessary for continued employment such as tools, materials, union dues, transportation to service customers not furnished by the employer; and
 - (e) Uniforms needed on the job and not suitable for wear away from the job.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0630, filed 5/17/05, effective 6/17/05.]

VOLUNTEER CHORE

WAC 388-106-0650 What services may I receive under volunteer chore? Volunteer chore is a state-funded

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program which provides volunteer assistance with household tasks and:

- (1) Assists people who need but are not eligible for DSHS services.
- (2) Complements DSHS services by using volunteer assistance to perform tasks which do not require specially-skilled personnel.
- (3) Provides assistance with housework, laundry, shopping, cooking, moving, minor home repair, yard care, limited personal care, monitoring and transportation.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0650, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0655 Am I eligible to receive volunteer chore services? You may receive volunteer chore services if you are:

- (1) Eighteen years of age or older;
- (2) Living at home unless you are moving from a residential facility to home and need assistance moving;
- (3) Unable to perform certain personal care tasks due to functional or cognitive impairment;
- (4) Financially unable to purchase services from a private provider;
- (5) Not receiving services under COPES, MNIW, MPC, or chore because you:
 - (a) Do not meet the eligibility requirements; or
 - (b) Decline these services.
- (6) In need of assistance from volunteer chore in addition to or in substitution of paid services under COPES, MNIW, MPC, or chore.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0655, filed 5/17/05, effective 6/17/05.]

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

WAC 388-106-0700 What services may I receive under PACE? Under their contract with the department, the PACE provider develops an individualized plan of care, as defined in 42 CFR 460.106, that integrates necessary long-term care, medical services, mental health services, and alcohol and substance abuse treatment services.

- (1) The care plan includes, but is not limited to any of the following long-term care services:
 - (a) Care coordination;
 - (b) Home and community-based services:
 - (i) Personal (in-home) care;
 - (ii) Residential care.
 - (c) And, if necessary, nursing facility care.
- (2) The care plan may also include, but is not limited to, the following medical services:
 - (a) Primary medical care;
 - (b) Vision care;
 - (c) End of life care;
 - (d) Restorative therapies, including speech, occupational, and physical therapy;
 - (e) Oxygen therapy;
 - (f) Audiology (including hearing aids);
 - (g) Transportation;
 - (h) Podiatry;
 - (i) Durable medical equipment (e.g., wheelchair);

[Title 388 WAC—p. 607]

- (j) Dental care;
- (k) Pharmaceutical products;
- (l) Immunizations and vaccinations;
- (m) Emergency room visits and inpatient hospital stays.

(3) The care plan may also include any other services determined necessary by the interdisciplinary team to improve and maintain your overall health status.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0700, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0705 Am I eligible for PACE services?

To qualify for Medicaid-funded PACE services, you must apply for an assessment by contacting your local home and community services office. The department will assess and determine whether you:

- (1) Are age:

(a) Fifty-five or older, and blind or have a disability, as defined in WAC 388-511-1105, SSI-related eligibility requirements; or

- (b) Sixty-five or older.

(2) Need nursing facility level of care as defined in WAC 388-106-0355;

(3) Live within the designated service area of the PACE provider;

(4) Meet financial eligibility requirements. This means the department will assess your finances, determine if your income and resources fall within the limits, and determine the amount you may be required to contribute, if any, toward the cost of your care as described in WAC 388-515-1505;

(5) Not be enrolled in any other Medicare or Medicaid prepayment plan or optional benefit; and

(6) Agree to receive services exclusively through the PACE provider and the PACE provider's network of contracted providers.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.-020, 06-05-022, § 388-106-0705, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0705, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0710 How do I pay for PACE services? Depending on your income and resources, you may be required to pay for part of the PACE services. The department's financial worker will determine what amount, if any, you must contribute if you decide to enroll. The department pays the PACE provider the remaining amount.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0710, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0715 How do I end my enrollment in the PACE program? (1) You may choose to voluntarily end your enrollment in the PACE program without cause at any time. To do so, you must give the PACE provider written notice. If you give notice:

(a) Before the fifteenth of the month, the department will end your enrollment effective at the end of the month; or

(b) After the fifteenth, the department will end your enrollment effective until the end of the following month.

- (2) Your enrollment may also end involuntarily if you:

(a) Move out of the designated service area or are out of the service area for more than thirty consecutive days, unless

the PACE provider agrees to a longer absence due to extenuating circumstances;

(b) Engage in disruptive or threatening behavior such that the behavior jeopardizes your health or safety, or the safety of others;

(c) Fail to comply with your plan of care or the terms of the PACE enrollment agreement;

(d) Fail to pay or make arrangements to pay your part of the costs after the thirty-day grace period;

(e) Become financially ineligible for Medicaid services, unless you choose to pay privately;

(f) Are enrolled with a provider that loses its license and/or contract; or

(g) No longer meet the nursing facility level of care requirement as defined in WAC 388-106-0205.

(3) For any of the above reasons, the PACE provider must give you written notice, explaining that they are terminating benefits. If the provider gives you notice:

(a) Before the fifteenth of the month, then the department will end your enrollment at the end of the month; or

(b) After the fifteenth, then the department will end your enrollment at the end of the following month.

(4) Before the PACE provider can involuntarily end your enrollment in the PACE program, the department must review and approve it.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.-020, 06-05-022, § 388-106-0715, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0715, filed 5/17/05, effective 6/17/05.]

MEDICARE/MEDICAID INTEGRATION PROGRAM (MMIP) SERVICES

WAC 388-106-0720 What services may I receive under MMIP? (1) Once you are determined eligible, your care plan could include, but is not limited to, any of the following long-term care services:

(a) Care coordination;

(b) Personal care services in your own home or in a residential facility;

(c) Home health aide;

(d) Adult day services;

(e) Environmental modifications;

(f) Personal emergency response system (PERS);

(g) Skilled nursing;

(h) Specialized medical equipment and supplies;

(i) Home delivered meals;

(j) Residential care;

(k) Nursing facility care.

(2) The care plan may also include, but is not limited to, the following medical services:

(a) Primary medical care;

(b) Restorative therapies, including speech, occupational, and physical therapy;

(c) Nursing services;

(d) Durable medical equipment (e.g., wheelchair);

(e) Pharmaceutical products;

(f) Immunizations and vaccinations;

(g) Vision care;

(h) Emergency room visits and inpatient hospital stays.

The care plan may also include other services determined

necessary by the interdisciplinary team to improve and maintain your overall health status.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. 05-19-045, § 388-106-0720, filed 9/15/05, effective 10/16/05.]

WAC 388-106-0725 Am I eligible for MMIP services? To qualify for Medicaid-funded MMIP services, you must:

- (1) Be age sixty-five or older;
- (2) Live within the designated MMIP service area;
- (3) Be eligible for Medicare (Parts A and B);
- (4) Be eligible for Medicaid-funded medical and/or long-term care services.

(a) To be eligible to receive long-term care services under this program, you must meet functional eligibility for one of the long-term care programs per WAC 388-106-0210(2), 388-106-0310(4), or 388-106-0355(1) and financial eligibility for noninstitutional categorically needy, or institutional categorically needy as described in chapter 388-513 WAC and WAC 388-515-1505.

(b) Ongoing functional and financial eligibility for long-term care services will be determined at least annually by the state.

(c) If you are determined not eligible for long-term care services, you may be eligible to receive medical services under MMIP; and

(5) Not be enrolled in any other medical coverage plan that purchases services on a prepaid basis (e.g., prepaid health plan).

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. 05-19-045, § 388-106-0725, filed 9/15/05, effective 10/16/05.]

WAC 388-106-0730 How do I pay for MMIP services? Depending on your income and resources, you may be required to pay for part of your MMIP services. The department's financial worker will determine what amount, if any, you must contribute toward the cost of your care.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. 05-19-045, § 388-106-0730, filed 9/15/05, effective 10/16/05.]

WAC 388-106-0735 How do I disenroll from MMIP? You may choose to disenroll from MMIP for any reason at any time. See WAC 388-538-061 for additional information on ending enrollment in MMIP.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. 05-19-045, § 388-106-0735, filed 9/15/05, effective 10/16/05.]

WAC 388-106-0740 What is the fair hearing process for enrollee appeals of managed care organization actions? See WAC 388-538-112 for additional information about the fair hearing process.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act, Section 1915(c) waiver rules, 42 C.F.R. 438. 05-19-045, § 388-106-0740, filed 9/15/05, effective 10/16/05.]

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WASHINGTON MEDICAID INTEGRATION PARTNERSHIP (WMIP)

WAC 388-106-0745 What services may I receive under WMIP? (1) Once you are determined eligible, your care plan could include, but is not limited to, any of the following long-term care services:

- (a) Care coordination;
 - (b) Personal care services in your own home or in a residential facility;
 - (c) Home health aide;
 - (d) Adult day services;
 - (e) Environmental modifications;
 - (f) Personal emergency response system (PERS);
 - (g) Skilled nursing;
 - (h) Specialized medical equipment and supplies;
 - (i) Home delivered meals;
 - (j) Residential care;
 - (k) Nursing facility care.
- (2) The care plan may also include medical, chemical dependency, and/or mental health services.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. 06-18-058, § 388-106-0745, filed 8/31/06, effective 10/1/06.]

WAC 388-106-0750 Am I eligible to enroll in WMIP? (1) To enroll in WMIP you must:

- (a) Be aged, blind, or disabled;
- (b) Be twenty-one years of age or older;
- (c) Receive, or be eligible for, categorically needy medical assistance per WAC 388-500-0005; and
- (d) Not be enrolled in any other comparable third party insurance coverage plan that purchases services on a prepaid basis (for example, a prepaid health plan).

(2) To be eligible to receive long-term care services under this program, you must meet functional eligibility for one of the long-term care programs per WAC 388-106-0210(2), 388-106-0310(4), or 388-106-0355(1) and financial eligibility for noninstitutional categorically needy, or institutional categorically needy as described in chapter 388-513 WAC and WAC 388-515-1505.

(3) Ongoing functional and financial eligibility for long-term care services will be determined at least annually by the state.

(4) If you are determined ineligible for long-term care services, you may continue to receive medical, mental health and chemical dependency treatment services through WMIP as long as you continue to meet the criteria listed in subsection (1) above.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. 06-18-058, § 388-106-0750, filed 8/31/06, effective 10/1/06.]

WAC 388-106-0755 How do I pay for WMIP services? Depending on your income and resources, you may be required to pay for part of your long-term care services you receive through WMIP. The department will determine what amount, if any, you must contribute toward the cost of your care.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. 06-18-058, § 388-106-0755, filed 8/31/06, effective 10/1/06.]

WAC 388-106-0760 How do I disenroll from WMIP?

You may choose to disenroll from WMIP for any reason at any time. See WAC 388-538-061 for additional information on ending enrollment in WMIP.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. 06-18-058, § 388-106-0760, filed 8/31/06, effective 10/1/06.]

WAC 388-106-0765 What is the fair hearing process for enrollee appeals of managed care organization actions? See WAC 388-538-112 for additional information specific to the managed care fair hearing process. For hearing information specific to long-term care services eligibility, see WAC 388-106-1305.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438. 06-18-058, § 388-106-0765, filed 8/31/06, effective 10/1/06.]

ADULT DAY SERVICES

WAC 388-106-0800 What adult day care services may I receive? You may receive the following services in an adult day care:

- (1) Core services, which include assistance with:
 - (a) Locomotion outside of room, locomotion in room, walk in room;
 - (b) Body care;
 - (c) Eating;
 - (d) Repositioning;
 - (e) Medication management that does not require a licensed nurse;
 - (f) Transfer;
 - (g) Toileting;
 - (h) Personal hygiene at a level that ensures your safety and comfort while in attendance at the program; and
 - (i) Bathing at a level that ensures your safety and comfort while in attendance at the program.
- (2) Social services on a consultation basis, which may include:
 - (a) Referrals to other providers for services not within the scope of Medicaid reimbursed adult day care services;
 - (b) Caregiver support and education; or
 - (c) Assistance with coping skills.
- (3) Routine health monitoring with consultation from a registered nurse that a consulting nurse acting within the scope of practice can provide with or without a physician's order. Examples include:
 - (a) Obtaining baseline and routine monitoring information on your health status, such as vital signs, weight, and dietary needs;
 - (b) General health education such as providing information about nutrition, illnesses, and preventative care;
 - (c) Communicating changes in your health status to your caregiver;
 - (d) Annual and as needed updating of your medical record; or
 - (e) Assistance as needed with coordination of health services provided outside of the adult day care program.

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(4) General therapeutic activities that an unlicensed person can provide or that a licensed person can provide with or without a physician's order. These services are planned for and provided based on your abilities, interests, and goals. Examples include:

- (a) Recreational activities;
- (b) Diversionary activities;
- (c) Relaxation therapy;
- (d) Cognitive stimulation; or
- (e) Group range of motion or conditioning exercises.

(5) General health education that an unlicensed person can provide or that a licensed person can provide with or without a physician's order, including but not limited to topics such as:

- (a) Nutrition;
- (b) Stress management;
- (c) Disease management skills; or
- (d) Preventative care.

(6) A nutritional meal and snacks are provided every four hours, including a modified diet if needed and within the scope of the program, as provided under WAC 388-71-0768;

(7) Supervision and/or protection if needed for your safety;

(8) Assistance with arranging transportation to and from the program; and

(9) First aid and provisions for obtaining or providing care in an emergency. NOTE: If you require the intervention or services of a registered nurse or licensed rehabilitative therapist acting under the supervision of your physician, consider adult day health services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0800, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0805 Am I eligible for adult day care?

(1) If you receive COPES or MNIW, you may be eligible for adult day care as a waiver service if you are assessed as having an unmet need for one or more of the following core services:

- (a) Personal care services;
- (b) Routine health monitoring with consultation from a registered nurse;
- (c) General therapeutic activities; or
- (d) Supervision and/or protection if required for your safety.

(2) You are not eligible for adult day care if you receive COPES or MNIW and you:

- (a) Can independently perform or obtain the services provided at an adult day care center;
- (b) Have unmet needs that can be met through the COPES or MNIW program more cost effectively without authorizing day care services;
- (c) Have referred care needs that:
 - (i) Exceed the scope of authorized services that the adult day care center is able to provide;
 - (ii) Can be met in a less structured care setting; or
 - (iii) Are being met by paid or unpaid caregivers.
- (d) Live in a nursing home, boarding home, adult family home, or other licensed institutional or residential facility; or
- (e) Are not capable of participating safely in a group care setting.

(2007 Ed.)

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0805, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0810 What adult day health services may I receive? You may receive the following adult day health services:

- (1) All core services under WAC 388-106-0800;
- (2) Skilled nursing services other than routine health monitoring with nurse consultation;
- (3) At least one of the following skilled therapy services: physical therapy, occupational therapy, or speech-language pathology or audiology, as defined under chapters 18.74, 18.59, and 18.35 RCW, and
- (4) Psychological or counseling services, including assessing for psycho-social therapy need, dementia, abuse or neglect, and alcohol or drug abuse; making appropriate referrals; and providing brief, intermittent supportive counseling.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0810, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0815 Am I eligible for adult day health? (1) You are eligible for adult day health services if you meet all of the following criteria. You are:

- (a) Age eighteen years or older.
 - (b) Enrolled in one of the following medical assistance programs:
 - (i) Categorically needy (CNP);
 - (ii) Categorically needy qualified Medicare beneficiaries (CNP-QMB);
 - (iii) General assistance—Expedited Medicaid disability (GA-X); or
 - (iv) Alcohol and Drug Abuse Treatment and Support Act (ADATSA).
 - (c) Assessed as having an unmet need for skilled nursing under WAC 388-71-0712 or skilled rehabilitative therapy under WAC 388-71-0714; and
 - (i) There is a reasonable expectation that these services will improve, restore or maintain your health status, or in the case of a progressive disabling condition, will either restore or slow the decline of your health and functional status or ease related pain or suffering; and
 - (ii) You are at risk for deteriorating health, deteriorating functional ability, or institutionalization; and
 - (iii) You have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment.
 - (d) Assessed as having needs for personal care or other core services, whether or not those needs are otherwise met.
- (2) You are not eligible for adult day health if you:
- (a) Can independently perform or obtain the services provided at an adult day health center;
 - (b) Have referred care needs that:
 - (i) Exceed the scope of authorized services that the adult day health center is able to provide;
 - (ii) Do not need to be provided or supervised by a licensed nurse or therapist;
 - (iii) Can be met in a less structured care setting; or
 - (iv) In the case of skilled care needs, are being met by paid or unpaid caregivers.
 - (c) Live in a nursing home or other institutional facility;
- or

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(d) Are not capable of participating safely in a group care setting.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0815, filed 5/17/05, effective 6/17/05.]

GAU-FUNDED RESIDENTIAL CARE

WAC 388-106-0900 What services may I receive under GAU-funded residential care? You may receive personal care services in an adult family home or a licensed boarding home contracted with the department to provide adult residential care services. You may also receive nurse delegation services under this program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0900, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0905 Am I eligible to receive GAU-funded residential care services? You are eligible to receive GAU-funded residential care services if:

- (1) You meet financial eligibility requirements for general assistance unemployable (GAU), described in WAC 388-400-0025;
- (2) You are not eligible for services under COPES, MNRW, or MPC; and
- (3) You are assessed in CARE and meet the functional criteria outlined in WAC 388-106-0210(2).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0905, filed 5/17/05, effective 6/17/05.]

RESIDENTIAL CARE DISCHARGE ALLOWANCE

WAC 388-106-0950 What services may I receive under the residential care discharge allowance? The residential care discharge allowance is a one-time payment used to help you establish or resume living in your own home. You may receive up to eight hundred and sixteen dollars to cover necessary equipment, remodeling, rent, and utilities.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0950, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0955 Am I eligible for residential care discharge allowance? You are eligible for a residential discharge allowance if you:

- (1) Receive long-term care services from home and community services;
- (2) Are being discharged from a hospital, nursing facility, a licensed boarding home, or adult family home to your own home;
- (3) Do not have other programs, services, or resources to assist you with these costs; and
- (4) Have needs beyond what is covered under the community transition service (under COPES, MNRW, and MNIW).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0955, filed 5/17/05, effective 6/17/05.]

PRIVATE DUTY NURSING

WAC 388-106-1000 What is the intent of WAC 388-106-1000 through 388-106-1055? The intent of WAC 388-106-1000 through 388-106-1055 is to:

[Title 388 WAC—p. 611]

(1) Describe the eligibility requirements under which an adult age eighteen or older may receive private duty nursing (PDN) services through the department's aging and disability services administration (ADSA);

(2) Provide assistance to clients and enable families to support clients in their own homes; and

(3) Describe the requirements clients and their families, home health agencies, and privately contracted registered nurses (RNs) and licensed practical nurses (LPNs) must meet in order for services to be authorized for PDN.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1000, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1005 What services may I receive under private duty nursing (PDN)? PDN is a program that provides skilled nursing care if you have complex medical needs that cannot be met through other services. PDN is an alternative to institutional care and is the program of last resort.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1005, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1010 Am I eligible for Medicaid-funded private duty nursing services? In order to be eligible for Medicaid-funded PDN, you must:

(1) Be financially eligible, which means you:

(a) Meet Medicaid requirements under the categorically needy program or the medically needy program (MNP).

(b) Use private insurance as first payer, as required by Medicaid rules. Private insurance benefits, which cover hospitalization and in-home services, must be ruled out as the first payment source to PDN.

(2) Be medically eligible, which means an ADSA department's community nurse consultant (CNC) or ADSA's division of disabilities services' (DDS) nursing care consultant (NCC) must assess you using the CARE assessment and the PDN skilled nursing task log for initial eligibility determination and thereafter every six months, and determine that you:

(a) Require care in a hospital or meet nursing facility level of care, as defined in WAC 388-106-0310; and

(b) Have unmet skilled nursing needs that cannot be met in a less costly program or less restrictive environment; and

(c) Are not able to have your care tasks provided through nurse delegation, WAC 246-840-910 through 246-840-970; through COPES skilled nursing, WAC 388-515-1505; or through self-directed care RCW 74.39.050; and

(d) Have a complex medical need that requires four or more hours every day of continuous skilled nursing care which can be safely provided outside a hospital or nursing facility; and

(e) Require skilled nursing care that is medically necessary, per WAC 388-500-0005; and

(f) Be able to supervise your care (provider) or have a guardian who is authorized to supervise your care; and

(g) Have family or other appropriate informal support who is responsible for assuming a portion of your care; and

(h) Have your primary care physician or ARNP document your medical stability and appropriateness for PDN and:

(i) Provide orders for medical services; and

(ii) Document approval of the service provider's PDN plan of care.

(i) Do not have other resources or means for obtaining this service; and

(j) Are dependant upon technology every day, with at least one of the following skilled care needs:

(i) You need mechanical ventilation, and the use of a mechanical device to fill the lungs with oxygenated air and then allow time for passive exhalation; or

(ii) You need complex respiratory support, which means that:

(A) You require two of the following treatment needs:

(I) Postural drainage and chest percussion; or

(II) Application of respiratory vests; or

(III) Nebulizer treatments with or without medications;

or

(IV) Intermittent positive pressure breathing; or

(V) O2 saturation measurement with treatment decisions dependent on the results; and

(B) Your treatment needs must be assessed and provided by an RN or LPN; and

(C) Your treatment needs cannot be nurse delegated or self-directed;

(iii) You need tracheostomy care, and tracheal suctioning;

(iv) You need intravenous/parenteral administration of multiple medications, and care is occurring on a continuing or frequent basis; or

(v) You need intravenous administration of nutritional substances, and care is occurring on a continuing or frequent basis.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1010, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1020 How do I pay for my PDN services? You are not required to pay participation for PDN services, but the cost of services is subject to estate recovery, under chapter 388-527 WAC. If you are also receiving other services (e.g. COPES), you may be responsible for paying participation as required under WAC 388-515-1505, 388-515-1540, or 388-515-1550. Your financial worker will inform you about your participation requirements for those services.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1020, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1025 Who can provide my PDN services? In addition to a family member(s) or an individual provider providing self-directed care under RCW 74.39.050 or an individual provider or home care agency caregiver providing nurse delegation per WAC 246-840-910 through 246-840-970:

(1) A home health agency licensed by the Washington state department of health can provide your PDN services as long as it also has a PDN contract with DSHS's aging and disability services administration.

(2) If a home health agency described in subsection (1) is not willing to provide your PDN services, or is not available due to your geographic location, an ADSA private registered nurse (RN) or licensed practical nurse (LPN) who meets the

requirements of WAC 388-106-1040 may be able to provide your PDN services.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1025, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1030 Are there limitations or other requirements for PDN? The limits to PDN services are:

(1) Your PDN services can be authorized for four to sixteen hours per day, except as noted in WAC 388-106-1045(4). This authorization is based on a combination of skilled nursing tasks identified in CARE, the department designated PDN skilled nursing task log or equivalent which has been approved by ADSA prior to use, and detailed information provided to CNC or NCC. The CNC or NCC determines initial eligibility for PDN, up to a maximum of sixteen hours per day. After the initial determination of eligibility is made by the CNC or NCC, the PDN skilled nursing task log or its approved equivalent will be initiated and completed by the agency or private nurse(s) for fourteen days and submitted to the CNC or NCC for review. At the end of the fourteen-day review period, a final determination will be made on the number of PDN hours required to meet your care needs. PDN skilled task logs or their approved equivalent will also be completed for fourteen days prior to the six-month reassessment for review by the CNC or NCC to determine ongoing eligibility and required PDN hours.

(2) Trained family members must provide for any hours above your assessment determination, or you or your family must pay for these additional hours.

(3) In instances where your family is temporarily absent due to vacations, additional PDN hours must be:

(a) Paid for by you or your family; or

(b) Provided by other trained family members. If this is not possible, you may need placement in a long-term care facility during their absence.

(4) You may use respite care if you and your unpaid family caregiver meet the eligibility criteria defined in WAC 388-106-1210.

(5) You may receive additional hours, up to thirty days only when:

(a) Your family is being trained in care and procedures;

(b) You have an acute episode that would otherwise require hospitalization;

(c) Your caregiver is ill or temporarily unable to provide care; or

(d) There is a family emergency.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1030, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1035 What requirements must a home health agency meet in order to provide and get paid for my PDN? A home health agency must:

(1) Be licensed by the Washington state department of health and have a contract to provide private duty nursing services with aging and disability services administration;

(2) Operate under physician orders;

(3) Develop and follow a detailed service plan that is reviewed and signed at least every six months by the client's physician;

(4) Initiate and complete the PDN skilled nursing task log or approved equivalent for fourteen days and submitted to

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the CNC or NCC for review for initial eligibility determination and fourteen days prior to the six-month reassessments;

(5) Meet all documentation requirement required by DOH In-home licensing, WAC 246-335-055, 246-335-080, and 246-335-110; and

(6) Submit timely and accurate invoices to the social services payment system (SSPS).

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1035, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1040 What requirements must a private duty RN, or LPN under the supervision of an RN, meet in order to provide and get paid for my PDN services? In order to be paid by the department, a private RN under the supervision of a physician/ARNP, or an LPN under the supervision of an RN, must:

(1) Have a license in good standing, per RCW 18.79.030 (1)(3);

(2) Complete a PDN contract with ADSA;

(3) Provide services according to the plan of care under the supervision/direction of a physician;

(4) Complete a background inquiry application. This will require fingerprinting if the RN or LPN has lived in the state of Washington less than three years;

(5) Have no conviction for a disqualifying crime, as stated in RCW 43.43.830 and 43.43.842 and WAC 388-71-0500 through 388-71-05640 series;

(6) Have no stipulated finding of fact and conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority, a court of law, or entered into a state registry with a finding of abuse, neglect, abandonment or exploitation of a minor or vulnerable adult;

(7) Meet provider requirements under WAC 388-71-0510, 388-71-0515, 388-71-0540, 388-71-0551, and 388-71-0556;

(8) Complete time sheets monthly;

(9) Complete documentation regarding all PDN services provided per the plan of care as required in WAC 388-502-0020 and 246-840-700;

(10) The PDN skilled nursing task log or its approved equivalent must be initiated and completed by the licensed nurse for fourteen days and submitted to the CNC or NCC for review for initial eligibility determination and fourteen days prior to the six-month reassessment determination. The licensed nurse is responsible to submit these logs to the NCC or CNC when they are completed; and

(11) Submit timely and accurate invoices to SSPS.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1040, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1045 Can I receive PDN services in a licensed adult family home (AFH)? You may be eligible to receive PDN services if you are residing in an adult family home (AFH) if the AFH provider (owner and operator) meets the following requirements:

(1) Possesses current Washington state registered nurse license in good standing;

(2) Signs a contract amendment with ADSA in which the provider agrees to ensure provision of twenty-four-hour per-

sonal care and nursing care services. Nursing care service will be provided in accordance with chapter 18.79 RCW;

(3) Provides your PDN service through an RN, or LPN under the supervision of an RN. PDN services are based on the CARE assessment, the department designated PDN skilled task log or its approved equivalent, and other documentation which determines eligibility and the number of PDN hours to be authorized;

(4) Provides the PDN services to you. Your service plan may be authorized for four to eight hours per day and cannot exceed a maximum of eight PDN care hours per day based on the CARE assessment, the department designated PDN skilled task log or its approved equivalent, and other documentation;

(5) Have a nursing service plan prescribed by your primary physician or ARNP. The physician/ARNP is responsible for:

(a) Overseeing your plan of care, which must be updated at least every six months;

(b) Monitoring client's medical stability; and

(6) Document the services provided per the plan of care and the department designated PDN skilled task log or its approved equivalent at initial eligibility determination and fourteen days prior to the six-month reassessment determination and other documentation; and

(7) Keep records in accordance with AFH licensing and contract requirements.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1045, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1050 May I receive other long-term care services in addition to PDN? (1) In addition to PDN services, you may be eligible to receive care through community options program entry system (COPES), medically needy residential waiver (MNRW), medically needy in-home waiver (MNIW), or Medicaid personal care (MPC), for unmet personal needs not performed by your family/informal support system.

(2) If you receive personal care services in addition to PDN services, you cannot receive your personal care and household tasks from an individual provider, personal aide, or home care agency provider at the same time that your PDN provider is providing your care. The agency or privately contracted nurse is responsible for providing personal care and/or household tasks that occur during the time that they are providing your PDN services, unless you have an informal support that is providing or assisting you at the same time.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1050, filed 12/6/05, effective 1/6/06.]

WAC 388-106-1055 Can I choose to self-direct my care if I receive PDN services? You may choose to self-direct part of your health-related tasks to an individual provider, as outlined in RCW 74.39.050. You may also still receive PDN services, if you meet the PDN eligibility requirements.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 440.80. 05-24-091, § 388-106-1055, filed 12/6/05, effective 1/6/06.]

[Title 388 WAC—p. 614]

SENIOR CITIZENS' SERVICES

WAC 388-106-1100 What services can I receive under the Senior Citizens' Services Act (SCSA) fund? You may receive community-based services, described in RCW 74.38.040.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1100, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1105 How do I apply for SCSA-funded services? To receive SCSA-funded services, you or your representative must:

(1) Complete and submit a department application form, providing complete and accurate information; and

(2) Promptly submit a written report of any changes in income or resources. For the definition of income and resources, refer to WAC 388-500-0005.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1105, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1110 Am I eligible for SCSA-funded services at no cost? To be eligible for SCSA-funded services at no cost, you must:

(1) Be age:

(a) Sixty-five or older; or

(b) Sixty or older, and:

(i) Either unemployed, or

(ii) Working twenty hours a week or less;

(2) Have a physical, mental, or other type of impairment, which without services would prevent you from remaining in your home;

(3) Have income at or below forty percent of the state median income (SMI), based on family size; and

(4) Have nonexempt resources (including cash, marketable securities, and real or personal property) not exceeding ten thousand dollars for a single person or fifteen thousand for a family of two, increased by one thousand dollars for each additional family member of the household. Household means a person living alone or a group of people living together.

(5) If you have income over forty percent of SMI, you may be eligible for services on a sliding fee basis.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1110, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1115 What income and resources are exempt when determining eligibility? The following income and resources, regardless of value, are exempt when determining whether you are eligible for SCSA-funded services:

(1) Your home, and the lot it is upon;

(2) Garden produce, livestock, and poultry used for home consumption;

(3) Program benefits which are exempt from consideration in determining eligibility for needs based programs (e.g., uniform relocation assistance, Older Americans Act funds, foster grandparents' stipends or similar monies);

(4) Used and useful household furnishings, personal clothing, and automobiles;

(5) Personal property of great sentimental value;

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(6) Personal property used by the individual to earn income or for rehabilitation;

(7) One cemetery plot for each member of the family unit;

(8) Cash surrender value of life insurance;

(9) Real property held in trust for an individual Indian or Indian tribe; and

(10) Any payment received from a foster care agency for children in the home.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1115, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1120 What if I am not eligible to receive SCSA-funded services at no cost? (1) Even if your income is above the forty percent SMI limit to receive SCSA-funded services at no cost, you may receive SCSA-subsidized services. The department uses a sliding fee schedule to determine what percentage the department pays for the cost of your services. You pay the remaining amount, but not more than the usual rate paid for services, as negotiated by the AAA or the department. The formula for determining the department's share of the cost of the services is:

100% State Median Income (SMI) - Household Income x 100

100% - 40% SMI

(2) Service providers must be responsible for collecting fees owed by eligible persons and reporting to area agencies all fees paid or owed by eligible persons.

(3) Some services are provided at no charge regardless of income or need requirements. These services include, but are not limited to, nutritional services, health screening, services under the long-term care ombudsman program, and access services. Note: Well adult clinic services may be provided in lieu of health screening services if such clinics use the fee schedule established by this section.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1120, filed 5/17/05, effective 6/17/05.]

RESPIRE CARE SERVICES

WAC 388-106-1200 What definitions apply to respite care services? The following definitions apply to respite care services:

"Caregivers" means a spouse, relative, or friend who has primary responsibility for the daily care of an adult with a functional disability without receiving payment for services provided.

"Continuous care or supervision" means daily assistance or oversight of an adult with a functional disability.

"Functionally disability" means a condition requiring substantial assistance in completing activities of daily living and community living skills.

"Participant" means an adult with a functional disability who needs substantial daily continuous care or supervision.

"Service provider" means an individual, agency, or organization under contract to the area agency on aging (AAA) or its subcontractor.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1200, filed 5/17/05, effective 6/17/05.]

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WAC 388-106-1205 What are respite care services?

Respite services relieve unpaid caregivers by providing temporary care or supervision to adults with a functional disability.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1205, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1210 Who is eligible to receive respite care services? (1) To be eligible to receive respite care services, the caregivers must:

(a) Have primary responsibility for the daily continuous care or supervision of an adult with a functional disability;

(b) Provide a minimum of an average of twelve hours per day for care or supervision;

(c) Not be compensated for the care; and

(d) Be assessed as being at risk of placing the participant in a long-term care facility if home and community support services, including respite care, are not available.

(2) An eligible participant is an adult who:

(a) Has a functional disability;

(b) Needs daily substantial continuous care or supervision; and

(c) Is assessed as requiring placement in a long-term care facility if home and community support services, including respite care, are not available.

(3) The area agency on aging (AAA) determines how many hours of continuous care or supervision a day an unpaid caregiver must provide to a participant to become eligible for respite care services, as long as it is a minimum of twelve hours per day, as outlined in subsection (1)(b) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1210, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1215 Who may provide respite care services? Respite care providers include, but are not limited to the following:

(1) Nursing homes (chapter 388-97 WAC).

(2) Adult day services, which includes adult day care and adult day health.

(3) Home health/care agencies.

(4) Hospitals.

(5) Licensed residential care facilities such as boarding homes, adult family homes, and assisted living facilities.

(6) Providers such as volunteer chore workers, senior companions, and individual providers.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1215, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1220 How are respite care providers reimbursed for their services? The department reimburses:

(1) Respite care providers for the number of hours or days of services authorized and used. The rate that is established for the services is negotiated between the respite care program of the local area agency on aging and the respite care service provider.

(2) Medicaid-certified nursing homes and DDD-certified group homes providing respite services the Medicaid rate approved for that facility. Contracted nursing homes must not charge more than the Medicaid rate for any services covered from the date of eligibility, unless authorized by the department.

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ment (see RCW 18.51.070). Participants must pay for services not included in the Medicaid rate.

(3) Private nursing homes at their published daily rate.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1220, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1225 Are participants required to pay for the cost of their services? (1) There is no charge to the participant whose income is at or below forty percent of the state median income, based on family size.

(2) If the participant's gross income is above forty percent of the state median income, he or she is required to pay for part or all of the cost of the respite care services. The department will determine what amount the participant must contribute based on the state median income and family size.

(3) If the participant's gross income is one hundred percent or more of the state median income, the participant must pay the full cost of services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1225, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1230 Are there waiting lists for respite services? (1) The department must first consider requests for emergency respite care. An example of an emergency is when the caregiver becomes ill or injured to the extent that the caregiver's ability to care for the participant is impaired.

(2) In nonemergency situations, respite care is allocated based upon available respite funds at the local level. Respite care must be provided on a first-come, first-served basis. If sufficient funds are not available when respite care is requested, services are made available using waiting lists and department-approved priority categories, developed by the AAA, including caregiver vulnerability and health condition, availability of other support systems, and whether other family members need care.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1230, filed 5/17/05, effective 6/17/05.]

CLIENT RIGHTS

WAC 388-106-1300 What rights do I have as a client of the department? As a client of the department, you have a right to:

(1) Be treated with dignity, respect and without discrimination;

(2) Not be abused, neglected, financially exploited, abandoned;

(3) Have your property treated with respect;

(4) Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible for the department to offer some services if you do not give enough information;

(5) Be told about all services you can receive and make choices about services you want or don't want;

(6) Have information about you kept private within the limits of the laws and DSHS regulations;

(7) Be told in writing of agency decisions and receive a copy of your care plan;

(8) Make a complaint without fear of harm;

(9) Not be forced to answer questions or do something you don't want to;

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(10) Talk with your social service worker's supervisor if you and your social service worker do not agree;

(11) Request a fair hearing;

(12) Have interpreter services provided to you free of charge if you cannot speak or understand English well;

(13) Take part in and have your wishes included in planning your care;

(14) Choose, fire, or change a qualified provider you want; and

(15) Receive results of the background check for any individual provider you choose.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1300, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1303 What responsibilities do I have as a client of the department? As a client of the department, you have a responsibility to:

(1) Give us enough information to assess your needs;

(2) Let the social services worker into your home so that your needs can be assessed;

(3) Follow your care plan;

(4) Not act in a way that puts anyone in danger;

(5) Provide a safe work place;

(6) Tell your social services worker if there is a change in:

(a) Your medical condition;

(b) The help you get from family or other agencies;

(c) Where you live; or

(d) Your financial situation.

(7) Tell your social services worker if someone else makes medical or financial decision for you;

(8) Choose a qualified provider;

(9) Keep provider background checks private;

(10) Tell your social services worker if you are having problems with your provider; and

(11) Choose your own health care. Tell your social services worker when you do not do what your doctor says.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020. 06-05-022, § 388-106-1303, filed 2/6/06, effective 3/9/06.]

WAC 388-106-1305 What if I disagree with the result of the CARE assessment and/or other eligibility decisions made by the department? You have a right to contest the result of your CARE assessment and/or other eligibility decisions made by the department. The department will notify you in writing of the right to contest a decision and provide you with information on how to request a hearing.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1305, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1310 When I request a fair hearing on my CARE assessment and another CARE assessment(s) is done between my fair hearing request and the fair hearing, which CARE assessment must the administrative law judge review? When you request a fair hearing on your CARE assessment and another CARE assessment(s) is done between your fair hearing request and the fair hearing, the administrative law judge must review the most recent CARE assessment.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-1310, filed 5/17/05, effective 6/17/05.]

WAC 388-106-1315 Do I have a right to an administrative hearing if my total in-home personal care hours approved as an exception to rule are reduced or terminated or if my increased residential payment rate approved as an exception to rule is reduced or terminated? Notwithstanding WAC 388-440-0001(3), you have a right to an administrative hearing regarding the department's exception to rule decision if:

(1) You receive services in your own home, and:

(a) The total number of in-home personal care hours you are currently receiving includes in-home personal care hours approved as an exception to rule in addition to the number of in-home care hours determined to be available to you by CARE; and

(b) The total number of in-home personal care hours you are currently receiving is reduced because of a reduction or termination in the number of in-home personal care hours approved as an exception to rule.

(2) You receive services in a residential facility, and:

(a) You currently have an increased residential payment rate approved as an exception to rule; and

(b) Your increased residential payment rate that was approved as an exception to rule is reduced or terminated.

[Statutory Authority: RCW 74.08.090, 74.09.520, chapters 74.39 and 74.39A RCW. 07-01-046, § 388-106-1315, filed 12/14/06, effective 1/14/07.]

NEW FREEDOM CONSUMER DIRECTED SERVICES (NFCDS)

WAC 388-106-1400 What services may I receive under New Freedom consumer directed services (NFCDS)? You may use your individual budget to purchase services that address an identified need in the CARE assessment. Service categories are:

(1) **Personal assistance services**, defined as supports involving the labor of another person to help participants carry out activities they are unable to perform independently as identified in the CARE assessment. Services may be provided in the participant's home or in the community and may include:

(a) Direct personal care services defined as activities of daily living, as defined in WAC 388-106-0010;

(b) Delegated health related tasks, per WAC 388-71-05805 through 388-71-05830. Providers of direct personal care services may be asked to do nurse delegated tasks under supervision of a nurse;

(c) Homemaking, or assistance with instrumental activities of daily living (essential shopping, housework and meal preparation);

(d) Other tasks or assistance with activities that support independent functioning, and are necessary due to functional disability;

(e) Personal assistance with transportation.

(2) **Treatment and health maintenance** activities that:

(a) Are beyond the scope of the Medicaid state plan that are necessary to promote the participant's health and ability to live and participate in the community;

(b) Are provided for the purpose of preventing further deterioration, or improving or maintaining the participant's current level of functioning; and

(c) Are performed or provided by people with specialized skill, registration, certification or licenses as required by state law.

(3) **Individual directed goods, services and supports**, defined as services, equipment or supplies not otherwise provided through this waiver or through the Medicaid state plan, and address an identified need in the CARE assessment; and

(a) Will allow the participant to function more independently; or

(b) Increase safety and welfare; or

(c) Allow the person to perceive, control, or communicate with their environment.

(4) **Environmental or vehicle modifications**, defined as:

(a) Alterations to a participant's residence or vehicle that:

(i) Are necessary to accommodate the participant's disability and promote functional independence, health, safety and welfare; and

(ii) Are not adaptations or improvements, which are of general utility or add to the total square footage.

(b) Vehicles subject to modification must be owned by the participant or participant's family who reside with the participant; and

(i) Must be in good working condition, licensed, and insured according to Washington state law; and

(ii) Modifications demonstrate cost effectiveness when compared to available alternative transportation.

(5) **Training and educational supports**, which are supports beyond the scope of Medicaid state plan services that are necessary to promote the participant's health and ability to live and participate in the community and maintains, slows decline, or improves functioning and adaptive skills. Examples include:

(a) Training or education on participant health issues, or personal skill development;

(b) Training/education to paid or unpaid caregivers related to the needs of the participant.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1400, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1410 Am I eligible for New Freedom consumer directed services (NFCDS)-funded services?

You are eligible for NFCDS-funded services if you reside in your own home and meet all of the following criteria. The department must assess your needs using CARE and determine that:

(1) You are in NFCDS HCBS waiver specified target groups of:

(a) Eighteen or older and blind or have a physical disability; or

(b) Sixty-five or older; and

(2) You meet financial eligibility requirements. This means the department will assess your finances, determine if your income and resources fall within the limits, and determine the amount you may be required to contribute, if any, toward the cost of your care as described in WAC 388-515-1505; and

(3) You:

(a) Are not eligible for Medicaid personal care services (MPC); or

(b) Are eligible for MPC services, but the department determines that the amount, duration, or scope of your needs is beyond what MPC can provide; and

(4) Your CARE assessment shows you need the level of care provided in a nursing facility as defined in WAC 388-106-0355; and

(5) You live in your own home, or will be living in your own home by the time NFCDS start.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1410, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1415 When do New Freedom consumer directed services (NFCDS) start? Your eligibility for NFCDS begins the date the department authorizes services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1415, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1420 How do I remain eligible for New Freedom consumer directed services (NFCDS)? (1) In order to remain eligible for NFCDS, you must be in need of services in accordance with WAC 388-106-1410, as determined through a CARE assessment. The CARE assessment must be performed at least annually or more often when there are significant changes in your functional or financial circumstances.

(2) When eligibility statutes, regulations, and/or rules for NFCDS change, irrespective of whether your functional or financial circumstances have changed, if you do not meet the changed eligibility requirements, the department will terminate your NFCDS services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1420, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1425 How do I pay for New Freedom consumer directed services (NFCDS)? Depending on your income and resources, you may be required to pay participation toward the cost of your care, as described in WAC 388-515-1505. If you have nonexempt income that exceeds the cost of NFCDS services, you may keep the difference. Since you are receiving services in your own home, you are allowed to keep some of your income for a maintenance allowance.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1425, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1430 Can I be employed and receive New Freedom consumer directed services (NFCDS)? You can be employed and receive NFCDS, per WAC 388-515-1505.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1430, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1435 Who can direct New Freedom consumer directed services (NFCDS)? The NFCDS participant directs services. The participant can also designate a representative to assist them.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1435, filed 7/25/06, effective 8/25/06.]

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WAC 388-106-1440 What is an individual budget?

An individual budget means the maximum amount of funding authorized by the department and allocated to the participant for the purchase of New Freedom consumer directed services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1440, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1445 How is the amount of the individual budget determined? The department will calculate the individual budget amount after the NFCDS participant is assigned a classification resulting from completion of the comprehensive assessment reporting and evaluation tool, CARE. The calculation will be based on:

(a) The published hourly rate for individual provider personal care paid by the department multiplied by the number of hours generated by the assessment, multiplied by a factor of .95, plus an amount equal to the average per participant expenditures for nonpersonal care supports purchased in the COPES waiver. The average will be recalculated in July of each year.

(b) If the participant selects a home care agency, an adjustment will be made for each hour of personal care identified in the NFSP for an amount equal to the difference between the published individual provider rate and home care agency rate.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1445, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1450 Is the individual budget intended to fully meet all of my needs? The program provides funds in an amount proportionate to the amount of resources you would receive through COPES, and gives you flexibility to self-direct the purchase of goods and services to meet your long-term care needs. The degree to which the budget meets your needs depends on the supports you identify and prioritize in your spending plan. Depending on your decisions, after your budget is exhausted, some of your needs may be unmet, or you may find other resources to address them.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1450, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1455 What happens to unused funds from my individual budget? Unused funds, up to three thousand dollars, may be held in reserve for future purchases documented in the NFSP. Reserves in excess of three thousand dollars may be maintained for planned purchases with approval from the department.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1455, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1460 When can my New Freedom spending plan (NFSP) be denied? Your NFSP may be denied when the plan you develop does not:

- (a) Include services in the New Freedom definition;
- (b) Address your needs as it relates to performance of activities of daily living and instrumental activities of daily living;
- (c) Include strategies and steps to address known critical risks;

- (d) Identify the payment rate; or
- (e) Adequately describe the service.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1460, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1465 Who can deny my New Freedom spending plan (NFSP)? Your plan can be denied by your New Freedom consultant, who assists NFCDS participants to develop and use a New Freedom spending plan to:

- (a) Meet identified needs;
- (b) Address health and safety needs;
- (c) Develop options to meet those needs;
- (d) Make informed decisions about their individual budget; and
- (e) Obtain identified supports and services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1465, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1470 Are there waiting lists for New Freedom consumer directed services (NFCDS)? The department will create a waiting list for NFCDS in accordance with caseload limits determined by legislative funding. Participants on the waiting list will gain access in the following order:

- (1) Nursing home residents who are returning home and are assessed for NFCDS waiver services will be ranked first on the waiting list by date of application for services;
- (2) Individuals living in the community with a higher level of need, as determined by the CARE assessment, will be ranked higher on the wait list over participants with a lower level of need; and
- (3) When two or more individuals on the waiting list have equal need levels, the individual with the earlier application for NFCDS will have priority over later applications for services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1470, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1475 How do I end enrollment in New Freedom consumer directed services (NFCDS)? (1) You may choose to voluntarily end your enrollment from NFCDS without cause at any time. To do so, you must give notice to the department. If you give notice:

- (a) Before the fifteenth of the month, the department will end your enrollment at the end of the month; or
- (b) After the fifteenth, the department will end your enrollment the end of the following month.
- (2) Your enrollment may also end involuntarily if you:
 - (a) Move out of the designated service area or are out of the service area for more than thirty consecutive days, unless you have documented the purpose of the longer absence in the NFSP; or

(b) Do not meet the terms for consumer direction of services outlined in the NFCDS enrollment agreement when:

- (i) Even with help from a representative, you are unable to develop a NFSP or self-direct services or manage your individual budget or NFSP;
- (ii) Any one factor or several factors of such a magnitude jeopardize the health, welfare, and safety of you and others, requiring termination of services under WAC 388-106-0047;

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- (iii) You become financially ineligible for Medicaid services; or
- (iv) You no longer meet the nursing facility level of care requirement as defined in WAC 388-106-0355.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1475, filed 7/25/06, effective 8/25/06.]

WAC 388-106-1480 What are my hearing rights to appeal New Freedom consumer directed services (NFCDS) actions? You have a right to a hearing under WAC 388-106-1300 through 388-106-1310, and under chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030. 06-16-035, § 388-106-1480, filed 7/25/06, effective 8/25/06.]

Chapter 388-110 WAC

CONTRACTED RESIDENTIAL CARE SERVICES

WAC

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388-110-060	Resident rights. [Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-060, filed 5/8/96, effective 6/8/96.] Repealed by 04-16-063, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW.
388-110-080	Social and recreational activities. [Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-080, filed 5/8/96, effective 6/8/96.] Repealed by 04-16-063, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW.

- 388-110-110 Caregiver education and training requirements. [Statutory Authority: RCW 74.39A.010 and 74.39A.020. 97-19-020, § 388-110-110, filed 9/8/97, effective 10/9/97. Statutory Authority: RCW 74.39A.010, 74.39A.020 and 74.39A.080. 96-21-050, § 388-110-110, filed 10/11/96, effective 11/11/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-110, filed 5/8/96, effective 6/8/96.] Repealed by 02-15-065, filed 7/11/02, effective 8/11/02. Statutory Authority: RCW 18.20.090, 70.129.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233.
- 388-110-170 Education and training requirements. [Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-170, filed 5/8/96, effective 6/8/96.] Repealed by 04-16-063, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW.
- 388-110-180 Nurse delegation training and registration. [Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-180, filed 5/8/96, effective 6/8/96.] Repealed by 04-16-063, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW.
- 388-110-190 Performance of delegated nursing care tasks. [Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-190, filed 5/8/96, effective 6/8/96.] Repealed by 04-16-063, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW.
- 388-110-200 Nurse delegation—Penalties. [Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-200, filed 5/8/96, effective 6/8/96.] Repealed by 04-16-063, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-070, and chapter 74.39A RCW.
- 388-110-210 Client service eligibility. [Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-210, filed 5/8/96, effective 6/8/96.] Repealed by 02-21-098, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090.
- 388-110-230 Client eligibility. [Statutory Authority: RCW 74.39A.-010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.-170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-230, filed 5/8/96, effective 6/8/96.] Repealed by 02-21-098, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090.
- 388-110-250 Client service eligibility. [Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-250, filed 5/8/96, effective 6/8/96.] Repealed by 02-21-098, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.08.090, 74.09.520, and 74.39A.090.

PART I ALL CONTRACTED RESIDENTIAL CARE SERVICES

WAC 388-110-005 Authority. The following rules are adopted under RCW 74.39A.010, 74.39A.020, 74.39A.060, and 74.39A.070.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.-070, and chapter 74.39A RCW. 04-16-063, § 388-110-005, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.-020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-005, filed 5/8/96, effective 6/8/96.]

[Title 388 WAC—p. 620]

WAC 388-110-010 Scope and applicability. (1) These rules apply only to boarding homes licensed under chapter 18.20 RCW, or boarding homes located within the boundaries of a federally recognized Indian reservation and licensed by a tribe, that contract with the department to provide assisted living services, enhanced adult residential care, enhanced adult residential care-specialized dementia care services, or adult residential care.

(2) Only services provided to or on behalf of the assisted living services, enhanced adult residential care, enhanced adult residential care-specialized dementia care services, or adult residential care resident, and paid for fully or partially by the department shall be subject to these rules.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-010, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.-020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-010, filed 5/8/96, effective 6/8/96.]

WAC 388-110-020 Definitions. "Adult residential care" is a package of services provided by a boarding home that is licensed under chapter 18.20 RCW and that has a contract with the department under RCW 74.39A.020 to provide personal care services in accordance with Parts I and IV of this chapter.

"Applicant" means the individual, partnership, corporation or other entity which has applied for a contract with the department to provide assisted living services, enhanced adult residential care, enhanced adult residential care-specialized dementia care services, or adult residential care to state funded residents in a licensed boarding home.

"Assisted living services" is a package of services provided by a boarding home that has a contract with the department under RCW 74.39A.010 to provide personal care services, intermittent nursing services, and medication administration services in accordance with Parts I and II of this chapter. Assisted living services include housing for the resident in a private apartment-like unit.

"Boarding home" means the same as the definition found in RCW 18.20.020, or a boarding home located within the boundaries of a federally recognized Indian reservation and licensed by the tribe.

"Case manager" means the department staff person or designee assigned to negotiate, monitor, and facilitate a service plan for residents receiving services fully or partially paid for by the department.

"Contractor" means the individual, partnership, corporation, or other entity which is licensed by the department or tribe to operate the boarding home and contracts with the department to provide assisted living services, enhanced adult residential care, enhanced adult residential care-specialized dementia care services, or adult residential care to state funded residents in a licensed boarding home.

"Department" means the Washington state department of social and health services (DSHS).

"Dignity" means the quality or condition of being esteemed and respected in such a way as to validate the self-worth of the resident.

"Enhanced adult residential care" is a package of services provided by a boarding home that is licensed under chapter 18.20 RCW and that has a contract with the depart-

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ment to provide personal care services, intermittent nursing services, and medication administration services in accordance with Parts I and III of this chapter.

"Enhanced adult residential care-specialized dementia care services" is a package of service, including specialized dementia care assessment and care planning, personal care services, intermittent nursing services, medication administration services, specialized environmental features and accommodations, and activity programming. Enhanced adult residential care-specialized dementia care services are delivered only within:

(1) Contracted boarding homes that are dedicated solely to the care of individuals with dementia, including Alzheimer's disease, and that meet the requirements of parts I and III of this chapter; or

(2) Designated, separate units located within contracted boarding homes that are dedicated solely to the care of individuals with dementia, including Alzheimer's disease, and that meet the requirements of parts I and III of this chapter.

"Homelike" means an environment having the qualities of a home, including privacy, comfortable surroundings, and the opportunity to decorate one's living area and arrange furnishings to suit one's individual preferences. A homelike environment provides residents with an opportunity for self-expression, and encourages interaction with the community, family and friends.

"Independence" means free from the control of others and being able to assert one's own will, personality and preferences.

"Individuality" means the quality of being unique; the aggregate of qualities and characteristics that distinguishes one from others. Individuality is supported by modifying services to suit the needs or wishes of a specific individual.

"Medication administration" means the direct application of a prescribed medication, whether by injection, inhalation, ingestion, or any other means, to the body of a resident by a person legally authorized to do so.

"Personal care services" means the same as physical or verbal assistance with activities of daily living included under "personal care services" described in WAC 388-106-0010. Personal care services do not include assistance with instrumental activities of daily living described in WAC 388-106-0010, nor assistance with tasks that must be performed by a licensed health professional.

"Resident" means a person residing in a boarding home for whom services are paid for, in whole or in part, by the department under a contract for assisted living services, enhanced adult residential care, enhanced adult residential care-specialized dementia care services, or adult residential care. **"Resident"** includes former residents when examining complaints about admissions, readmissions, transfers or discharges. For decision-making purposes, the term **"resident"** includes the resident's surrogate decision maker in accordance with state law or at the resident's request.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.-020. 06-05-022, § 388-110-020, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063 and 04-18-001, § 388-110-020, filed 7/30/04 and 8/19/04, effective 9/19/04. Statutory Authority: RCW 74.08.-090, 74.09.520, and 74.39A.090. 02-21-098, § 388-110-020, filed 10/21/02, effective 11/21/02. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and (2007 Ed.)

70.129.040. 96-11-045 (Order 3979), § 388-110-020, filed 5/8/96, effective 6/8/96.]

WAC 388-110-030 Contract application. (1) In order to apply for a contract with the department to provide assisted living services, enhanced adult residential care, enhanced adult residential care-specialized dementia care services, or adult residential care, an applicant must:

(a) Have a valid boarding home license issued by the department or tribe, or have applied for a boarding home license for the boarding home at which the contracted services will be provided;

(b) Complete and submit a contract application on department provided forms at least ninety days before the requested effective date for the contract; and

(c) Provide information regarding any licensed care facilities with which any of the following have been affiliated within the last ten years:

(i) The applicant;

(ii) Any partner, or owner of five percent or more of the applicant; and

(iii) Any officer, director, or managerial employee of the applicant.

(2) The department must confirm that the applicant has a valid boarding home license issued by the department or tribe and meets the requirements of this chapter before issuing a contract.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-030, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.-020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-030, filed 5/8/96, effective 6/8/96.]

WAC 388-110-040 Contract qualifications. (1) The department must consider separately and jointly as applicants each person and entity named in the application for a contract for assisted living services, enhanced adult residential care, enhanced adult residential care-specialized dementia care services, or adult residential care. If the department finds any person or entity unqualified, the department must deny the contract.

(2) In making a determination whether to grant a contract, the department must review and consider:

(a) The information in the application;

(b) Other documents and information the department deems relevant, including inspection and complaint investigation findings for each licensed care facility, and each care facility that was required by law to be licensed but was not, with which any of the following have been affiliated within the last ten years:

(i) The applicant;

(ii) Any partner, or owner of five percent or more of the applicant; or

(iii) Any officer, director, or managerial employee of the applicant.

(c) The history and quality of services provided by the applicant; and

(d) Funding from the legislature available to the department to purchase residential care.

(3) The applicant and the boarding home for which a contract is sought must comply with all requirements estab-

lished by chapter 74.39A RCW, chapter 388-78A WAC and this chapter.

(4) The department shall review the qualifications of applicants for enhanced adult residential care-specialized dementia care services contracts and may select a limited number with which to enter into contracts, based on:

(a) Which applicants are best qualified to provide specialized dementia care services, as determined by the department;

(b) The need for services in the area of the state in which the applicant is located; and

(c) Other qualifications specified in this section.

(5) The department must deny, suspend, revoke or refuse to renew a contract if an applicant or contractor or any partner, officer, director, managerial employee, or owner of five percent or more of the contractor or applicant has a history of significant noncompliance with federal or state regulations, rules or laws in providing care or services to frail elders, vulnerable adults or children. The department must consider evidence of noncompliance on a case-by-case basis.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-040, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020 and 74.39A.080. 96-21-050, § 388-110-040, filed 10/11/96, effective 11/11/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-040, filed 5/8/96, effective 6/8/96.]

WAC 388-110-050 Change of contractor. (1) A change of contractor must occur when there is a change in the boarding home licensee per WAC 388-78A-2770.

(2) When a change of licensee and contractor is contemplated, the current contractor must notify the department and all residents and residents' representatives at least ninety days prior to the proposed date of change. The notice must be in writing and must contain the following information:

(a) Name of the present contractor and prospective contractor;

(b) Name and address of the boarding home being changed; and

(c) Date of proposed change.

(3) The operation of an assisted living services, enhanced adult residential care, enhanced adult residential care-specialized dementia care services, or adult residential care contract must not be changed until the new operator has entered into a contract with the department. The new contractor must comply with contract application requirements in WAC 388-110-030.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-050, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-050, filed 5/8/96, effective 6/8/96.]

WAC 388-110-070 General service standards. The contractor must:

(1) Provide the services agreed upon in the resident's negotiated service agreement and approved by the department case manager consistent with WAC 388-78A-2150, including any reasonable accommodations required by chapter 70.129 RCW, Long-term care residents rights; and

(2) Provide the resident and case manager with a copy of the negotiated service agreement developed according to chapter 388-78A WAC.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-070, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-070, filed 5/8/96, effective 6/8/96.]

WAC 388-110-090 Administration. The contractor must:

(1) Maintain substantial compliance with all requirements of chapters 18.20 RCW, Boarding homes, and 70.129 RCW, Long-term care resident rights, and chapters 388-78A WAC, Boarding home licensing rules, and 388-105 WAC Medicaid rates for contracted home and community residential care services;

(2) Permit department representatives to enter the boarding home without prior notification and cooperate with department representatives as they monitor the contract requirements under this chapter and conduct complaint investigations, including but not limited to observing and privately interviewing residents, and accessing resident records.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-090, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-090, filed 5/8/96, effective 6/8/96.]

WAC 388-110-100 Discharge, social leave, and bed hold. The contractor is not required to discharge (move out) and readmit a resident for absences of less than twenty-one consecutive days. The contractor must:

(1) Note an absence in a resident's record when a resident is absent from the boarding home for more than seventy-two consecutive hours;

(2) Obtain department approval for payment for social leave in excess of eighteen calendar days per year;

(3) Notify the department within one working day whenever the resident:

(a) Is hospitalized;

(b) Is discharged to another boarding home, nursing home or other health care facility;

(c) Dies; or

(d) Is missing from the boarding home and his or her whereabouts are unknown.

(4) Include the department's case manager in the development of a discharge (move out) plan, and have the case manager approve the plan before any required notice of discharge is issued to the resident, except in an emergency;

(5) Notify the Medicaid resident of the boarding home's policies regarding bed-holds, consistent with subsections (6) and (7) of this section and WAC 388-105-0045 as soon as possible before, or as soon as practicable following hospitalization or discharge to a nursing home. The notification must include information concerning:

(a) Options for bed-hold payments, and

(b) Rights to return to the boarding home.

(6) Retain a bed or unit for a Medicaid resident who is hospitalized or temporarily placed in a nursing home for up to

twenty days when the Medicaid resident is likely to return to the boarding home and the department makes payment to the boarding home for holding the bed or unit consistent with WAC 388-105-0045. If, prior to the end of the twenty days, the department determines, or the contractor determines and the department concurs, that the Medicaid resident will likely not return to the boarding home:

(a) The department must terminate the bed-hold payment; and (b) The contractor may rent that bed or unit to another resident.

(7) Not seek third-party payment for the first twenty days of retaining the bed for a Medicaid resident who is hospitalized or discharged to a nursing home and for whom the department is making a bed hold payment consistent with WAC 388-105-0045.

(a) The contractor may seek third-party payment consistent with RCW 18.20.290 and chapter 388-105 WAC to hold a bed or unit for the time following the first twenty days of a Medicaid resident's absence for hospitalization or nursing home care.

(b) If third-party payment is not available, the Medicaid resident may return to the first available and appropriate bed or unit if the Medicaid resident:

(i) Continues to meet the boarding home's admission criteria; and

(ii) Chooses to return to the boarding home.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-110-100, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-100, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-100, filed 5/8/96, effective 6/8/96.]

WAC 388-110-120 Resident personal funds. (1) Upon the death of a resident, the contractor must promptly convey the resident's personal funds held by the boarding home with a final accounting of such funds to the department or to the individual or probate jurisdiction administering the resident's estate no later than forty-five calendar days after the date of the resident's death:

(a) When the personal funds of the deceased resident must be paid to the state of Washington, those funds and the final accounting shall be made payable to the secretary, department of social and health services, and sent to the Office of Financial Recovery, Estate Recovery Unit, P.O. Box 9501, Olympia, Washington 98507-9501, or such address as may be directed by the department in the future;

(b) The check and final accounting accompanying the payment must contain the name and Social Security number of the deceased individual from whose personal funds account the monies are being paid; and

(c) The department of social and health services shall establish a release procedure for use of funds necessary for burial expenses.

(2) In situations where the resident is absent from the boarding home for an extended time without notifying the boarding home, and the resident's whereabouts is unknown:

(a) The contractor must make a reasonable effort to find the missing resident; and

(b) If the resident cannot be located after ninety days, the contractor must notify the department of revenue of the exist-

ence of "abandoned property," outlined in chapter 63.29 RCW. The contractor must deliver to the department of revenue the balance of the resident's personal funds within twenty days following such notification.

(3) Prior to the change of contractor of the boarding home business, the contractor must:

(a) Provide each resident with a written accounting of any personal funds held by the boarding home;

(b) Provide the new contractor with a written accounting of all resident funds being transferred; and

(c) Obtain a written receipt for those funds from the new operator.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-120, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-120, filed 5/8/96, effective 6/8/96.]

PART II

ASSISTED LIVING SERVICES

WAC 388-110-140 Assisted living services facility structural requirements. (1) In a boarding home with an assisted living services contract, the contractor must ensure each resident has a private apartment-like unit meeting the requirements of a type 'B' dwelling unit as defined by the International Code Council A117.1 as adopted by the Washington State Building Code Council. Except as provided in subsection (3) of this section, each unit must have at least the following:

(a) A minimum area of one hundred eighty square feet in an existing boarding home, and two hundred twenty square feet in a new boarding home. The minimum area may include counters, closets and built-ins, but must exclude the bathroom;

(b) A separate private bathroom, which includes a sink, toilet, and a shower or bathtub. In a new boarding home, the contractor must provide a minimum of one wheelchair accessible bathroom with a roll-in shower that is at least forty-eight inches by thirty inches for every two residents whose care is partially or fully funded by the department through the assisted living contract;

(c) A lockable entry door;

(d) A kitchen area equipped with a refrigerator, a microwave oven or stovetop, and a counter or table for food preparation. In a new boarding home, the kitchen area must also be equipped with a storage space for utensils and supplies, and a counter surface, a minimum of thirty inches wide by twenty-four inches in depth, a maximum height of thirty-four inches, and a knee space beneath at least twenty-seven inches in height; and

(e) A living area wired for telephone and, where available in the geographic location, wired for television service.

(2)(a) For purposes of this section, a new boarding home is:

(i) A new building to be used as a boarding home or part of a boarding home, for which plans are submitted to the department of health for construction review on or after June 8, 1996; or

(ii) An addition, modification, or alteration to an existing licensed boarding home, for which plans are submitted to the

department of health for construction review on or after June 8, 1996.

(A) The department may, in consultation with the office of construction review services in the department of health, exempt from selected new boarding home contract construction requirements, a limited addition, modification, or alteration to an existing licensed boarding home that will improve the quality of life for residents, if compliance with all new boarding home contract construction requirements would otherwise make the limited addition, modification, or alteration cost prohibitive. A limited addition, modification, or alteration means any physical change to an existing licensed boarding home that does not affect the structural integrity of the building, does not affect fire and life safety, and does not increase the boarding home's maximum facility capacity as defined in WAC 388-78A-2020.

(B) A major addition, modification, or alteration to an existing licensed boarding home must meet new boarding home contract construction requirements for applicable portions of the building. A major addition, modification, or alteration means any physical change within a room or area in an existing licensed boarding home that results in reconstruction to structural or other building systems.

(b) All boarding homes that are not new boarding homes under subsection (2)(a) of this section, are existing boarding homes. An existing building, or portion thereof, that is converted to boarding home use must be considered an existing boarding home unless there is an addition, modification or alteration to the existing building.

(3) If a boarding home submitted plans to the department of health for construction review on or after June 8, 1996, and the boarding home had an assisted living contract as of September 1, 2004, then the boarding home is "grandfathered" under the contracting rules for structural requirements that were in effect at the time of contracting and is considered to meet the assisted living structural requirements of subsection (1) of this section. However, if the same boarding home submits plans to the department of health for construction review for an addition, modification or alteration of the boarding home after September 1, 2004, then the boarding home must meet the current new boarding home requirements of subsection (1) for the applicable portions of the building.

(4) Married couples may share an apartment-like unit under an assisted living contract if:

(a) Both residents understand they are each entitled to live in a separate private unit; and

(b) Both residents mutually request to share a single apartment-like unit.

(5) In a new boarding home, the contractor must provide a private accessible mailbox in which the resident may receive mail.

(6) The contractor must provide homelike smoke-free common areas with sufficient space for socialization designed to meet resident needs. Common areas must be available for resident use at any time provided such use does not disturb the health or safety of other residents. The contractor must make access to outdoor areas available to all residents.

(7) The contractor must provide a space for residents to meet with family and friends outside the resident's living unit.

(8) The department may grant an exemption to the requirements of this section as they apply to a specified resident when it is in the best interest of the specific resident.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063 and 04-18-001, § 388-110-140, filed 7/30/04 and 8/19/04, effective 9/19/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-140, filed 5/8/96, effective 6/8/96.]

WAC 388-110-150 Assisted living service standards.

In a boarding home with an assisted living contract, the contractor must meet the requirements of parts I and II of this chapter, and for residents served under the assisted living contract:

(1) Ensure that both the physical environment and the delivery of assisted living services are designed to enhance autonomy in ways which reflect personal and social values of dignity, privacy, independence, individuality, choice and decision making of residents. The contractor must provide resident services in a homelike environment for residents who may have a range of needs and preferences.

(2) Must provide or arrange for, at no additional cost to the resident and consistent with chapter 388-78A WAC:

(a) Intermittent nursing services;

(b) Medication administration;

(c) Personal care services; and

(d) Supportive services that promote independence and self-sufficiency.

(3) Make available and offer at no additional cost to the resident generic personal care items needed by the resident such as soap, shampoo, toilet paper, toothbrush, toothpaste, deodorant, sanitary napkins, and disposable razors. This does not include items covered by medical coupons or preclude residents from choosing to purchase their own personal care items.

(4) Provide all residents with access to an on-site washing machine and dryer for resident use.

(5) Make beverages and snacks available to residents.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-150, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-150, filed 5/8/96, effective 6/8/96.]

PART III ENHANCED ADULT RESIDENTIAL CARE

WAC 388-110-220 Enhanced adult residential care service standards. (1) In a boarding home with an enhanced adult residential care contract, the contractor must meet the requirements of parts I and III of this chapter, and for residents served under the enhanced adult residential care contract:

(a) Develop for each resident a negotiated service agreement that supports the principles of dignity, privacy, choice in decision making, individuality, and independence.

(b) Provide or arrange for, at no additional cost to the resident and consistent with the resident's negotiated service agreement and chapter 388-78A WAC:

(i) Intermittent nursing services;

- (ii) Medication administration;
- (iii) Personal care services; and
- (iv) Supportive services that promote independence and self-sufficiency; and

(c) Not allow more than two residents per room.

(2) An enhanced adult residential care-specialized dementia care services contract is a distinct contract, separate from an enhanced adult residential care contract. In a boarding home with an enhanced adult residential care-specialized dementia care services contract, the contractor must:

(a) Meet the requirements of parts I and III of this chapter,

(b) Meet the requirements of subsection (1) of this section, and

(c) Maintain an enhanced adult residential care services contract or an assisted living services contract in addition to the enhanced adult residential care-specialized dementia care services contract.

(3) In a boarding home with an enhanced adult residential care-specialized dementia care services contract, for residents served under that contract, the contractor must:

(a) Complete a full assessment of residents as specified in chapter 388-78A WAC, at a minimum, on a semi-annual basis;

(b) Maintain awake staff twenty-four hours per day. The contractor must provide staffing that is adequate to respond to the assessed sleeping and waking patterns and needs of residents;

(c) Develop and implement policies and procedures:

(i) To manage residents who may wander;

(ii) To outline actions to be taken in case a resident elopes; and

(iii) To obtain consultative resources to address behavioral issues for residents. The contractor must include a plan that identifies the professional (i.e., clinical psychologist, psychiatrist, psychiatric nurse practitioner, or other behavioral specialist familiar with care of persons with dementia with complex or severe problems) who will provide the consultation, and when and how the consultation will be utilized.

(d) Ensure that each staff who works directly with residents has at least six hours of continuing education per year related to dementia, including Alzheimer's disease. This six hours of continuing education may be part of the ten hours of continuing education required by WAC 388-112-0205. Appropriate topics include, but are not limited to:

(i) Agitation: Caregiving strategies;

(ii) Challenging behaviors: Strategies for managing aggression and sexual behavior;

(iii) Delusions and hallucinations;

(iv) Using problem-solving strategies in dementia care;

(v) Depression and dementia;

(vi) Fall prevention for people with dementia;

(vii) Personal care as meaningful activity;

(viii) Promoting adequate food and fluid consumption;

(ix) Promoting pleasant and purposeful activity;

(x) Resistance to care: Caregiving strategies; and

(xi) Recognizing and assessing pain in people with dementia.

(e) Provide all necessary physical assistance with bathing and toilet use for residents who require caregivers to perform these activities and subtasks of these activities, and

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required oversight and supervision, encouragement and cueing. For the purposes of this subsection:

(i) "Bathing" has the same meaning as described in WAC 388-106-0010; and

(ii) "Toilet use" has the same meaning as described in WAC 388-106-0010.

(f) Routinely provide assistance with eating as necessary, including required oversight and supervision, encouragement and cueing. The contractor must also provide all necessary physical assistance with eating on an occasional basis for residents who require total feeding assistance. However, the contractor is not required to provide total feeding assistance for an extended or indefinite period. As used in this section, eating has the same meaning as described in WAC 388-106-0010, except that the contractor is not required to provide tube feedings or intravenous nutrition.

(g) Provide daily activities consistent with the functional abilities, interests, habits and preferences of the individual residents. The contractor must support the participation of residents and the resident council, if there is one, in the development of recreational and activity programs that reflect the needs and choices of residents. On a daily basis, the contractor must provide residents access to:

(i) Opportunities for independent, self-directed, activities.

(ii) Individual activities, in which a staff person or volunteer engages the resident in a planned and/or spontaneous activity of interest. Activities may include personal care activities that provide opportunities for purposeful and positive interactions; and

(iii) Group activities.

(h) Offer opportunities for activities that accommodate variations in a resident's mood, energy and preferences. The contractor must make appropriate activities available based upon the resident's individual schedule and interests. For example, individuals up at night must have access to staff support, food and appropriate activities;

(i) Make available multiple common areas, at least one of which is outdoors, that vary by size and arrangement such as: various size furniture groupings that encourage social interaction; areas with environmental cues that may stimulate activity, such as a resident kitchen or workshop; areas with activity supplies and props to stimulate conversation; a garden area; and paths and walkways that encourage exploration and walking. These areas must accommodate and offer opportunities for individual or group activity;

(j) Ensure that the outdoor area for residents:

(i) Is accessible to residents without staff assistance;

(ii) Is surrounded by walls or fences at least seventy-two inches high;

(iii) Has areas protected from direct sunshine and rain throughout the day;

(iv) Has walking surfaces that are firm, stable, slip-resistant and free from abrupt changes, and are suitable for individuals using wheelchairs and walkers;

(v) Has suitable outdoor furniture;

(vi) Has plants that are not poisonous or toxic to humans; and

(vii) Has areas for appropriate outdoor activities of interest to residents, such as walking paths, raised garden or flower beds, bird feeders, etc.

(k) Ensure that areas used by residents have a residential atmosphere, and residents have opportunities for privacy, socialization, and wandering behaviors;

(l) Ensure any public address system in the area of specialized dementia care services is used only for emergencies;

(m) Encourage residents' individualized spaces to be furnished and or decorated with personal items based on resident needs and preferences;

(n) Ensure residents have access to their own rooms at all times without staff assistance; and

(o) Make available and offer at no additional cost to the resident generic personal care items needed by the resident such as soap, shampoo, toilet paper, toothbrush, toothpaste, deodorant, sanitary napkins, and disposable razors. This does not include items covered by medical coupons or preclude residents from choosing to purchase their own personal care items.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-110-220, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063 and 04-18-001, § 388-110-220, filed 7/30/04 and 8/19/04, effective 9/19/04. Statutory Authority: RCW 74.39A.-010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-220, filed 5/8/96, effective 6/8/96.]

PART IV ADULT RESIDENTIAL CARE

WAC 388-110-240 Adult residential care service standards. In a boarding home with an adult residential care contract, the contractor must meet the requirements of parts I and IV of this chapter, and for residents served under the adult residential care contract:

(1) Develop for each resident a negotiated service agreement that supports the principles of dignity, privacy, choice in decision making, individuality, and independence; and

(2) Provide personal care services based on the resident's negotiated service agreement.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-240, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.-020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-240, filed 5/8/96, effective 6/8/96.]

PART V REMEDIES FOR ASSISTED LIVING, ENHANCED ADULT RESIDENTIAL CARE, ENHANCED ADULT RESIDENTIAL CARE—SPECIALIZED DEMENTIA CARE, AND ADULT RESIDENTIAL CARE

WAC 388-110-260 Remedies. (1) The department may take one or more of the actions listed in subsection (3)(a) of this section in any case in which the department finds that a contractor of assisted living services, enhanced adult residential care services, enhanced residential care-specialized dementia care services, or adult residential care services has:

(a) Failed or refused to comply with the applicable requirements of chapter 74.39A RCW, of chapter 70.129 RCW, chapter 388-78A WAC or of this chapter;

(b) Operated without a license or under a revoked license;

(c) Knowingly, or with reason to know, made a false statement of material fact on his or her application for a contract or any data attached thereto, or in any matter under investigation by the department; or

(d) Willfully prevented or interfered with any inspection or investigation by the department.

(2)(a) For failure or refusal to comply with any applicable requirements of chapter 74.39A RCW, of chapter 70.129 RCW, chapter 388-78A WAC or of this chapter, the department may provide consultation before imposing remedies under subsection (3)(a) unless the violations pose a serious risk to residents, are recurring or have been uncorrected.

(b) When violations of this chapter pose a serious risk to a resident, are recurring or have been uncorrected, the department must impose a remedy or remedies listed under subsection (3)(a). In determining which remedy or remedies to impose, the department must take into account the severity of the impact of the violations on residents and which remedy or remedies are likely to improve resident outcomes and satisfaction in a timely manner.

(3)(a) Actions and remedies the department is authorized to impose include:

(i) Refusal to enter into a contract;

(ii) Imposition of reasonable conditions on a contract, such as correction within a specified time, training, and limits on the type of clients the provider may admit or serve;

(iii) Imposition of civil penalties of not more than one hundred dollars per day per violation;

(iv) Suspension, termination, or refusal to renew a contract; or

(v) Order stop placement of persons under the contract.

(b) When the department orders stop placement, the boarding home must not admit any person under the contract until the stop placement order is terminated. The department may approve readmission of a resident to the boarding home from a hospital or nursing home during the stop placement. The department must terminate the stop placement when the department determines that:

(i) The violations necessitating the stop placement have been corrected; and

(ii) The provider exhibits the capacity to maintain adequate care and service.

(c) Conditions the department may impose on a contract include, but are not limited to the following:

(i) Correction within a specified time;

(ii) Training related to the violations; and

(iii) Discharge of any resident when the department determines discharge is needed to meet that resident's needs or for the protection of other residents.

(d) When a contractor fails to pay a fine when due under this chapter, the department may, in addition to other remedies, withhold an amount equal to the fine plus interest, if any, from the contract payment.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-260, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.-020 and 74.39A.080. 96-21-050, § 388-110-260, filed 10/11/96, effective 11/11/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-260, filed 5/8/96, effective 6/8/96.]

WAC 388-110-270 Notice, hearing rights, effective dates relating to imposition of remedies. (1) Chapter 34.05 RCW applies to department actions under this chapter and chapter 74.39A RCW, except that orders of the department imposing contract suspension, stop placement, or conditions for continuation of a contract are effective immediately upon notice and shall continue pending any hearing.

(2) Civil monetary penalties shall become due twenty eight days after the contractor is served with a notice of the penalty unless the contractor requests a hearing in compliance with chapter 34.05 RCW and RCW 43.20A.215. If a hearing is requested, the penalty becomes due ten days after a final decision in the department's favor is issued. Interest shall accrue beginning thirty days after the department serves the contractor with notice of the penalty at a rate of one percent per month in accordance with RCW 43.20B.695.

(3) A person contesting any decision by the department to impose a remedy must within twenty-eight days of receipt of the decision:

(a) File a written application for an adjudicative proceeding by a method showing proof of receipt with the Board of Appeals, P.O. Box 45803, Olympia, WA 98504; and

(b) Include in or with the application:

(i) The grounds for contesting the department decision; and

(ii) A copy of the contested department decision.

(4) Administrative proceedings shall be governed by chapter 34.05 RCW, RCW 43.20A.215, where applicable, this section, and chapter 388-02 WAC. If any provision in this section conflicts with chapter 388-02 WAC, the provision in this section governs.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-270, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-270, filed 5/8/96, effective 6/8/96.]

WAC 388-110-280 Dispute resolution. (1) When a contractor disagrees with the department's finding of a violation under this chapter, the contractor shall have the right to have the violation reviewed under the department's dispute resolution process. Requests for review must be made to the department within ten days of receipt of the written finding of a violation.

(2) When requested by a contractor, the department must expedite the dispute resolution process to review violations upon which a department order imposing contract suspension, stop placement, or a contract condition is based.

(3) Orders of the department imposing contracts suspension, stop placement, or conditions for continuation of a contract are effective immediately upon notice and shall continue pending dispute resolution.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063, § 388-110-280, filed 7/30/04, effective 9/1/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-280, filed 5/8/96, effective 6/8/96.]

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Chapter 388-112 WAC

RESIDENTIAL LONG-TERM CARE SERVICES

WAC

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TRAINING

SECTION I—PURPOSE AND DEFINITIONS

WAC 388-112-0001 What is the purpose of this chapter? The residential long-term care training requirements under this chapter apply to:

- (1) All adult family homes licensed under chapter 70.128 RCW; and
- (2) All boarding homes licensed under chapter 18.20 RCW.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0001, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0005 What definitions apply to this chapter? "Caregiver" means anyone providing hands-on personal care to another person including but not limited to cuing, reminding, or supervision of residents, on behalf of an adult family home or boarding home, except volunteers who are directly supervised.

"Challenge test" means a competency test taken without first taking the class for which the test is designed.

"Competency" means the minimum level of information and skill trainees are required to know and be able to demonstrate.

"Designee" means a person in a boarding home who supervises caregivers and who is designated by a boarding home administrator to take the trainings in this chapter required of the boarding home administrator. A boarding home administrator may have more than one designee.

"Direct supervision" means oversight by a person who has demonstrated competency in the basic training (and specialty training if required), or who has been exempted from the basic training requirements, is on the premises, and is quickly and easily available to the caregiver.

"DSHS" refers to the department of social and health services.

"Home" refers to adult family homes and boarding homes.

"Indirect supervision" means oversight by a person who has demonstrated competency in the basic training (and specialty training if required), or who has been exempted from the basic training requirements, and who is quickly and easily available to the caregiver, but not necessarily on-site.

"Learning outcomes" means the specific information, skills and behaviors desired of the learner as a result of a specific unit of instruction, such as what they would learn by the end of a single class or an entire course. Learning outcomes are generally identified with a specific lesson plan or curriculum.

"Resident" means a person residing and receiving long-term care services at a boarding home or adult family home. As applicable, the term resident also means the resident's legal guardian or other surrogate decision maker.

"Routine interaction" means contact with residents that happens regularly.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0005, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0010 When do the training requirements go into effect? The training requirements of this chapter begin September 1, 2002, or one hundred twenty days from the date of employment, whichever is later, and apply to:

(1) Adult family home providers, resident managers, and caregivers, and boarding home administrators, designees, and caregivers, who are hired or begin to provide hands-on personal care to residents subsequent to September 1, 2002; and

(2) Existing adult family home providers, resident managers, and caregivers, and boarding home administrators, designees, and caregivers, who on September 1, 2002, have not successfully completed the training requirements under RCW 74.39A.010, 74.39A.020, 70.128.120, or 70.128.130 and this chapter. Existing adult family home providers, resident managers, and caregivers, and boarding home administrators, designees, and caregivers, who have not successfully completed the training requirements under RCW 74.39A.010, 74.39A.020, 70.128.120, or 70.128.130 are subject to all applicable requirements of this chapter. However, until September 1, 2002, nothing in this chapter affects the current training requirements under RCW 74.39A.010, 74.39A.020, 70.128.120, or 70.128.130.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0010, filed 7/11/02, effective 8/11/02.]

SECTION II—ORIENTATION

WAC 388-112-0015 What is orientation? Orientation provides basic introductory information appropriate to the residential care setting and population served. The department does not approve specific orientation programs, materials, or trainers for homes. No test is required for orientation.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0015, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0020 What content must be included in an orientation? Orientation may include the use of video-

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tapes, audiotapes, and other media if the person overseeing the orientation is available to answer questions or concerns for the person(s) receiving the orientation. Orientation must include introductory information in the following areas:

- (1) The care setting;
- (2) The characteristics and special needs of the population served;
- (3) Fire and life safety, including:
 - (a) Emergency communication (including phone system if one exists);
 - (b) Evacuation planning (including fire alarms and fire extinguishers where they exist);
 - (c) Ways to handle resident injuries and falls or other accidents;
 - (d) Potential risks to residents or staff (for instance, aggressive resident behaviors and how to handle them); and
 - (e) The location of home policies and procedures.
- (4) Communication skills and information, including:
 - (a) Methods for supporting effective communication among the resident/guardian, staff, and family members;
 - (b) Use of verbal and nonverbal communication;
 - (c) Review of written communications and/or documentation required for the job, including the resident's service plan;
 - (d) Expectations about communication with other home staff; and
 - (e) Whom to contact about problems and concerns.
- (5) Universal precautions and infection control, including:
 - (a) Proper hand washing techniques;
 - (b) Protection from exposure to blood and other body fluids;
 - (c) Appropriate disposal of contaminated/hazardous articles;
 - (d) Reporting exposure to contaminated articles, blood, or other body fluids; and
 - (e) What staff should do if they are ill.
- (6) Resident rights, including:
 - (a) The resident's right to confidentiality of information about the resident;
 - (b) The resident's right to participate in making decisions about the resident's care, and to refuse care;
 - (c) Staff's duty to protect and promote the rights of each resident, and assist the resident to exercise his or her rights;
 - (d) How and to whom staff should report any concerns they may have about a resident's decision concerning the resident's care;
 - (e) Staff's duty to report any suspected abuse, abandonment, neglect, or exploitation of a resident;
 - (f) Advocates that are available to help residents (LTC ombudsmen, organizations); and
 - (g) Complaint lines, hot lines, and resident grievance procedures.
- (7) In adult family homes, safe food handling information must be provided to all staff, prior to handling food for residents.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230, and 2005 c 505. 06-01-046, § 388-112-0020, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0020, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0025 Is competency testing required for orientation? There is no competency testing required for orientation.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0025, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0030 Is there a challenge test for orientation? There is no challenge test for orientation.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0030, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0035 What documentation is required for orientation? The home must maintain documentation of completion of orientation, issued by the home, that includes:

- (1) The trainee's name;
- (2) A list of the specific information taught;
- (3) Signature of the person overseeing orientation, indicating completion of the required information;
- (4) The trainee's date of employment;
- (5) The name of the home giving the orientation; and
- (6) The date(s) of orientation.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0035, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0040 Who is required to complete orientation, and when must it be completed? Adult family home

(1) All paid or volunteer staff in adult family homes who begin work September 1, 2002 or later must complete orientation before having routine interaction with residents. Orientation must be provided by appropriate adult family home staff.

Boarding home

(2) Boarding home administrators (or their designees), caregivers, and all paid or volunteer staff who begin work September 1, 2002 or later must complete orientation before having routine interaction with residents. Orientation must be provided by appropriate staff.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0040, filed 7/11/02, effective 8/11/02.]

SECTION III—BASIC TRAINING

WAC 388-112-0045 What is basic training? Basic training includes the core knowledge and skills that caregivers need in order to provide personal care services effectively and safely. DSHS must approve basic training curricula.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0045, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0050 Is there an alternative to the basic training for some health care workers? Certain health care workers may complete the modified basic training instead of basic training if they meet the requirements in WAC 388-112-0105.

[Title 388 WAC—p. 630]

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0050, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0055 What knowledge and skills must be taught in basic training? (1) The basic training knowledge and skills must include all of the learning outcomes and competencies published by the department for the following core knowledge and skills:

- (a) Understanding and using effective interpersonal and problem solving skills with the resident, family members, and other care team members;
 - (b) Taking appropriate action to promote and protect resident rights, dignity, and independence;
 - (c) Taking appropriate action to promote and protect the health and safety of the resident and the caregiver;
 - (d) Correctly performing required personal care tasks while incorporating resident preferences, maintaining the resident's privacy and dignity, and creating opportunities that encourage resident independence;
 - (e) Adhering to basic job standards and expectations.
- (2) The basic training learning outcomes and competencies may be obtained from the DSHS aging and adult services administration.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0055, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0060 Is competency testing required for basic training? Passing the DSHS competency test is required for successful completion of basic training as provided under WAC 388-112-0290 through 388-112-0315.

For licensed adult family home providers and employees, successfully completing basic training includes passing the safe food handling section or obtaining a valid food handler permit.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230, and 2005 c 505. 06-01-046, § 388-112-0060, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0060, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0065 Is there a challenge test for basic training? Individuals may take the DSHS challenge test instead of the required training. If a person does not pass a challenge test on the first attempt, they may not retake the challenge test and must attend a class.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0065, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0070 What documentation is required for successful completion of basic training? (1) Basic training must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (a) The name of the trainee;
- (b) The name of the training;
- (c) The name of the home or training entity giving the training;
- (d) The instructor's name and signature; and
- (e) The date(s) of training.

(2007 Ed.)

(2) The trainee must be given an original certificate. A home must keep a copy of the certificate on file.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0070, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0075 Who is required to complete basic training, and when? Adult family homes

(1) Adult family home providers (including entity representatives as defined under chapter 388-76 WAC) must complete basic training and demonstrate competency before operating an adult family home.

(2) Adult family home resident managers must complete basic training and demonstrate competency before providing services in an adult family home.

(3) Caregivers in adult family homes must complete basic training within one hundred twenty days of when they begin providing hands-on personal care or within one hundred twenty days of September 1, 2002, whichever is later. Until competency in the basic training has been demonstrated, caregivers may not provide hands-on personal care without indirect supervision.

Boarding homes

(4) Boarding home administrators (or their designees), except administrators with a current nursing home administrator license, must complete basic training and demonstrate competency within one hundred twenty days of employment or within one hundred twenty days of September 1, 2002, whichever is later.

(5) Caregivers must complete basic training within one hundred twenty days of when they begin providing hands-on personal care or within one hundred twenty days of September 1, 2002, whichever is later. Until competency in the basic training has been demonstrated, caregivers may not provide hands-on personal care without direct supervision.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0075, filed 7/11/02, effective 8/11/02.]

SECTION IV—MODIFIED BASIC TRAINING

WAC 388-112-0080 What is modified basic training?

Modified basic training is a subset of the basic training curriculum designed for certain health care workers defined in WAC 388-112-0105, whose previous training includes many of the outcomes taught in the full basic training. DSHS must approve modified basic training curricula.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0080, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0085 What knowledge and skills must be included in modified basic training? (1) Modified basic training must include all of the learning outcomes and competencies published by DSHS for the following core knowledge and skills:

- (a) Resident rights, including mandatory reporting requirements;
- (b) Medication assistance regulations;
- (c) Nurse delegation regulations;

(2007 Ed.)

(d) Assessment and observations in home and community settings;

(e) Documentation in home and community settings;

(f) Service planning in home and community care settings;

(g) Resource information, including information on continuing education; and

(h) Self-directed care regulations for home care.

(2) The modified basic training learning outcomes and competencies may be obtained from the DSHS aging and adult services administration.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0085, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0090 Is competency testing required for modified basic training? Passing the DSHS competency test is required for successful completion of modified basic training as provided in WAC 388-112-0290 through 388-112-0315.

For licensed adult family home providers and employees, successfully completing modified basic training includes passing the safe food handling section or obtaining a valid food handler permit.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230, and 2005 c 505. 06-01-046, § 388-112-0090, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0090, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0095 Is there a challenge test for modified basic training? Individuals may take the department's challenge test instead of the required training. If a person does not pass a challenge test on the first attempt, they may not re-take the challenge test and must attend the class.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0095, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0100 What documentation is required for successful completion of modified basic training? (1) Modified basic training must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (a) The name of the trainee;
- (b) The name of the training;
- (c) The name of the home or training entity giving the training;
- (d) The instructor's name and signature; and
- (e) The date(s) of training.

(2) The trainee must be given an original certificate. A home must keep a copy of the certificate on file.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0100, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0105 Who may take modified basic training instead of the full basic training? Modified basic training may be taken, instead of the full basic training, by a person who can document that they have successfully completed training as a registered or licensed practical nurse, cer-

tified nursing assistant, physical therapist, occupational therapist, or Medicare-certified home health aide.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0105, filed 7/11/02, effective 8/11/02.]

SECTION V—SPECIALTY TRAINING

WAC 388-112-0110 What is specialty training? (1)

Specialty or "special needs" training, including caregiver specialty training, provides instruction in caregiving skills that meet the special needs of people living with mental illness, dementia, or developmental disabilities. Specialty trainings are different for each population served and are not interchangeable. Specialty training may be integrated with basic training if the complete content of each training is included. DSHS must approve specialty training curricula for managers and caregivers, except for adult family home caregiver specialty training.

(2) Manager specialty training for boarding home administrators (or designees), adult family home providers and resident managers:

(a) Developmental disabilities specialty training, under WAC 388-112-0120, is the required training on that specialty for adult family home providers and resident managers, and for boarding home administrators (or designees.)

(b) Dementia specialty training, under WAC 388-112-0125, and mental health specialty training, under WAC 388-112-0135, are the required trainings on those specialties for adult family home providers and resident managers, and for boarding home administrators (or designees).

(3) Caregiver specialty training for boarding homes:

(a) Developmental disabilities specialty training, under WAC 388-112-0120, is the required training on that specialty for boarding home caregivers.

(b) Caregiver dementia training, under WAC 388-112-0130, and caregiver mental health training, under WAC 388-112-0140, are the required trainings on those specialties for boarding home caregivers.

(4) Caregiver specialty training for adult family homes:

The provider or resident manager who has successfully completed the manager specialty training, or a person knowledgeable about the specialty area, trains adult family home caregivers in the specialty needs of the individual residents in the adult family home, and there is no required curriculum.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230. 06-16-072, § 388-112-0110, filed 7/28/06, effective 8/28/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0110, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0115 What specialty training, including caregiver specialty training, is required if a resident has more than one special need? If an individual resident has needs in more than one of the special needs areas, the home must determine which of the specialty trainings will most appropriately address the overall needs of the person and ensure that the specialty training that addresses the overall needs is completed as required. If additional training beyond the specialty training is needed to meet all of the resident's needs, the home must ensure that additional training is completed.

[Title 388 WAC—p. 632]

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0115, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0120 What knowledge and skills must manager and caregiver developmental disabilities specialty trainings include? (1) Manager and caregiver developmental disabilities specialty trainings must include all of the learning outcomes and competencies published by DSHS for the following core knowledge and skills:

- (a) Overview of developmental disabilities;
- (b) Values of service delivery;
- (c) Effective communication;
- (d) Introduction to interactive planning;
- (e) Understanding behavior;
- (f) Crisis prevention and intervention; and
- (g) Overview of legal issues and individual rights.

(2) For adult family homes, the division of developmental disabilities (DDD) will provide in-home technical assistance to the adult family home upon admission of the first resident eligible for services from DDD and, thereafter, as determined necessary by DSHS.

(3) The manager and caregiver developmental disabilities specialty training learning outcomes and competencies may be obtained from the DSHS division of developmental disabilities.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0120, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0125 What knowledge and skills must manager dementia specialty training include? (1) Manager dementia specialty training must include all the learning outcomes and competencies published by DSHS for the following core knowledge and skills:

- (a) Introduction to the dementias;
- (b) Differentiating dementia, depression, and delirium;
- (c) Caregiving goals, values, attitudes and behaviors;
- (d) Caregiving principles and dementia problem solving;
- (e) Effects of cognitive losses on communication;
- (f) Communicating with people who have dementia;
- (g) Sexuality and dementia;
- (h) Rethinking "problem" behaviors;
- (i) Hallucinations and delusions;
- (j) Helping with activities of daily living (ADLs);
- (k) Drugs and dementia;
- (l) Working with families;
- (m) Getting help from others; and
- (n) Self-care for caregivers.

(2) The manager dementia specialty training learning outcomes and competencies may be obtained from the DSHS aging and adult services administration.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0125, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0130 What knowledge and skills must caregiver dementia training include? (1) Caregiver dementia training must include all the learning outcomes and competencies published by DSHS for the following core knowledge and skills:

(2007 Ed.)

- (a) Introduction to the dementias;
- (b) Dementia, depression, and delirium;
- (c) Resident-based caregiving;
- (d) Dementia caregiving principles;
- (e) Communicating with people who have dementia;
- (f) Sexuality and dementia;
- (g) Rethinking "problem" behaviors;
- (h) Hallucinations and delusions;
- (i) Helping with activities of daily living (ADLs); and
- (j) Working with family and friends.

(2) The learning outcomes and competencies for caregiver dementia training may be obtained from the DSHS aging and adult services administration.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0130, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0135 What knowledge and skills must manager mental health specialty training include? (1) Manager mental health specialty training must include all the learning outcomes and competencies published by DSHS for the following core knowledge and skills:

- (a) Introduction to mental illness;
- (b) Culturally compassionate care;
- (c) Respectful communications;
- (d) Understanding mental illness - major mental disorders;

(e) Understanding mental illness - baseline, decompensation, and relapse planning; responses to hallucinations and delusions;

(f) Understanding and interventions for behaviors perceived as problems;

- (g) Aggression;
- (h) Suicide;
- (i) Medications;
- (j) Getting help from others; and
- (k) Self-care for caregivers.

(2) The manager mental health specialty training learning outcomes and competencies may be obtained from the DSHS aging and adult services administration.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0135, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0140 What knowledge and skills must caregiver mental health training include? (1) Caregiver mental health training must include all the learning outcomes and competencies published by DSHS for the following core knowledge and skills:

- (a) Understanding major mental disorders;
- (b) Individual background, experiences and beliefs;
- (c) Responding to decompensation, relapse, hallucinations and delusions;
- (d) Interventions for behaviors perceived as problems;
- (e) Aggression; and
- (f) Suicide.

(2) The learning outcomes and competencies for caregiver mental health training may be obtained from the DSHS aging and adult services administration.

(2007 Ed.)

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0140, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0145 Is competency testing required for specialty training, including caregiver specialty training? Passing the DSHS competency test is required for successful completion of specialty training for adult family home providers and resident managers, and for boarding home administrators (or designees) and caregivers, as provided under WAC 388-112-0290 through 388-112-0315. Competency testing is not required for adult family home caregivers.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0145, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0150 Is there a challenge test for specialty training, including caregiver specialty training? There is a challenge test for all the specialty trainings, including caregiver specialty trainings, except the adult family home caregiver training. Individuals may take the DSHS challenge test instead of required specialty training. A person who does not pass a challenge test on the first attempt must attend the class.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0150, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0155 What documentation is required for successful completion of specialty training, including caregiver specialty training? Specialty training, including caregiver specialty training, as applicable, must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (1) The trainee's name;
 - (2) The name of the training;
 - (3) The name of the home or training entity giving the training;
 - (4) The instructor's name and signature; and
 - (5) The date(s) of training.
- (6) The trainee must be given an original certificate. The home must keep a copy of the certificate on file.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0155, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0160 Who is required to complete manager specialty training, and when? Adult family homes

(1) Adult family home providers (including entity representatives as defined under chapter 388-76 WAC) and resident managers must complete manager specialty training and demonstrate competency before admitting and serving residents who have special needs related to mental illness, dementia, or a developmental disability.

(2) If a resident develops special needs while living in a home without a specialty designation, the provider and resident manager have one hundred twenty days to complete manager specialty training and demonstrate competency.

[Title 388 WAC—p. 633]

Boarding homes

(3) If a boarding home serves one or more residents with special needs, the boarding home administrator (or designee) must complete manager specialty training and demonstrate competency within one hundred twenty days of employment or within one hundred twenty days of September 1, 2002, whichever is later. A boarding home administrator with a current nursing home administrator license is exempt from this requirement, unless the administrator will train their facility caregivers in a caregiver specialty.

(4) If a resident develops special needs while living in a boarding home, the boarding home administrator (or designee) has one hundred twenty days to complete manager specialty training and demonstrate competency. A boarding home administrator with a current nursing home administrator license is exempt from this requirement, unless the administrator will train their facility caregivers in a caregiver specialty.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0160, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0165 Who is required to complete caregiver specialty training, and when? Adult family homes

If an adult family home serves one or more residents with special needs, all caregivers must receive training regarding the specialty needs of individual residents in the home. The provider or resident manager knowledgeable about the specialty area may provide this training.

Boarding homes

If a boarding home serves one or more residents with special needs, caregivers must complete caregiver specialty training and demonstrate competency.

(1) If the caregiver specialty training is integrated with basic training, caregivers must complete the caregiver specialty training within one hundred twenty days of when they begin providing hands-on personal care to a resident having special needs or within one hundred twenty days of September 1, 2002, whichever is later.

(2) If the caregiver specialty training is not integrated with basic training, caregivers must complete the relevant caregiver specialty training within ninety days of completing basic training.

(3) Until competency in the caregiver specialty has been demonstrated, caregivers may not provide hands-on personal care to a resident with special needs without direct supervision.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0165, filed 7/11/02, effective 8/11/02.]

SECTION VI—NURSE DELEGATION CORE TRAINING

WAC 388-112-0170 What is nurse delegation core training? Nurse delegation core training is required before a nursing assistant may be delegated a nursing task. DSHS approves instructors for nurse delegation core training.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0170, filed 7/11/02, effective 8/11/02.]

[Title 388 WAC—p. 634]

WAC 388-112-0175 What knowledge and skills must nurse delegation core training include? Only the curriculum developed by DSHS may be used for nurse delegation core training.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0175, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0180 Is competency testing required for nurse delegation core training? Passing the DSHS competency test is required for successful completion of nurse delegation core training, as provided under WAC 388-112-0265 through 388-112-0295.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0180, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0185 Is there a challenge test for nurse delegation core training? There is no challenge test for nurse delegation core training.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0185, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0190 What documentation is required for successful completion of nurse delegation core training? (1) Nurse delegation core training must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (a) The name of the trainee;
- (b) The name of the training;
- (c) The name of the training entity giving the training;
- (d) The instructor's name and signature; and
- (e) The date(s) of training.

(2) The trainee must be given an original certificate. Homes must keep a copy of the certificate on file.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0190, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0195 Who is required to complete nurse delegation core training, and when? Adult family homes

(1) Before performing any delegated nursing task, adult family home staff must:

- (a) Successfully complete DSHS-designated nurse delegation core training;
- (b) Be a nursing assistant registered or certified under chapter 18.88A RCW; and
- (c) If a nursing assistant registered, successfully complete basic training.

Boarding homes

(2) Before performing any delegated nursing task, boarding home staff must:

- (a) Successfully complete DSHS-designated nurse delegation core training;
- (b) Be a nursing assistant registered or certified under chapter 18.88A RCW; and
- (c) If a nursing assistant registered, successfully complete basic training.

(2007 Ed.)

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0195, filed 7/11/02, effective 8/11/02.]

SECTION VII—CONTINUING EDUCATION

WAC 388-112-0200 What is continuing education?

Continuing education is additional caregiving-related training designed to increase and keep current a person's knowledge and skills. DSHS does not preapprove continuing education programs or instructors.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0200, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0205 How many hours of continuing education are required each year? (1) Individuals subject to a continuing education requirement must complete at least ten hours of continuing education each calendar year (January 1 through December 31) after the year in which they successfully complete basic or modified basic training.

(2) One hour of completed classroom instruction or other form of training (such as a video or on-line course) equals one hour of continuing education.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0205, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0210 What kinds of training topics are required for continuing education? Continuing education must be on a topic relevant to the care setting and care needs of residents, including but not limited to:

- (1) Resident rights;
- (2) Personal care (such as transfers or skin care);
- (3) Mental illness;
- (4) Dementia;
- (5) Developmental disabilities;
- (6) Depression;
- (7) Medication assistance;
- (8) Communication skills;
- (9) Positive resident behavior support;
- (10) Developing or improving resident centered activities;
- (11) Dealing with wandering or aggressive resident behaviors;
- (12) Medical conditions; and
- (13) In adult family homes, safe food handling.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230, and 2005 c 505. 06-01-046, § 388-112-0210, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0210, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0215 Is competency testing required for continuing education? Competency testing is not required for continuing education.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0215, filed 7/11/02, effective 8/11/02.]

(2007 Ed.)

WAC 388-112-0220 May basic or modified basic training be completed a second time and used to meet the continuing education requirement? Retaking basic or modified basic training may not be used to meet the continuing education requirement.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0220, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0225 May specialty training be used to meet continuing education requirements? Manager specialty training and caregiver specialty training, except any specialty training completed through a challenge test, may be used to meet continuing education requirements.

(1) If one or more specialty trainings are completed in the same year as basic or modified basic training, the specialty training hours may be applied toward the continuing education requirement for up to two calendar years following the year of completion of the basic and specialty trainings.

(2) If one or more specialty trainings are completed in a different year than the year when basic or modified basic training was taken, the specialty training hours may be applied toward the continuing education requirement for the calendar year in which the specialty training is taken and the following calendar year.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0225, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0230 May nurse delegation core training be used to meet continuing education requirements? Nurse delegation training under WAC 388-112-0175 may be applied toward continuing education requirements for the calendar year in which it is completed.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0230, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0235 May residential care administrator training be used to meet continuing education requirements? Residential care administrator training under WAC 388-112-0275 may be used to meet ten hours of continuing education requirements.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0235, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0240 What are the documentation requirements for continuing education? (1) The adult family home or boarding home must maintain documentation of continuing education including:

- (a) The trainee's name;
- (b) The title or content of the training;
- (c) The instructor's name, name of the home or training entity giving the training, or the name of the video, on-line class, professional journal, or equivalent instruction materials completed;
- (d) The number of hours of training; and
- (e) The date(s) of training.

(2) The trainee must be given an original certificate or other documentation of continuing education.

[Title 388 WAC—p. 635]

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0240, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0245 Who is required to complete continuing education training, and when? Adult family homes

(1) Adult family home providers (including entity representatives as defined under chapter 388-76 WAC), resident managers, and caregivers must complete ten hours of continuing education each calendar year (January 1 through December 31) after the year in which they successfully complete basic or modified basic training.

(2) Continuing education must be on a topic relevant to the care setting and care needs of residents in adult family homes.

(3) Continuing education must include 0.5 hours per year on safe food handling in adult family homes.

Boarding homes

(4) Boarding home administrators (or their designees) and caregivers must complete ten hours of continuing education each calendar year (January 1 through December 31) after the year in which they successfully complete basic or modified basic training. A boarding home administrator with a current nursing home administrator license is exempt from this requirement.

(5) Continuing education must be on a topic relevant to the care setting and care needs of residents in boarding homes.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230, and 2005 c 505. 06-01-046, § 388-112-0245, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0245, filed 7/11/02, effective 8/11/02.]

SECTION VIII—CPR AND FIRST-AID TRAINING

WAC 388-112-0250 What is CPR training? Cardiopulmonary resuscitation (CPR) training is training provided by an authorized CPR instructor.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230, 06-16-072, § 388-112-0250, filed 7/28/06, effective 8/28/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0250, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0255 What is first-aid training? First-aid training is training that meets the guidelines established by the Occupational Safety and Health Administration and listed at www.osha.gov. Topics include:

- (1) General program elements, including:
 - (a) Responding to a health emergency;
 - (b) Surveying the scene;
 - (c) Basic cardiopulmonary resuscitation (CPR);
 - (d) Basic first aid intervention;
 - (e) Standard precautions;
 - (f) First aid supplies; and
 - (g) Trainee assessments.
- (2) Type of injury training, including:
 - (a) Shock;
 - (b) Bleeding;
 - (c) Poisoning;
 - (d) Burns;

- (e) Temperature extremes;
- (f) Musculoskeletal injuries;
- (g) Bites and stings;
- (h) Confined spaces; and
- (i) Medical emergencies; including heart attack, stroke, asthma attack, diabetes, seizures, and pregnancy.

(3) Site of injury training, including:

- (a) Head and neck;
- (b) Eye;
- (c) Nose;
- (d) Mouth and teeth;
- (e) Chest;
- (f) Abdomen; and
- (g) Hand, finger and foot.

(4) Successful completion of first aid training, following the OSHA guidelines, also serves as proof of the CPR training.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230, and 2005 c 505. 06-01-046, § 388-112-0255, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0255, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0260 What are the CPR and first-aid training requirements? Adult family homes

(1) Adult family home providers and resident managers must possess a valid CPR and first-aid card or certificate prior to providing care for residents, and must maintain valid cards or certificates.

(2) Licensed nurses working in adult family homes must possess a valid CPR card or certificate within thirty days of employment and must maintain a valid card or certificate. If the licensed nurse is an adult family home provider or resident manager, the valid CPR card or certificate must be obtained prior to providing care for residents.

(3) Adult family home caregivers must obtain and maintain a valid CPR and first-aid card or certificate:

(a) Within thirty days of beginning to provide care for residents, if the provision of care for residents is directly supervised by a fully qualified caregiver who has a valid first-aid and CPR card or certificate; or

(b) Before providing care for residents, if the provision of care for residents is not directly supervised by a fully qualified caregiver who has a valid first-aid and CPR card or certificate.

Boarding homes

(4) Boarding home administrators who provide direct care, and caregivers must possess a valid CPR and first-aid card or certificate within thirty days of employment, and must maintain valid cards or certificates. Licensed nurses working in boarding homes must possess a valid CPR card or certificate within thirty days of employment, and must maintain a valid card or certificate.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230, and 2005 c 505. 06-01-046, § 388-112-0260, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0260, filed 7/11/02, effective 8/11/02.]

SECTION IX—RESIDENTIAL CARE ADMINISTRATOR TRAINING

WAC 388-112-0265 What is residential care administrator training? Residential care administrator training is a minimum of forty-eight hours of training on topics related to the management of adult family homes. DSHS must approve residential care administrator training curricula.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0265, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0270 Who must take the forty-eight hour adult family home residential care administrator training and when? Providers licensed prior to December 31, 2006: Before operating more than one adult family home, the provider (including an entity representative as defined under chapter 388-76 WAC) must successfully complete the department approved forty-eight hour residential care administrator training.

Prospective providers applying for a license after January 1, 2007: Before a license for an adult family home is granted, the prospective provider must successfully complete the department approved forty-eight hour residential care administrator training for adult family homes.

[Statutory Authority: RCW 74.08.090, 18.20.090, 70.128.040, chapter 70.128 RCW and 2006 c 249. 07-01-045, § 388-112-0270, filed 12/14/06, effective 1/14/07. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0270, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0275 What knowledge and skills must residential care administrator training include? Minimally, residential care administrator training must have at least forty-eight hours of class time, and include all of the following:

- (1) Business planning and marketing;
- (2) Fiscal planning and management;
- (3) Human resource planning;
- (4) Resident health services;
- (5) Nutrition and food service;
- (6) Working with people who are elderly, chronically mentally ill, or developmentally disabled;
- (7) The licensing process;
- (8) Social and recreational activities;
- (9) Resident rights;
- (10) Legal issues;
- (11) Physical maintenance and fire safety; and
- (12) Housekeeping.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0275, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0280 Is competency testing required for residential care administrator training? Competency testing is not required for residential care administrator training.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0280, filed 7/11/02, effective 8/11/02.]

(2007 Ed.)

WAC 388-112-0285 What documentation is required for residential care administrator training? (1) Residential care administrator training must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (a) The trainee's name;
- (b) The name of the training;
- (c) The name of the training entity giving the training;
- (d) The instructor's name and signature; and
- (e) The date(s) of training.

(2) The trainee must be given an original certificate. A copy of the certificate must be in the adult family home's files.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0285, filed 7/11/02, effective 8/11/02.]

SECTION X—COMPETENCY TESTING

WAC 388-112-0290 What is competency testing? Competency testing, including challenge testing, is evaluating a trainee to determine if they can demonstrate the required level of skill, knowledge, and/or behavior with respect to the identified learning outcomes of a particular course.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0290, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0295 What components must competency testing include? Competency testing must include the following components:

- (1) Skills demonstration of ability to perform and/or implement specific caregiving approaches, and/or activities as appropriate for the training;
- (2) Written evaluation to show level of comprehension and knowledge of the learning outcomes for the training; and
- (3) A scoring guide for the tester with clearly stated criteria and minimum proficiency standards.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0295, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0300 What training must include the DSHS-developed competency test? Basic, modified basic, manager specialty, caregiver specialty, and nurse delegation core training must include the DSHS-developed competency test.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0300, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0305 How must competency test administration be standardized? To standardize competency test administration, testing must include the following components:

- (1) The person teaching the course must administer or supervise the administration of all testing; and
- (2) The tester must follow DSHS guidelines for:
 - (a) The maximum length of time allowed for testing;

[Title 388 WAC—p. 637]

(b) The amount and nature of instruction given to students before beginning a test;

(c) The amount of assistance to students allowed during testing;

(d) The accommodation guidelines for students with disabilities; and

(e) Accessibility guidelines for students with limited English proficiency.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0305, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0310 What form of identification must students provide before taking a competency or challenge test? Students must provide photo identification before taking a competency test (or challenge test, when applicable) for basic, modified basic, specialty, or nurse delegation training.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0310, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0315 How many times may a competency test be taken? (1) A competency test that is part of a course may be taken twice. If the test is failed a second time, the person must retake the course before any additional tests are administered. Licensed adult family providers and employees who fail the food handling section of the basic training competency test a second time, must obtain a valid food worker permit.

(2) If a challenge test is available for a course, it may be taken only once. If the test is failed, the person must take the classroom course.

[Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230, and 2005 c 505. 06-01-046, § 388-112-0315, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0315, filed 7/11/02, effective 8/11/02.]

SECTION XI—CURRICULUM APPROVAL

WAC 388-112-0320 What trainings must be taught with a curriculum approved by DSHS? (1) The following trainings must be taught using the DSHS curriculum or other curriculum approved by DSHS:

- (a) Basic;
- (b) Modified basic;
- (c) Manager mental health, dementia, and developmental disabilities specialty training;
- (d) Caregiver specialty training in boarding homes; and
- (e) Any training that integrates basic training with a manager or caregiver specialty training.

(2) The residential care administrator training must use a curriculum approved by DSHS.

(3) The nurse delegation training must use only the DSHS curriculum.

(4) A curriculum other than the DSHS curriculum must be approved before it is used. An attestation that the curriculum meets all requirements under this chapter will be sufficient for initial approval. Final approval will be based on curriculum review, as described under WAC 388-112-0330.

[Title 388 WAC—p. 638]

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0320, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0325 What are the minimum components that an alternative curriculum must include in order to be approved? In order to be approved, an alternative curriculum must at a minimum include:

(1) All the DSHS-published learning outcomes and competencies for the course;

(2) Printed student materials that support the curriculum, a teacher's guide or manual, and learning resource materials such as learning activities, audio-visual materials, handouts, and books;

(3) The recommended sequence and delivery of the material;

(4) The teaching methods or approaches that will be used for different sections of the course, including for each lesson:

- (a) The expected learning outcomes;
- (b) Learning activities that incorporate adult learning principles and address the learning readiness of the student population;
- (c) Practice of skills to increase competency;
- (d) Feedback to the student on knowledge and skills;
- (e) An emphasis on facilitation by the teacher; and
- (f) An integration of knowledge and skills from previous lessons to build skills.

(5) A list of the sources or references, if any, used to develop the curriculum;

(6) Methods of teaching and student evaluation for students with limited English proficiency and/or learning disabilities; and

(7) A plan for updating material. Substantial changes to a previously approved curriculum must be approved before they are used.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0325, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0330 What is the curriculum approval process? (1) An alternative curriculum must be submitted to DSHS for approval with:

(a) Identification of where each DSHS-published required learning outcome and competency is located in the alternate curriculum;

(b) All materials identified in WAC 388-112-0325; and

(c) A letter from the boarding home administrator or adult family home provider attesting that the training curriculum addresses all of the training competencies identified by DSHS;

(2) DSHS may approve a curriculum based upon the attestation in (1)(c) above, until it has been reviewed by DSHS;

(3) If, upon review by DSHS, the curriculum is not approved, the alternative curriculum may not be used until all required revisions have been submitted and approved by DSHS.

(4) After review of the alternative curriculum, DSHS will send a written response to the submitter, indicating approval or disapproval of the curriculum and if disapproved, the reasons for denial;

(2007 Ed.)

(5) If the alternative curriculum is not approved, a revised curriculum may be resubmitted to DSHS for another review.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0330, filed 7/11/02, effective 8/11/02.]

SECTION XII—HOME-BASED TRAINING

WAC 388-112-0335 What are the requirements for a boarding home or adult family home that wishes to conduct basic, modified basic, manager specialty, or caregiver specialty training? (1) A boarding home or adult family home wishing to conduct basic, modified basic, manager specialty, or caregiver specialty training for boarding home caregivers may do so if the home:

(a) Verifies and documents that all instructors meet each of the minimum instructor qualifications for the course they plan to teach;

(b) Teaches using a complete DSHS-developed or approved alternative curriculum.

(c) Notifies DSHS in writing of the home's intent to conduct staff training prior to providing the home's first training, and when changing training plans, including:

(i) Home name;

(ii) Name of training(s) the home will conduct;

(iii) Name of curriculum(s) the home will use;

(iv) Name of lead instructor and instructor's past employment in boarding homes and adult family homes; and

(v) Whether the home will train only the home's staff, or will also train staff from other homes;

(d) Ensures that DSHS competency tests are administered as required under this chapter;

(e) Provides a certificate of completion of training to all staff that successfully complete the entire course, including:

(i) The trainee's name;

(ii) The name of the training;

(iii) The name of the home giving the training;

(iv) The instructor's name and signature; and

(v) The date(s) of training;

(f) Keeps a copy of student certificates on file for six years, and gives the original certificate to the trainee;

(g) Keeps attendance records and testing records of students trained and tested on file for six years; and

(h) Reports training data to DSHS in DSHS-identified time frames

(2) An adult family home wishing to conduct caregiver specialty training that is taught by the provider, resident manager, or person knowledgeable about the specialty area, as required under WAC 388-112-0110 subsection (3), must document the specialty training as provided under WAC 388-112-0155.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0335, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0340 Do homes need department approval to provide continuing education for their staff? Homes may provide continuing education for their staff without prior approval of curricula or instructors by the department.

(2007 Ed.)

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0340, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0345 When can DSHS prohibit a home from conducting its own training? DSHS may prohibit a home from providing its own basic, modified basic, specialty, or caregiver specialty training when:

(1) DSHS determines that the training fails to meet the standards under this chapter;

(2) The home's instructor does not meet the applicable qualifications under WAC 388-112-0375 through 388-112-0395; or

(3) The home's instructor has been a licensee, boarding home administrator, or adult family home resident manager, as applicable, of any home subject to temporary management or subject to a revocation or summary suspension of the home's license, a stop placement of admissions order, a condition on the license related to resident care, or a civil fine of five thousand dollars or more, while the instructor was the licensee, administrator, or resident manager; or

(4) The home has been operated under temporary management or has been subject to a revocation or suspension of the home license, a stop placement of admissions order, a condition on the license related to resident care, or a civil fine of five thousand dollars or more, within the previous twelve months.

(5) Nothing in this section shall be construed to limit DSHS' authority under chapters 388-76 or 388-78A WAC to require the immediate enforcement, pending any appeal, of a condition on the home license prohibiting the home from conducting its own training programs.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0345, filed 7/11/02, effective 8/11/02.]

XIII—INSTRUCTOR APPROVAL

WAC 388-112-0350 What trainings must be taught by an instructor who meets the applicable minimum qualifications under this chapter? (1) The following trainings must be taught by an instructor who meets the applicable minimum qualifications for that training: Basic training; modified basic training; mental health, dementia, and developmental disability specialty training; and caregiver specialty training that is not taught by the boarding home administrator (or designee) or adult family home provider or resident manager.

(2) Nurse delegation training and residential care administrator training must be taught by an instructor who is approved by DSHS.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0350, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0355 What are an instructor's or training entity's responsibilities? The instructor or training entity is responsible for:

(1) Coordinating and teaching classes,

(2) Assuring that the curriculum used is taught as designed,

(3) Selecting qualified guest speakers where applicable,

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- (4) Administering or overseeing the administration of DSHS competency and challenge tests,
- (5) Maintaining training records including student tests and attendance records for a minimum of six years,
- (6) Reporting training data to DSHS in DSHS-identified time frames, and
- (7) Issuing or reissuing training certificates to students.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0355, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0360 Must instructors be approved by DSHS? (1) DSHS-contracted instructors

(a) DSHS must approve any instructor under contract with DSHS to conduct basic, modified basic, specialty, or nurse delegation core training classes using the training curricula developed by DSHS.

(b) DSHS may select contracted instructors through a purchased services contract procurement pursuant to chapter 236-48 WAC or through other applicable contracting procedures. Contractors must meet the minimum qualifications for instructors under this chapter and any additional qualifications established through a request for qualifications and quotations (RFQQ) or other applicable contracting procedure.

(2) Homes conducting their own training

Homes conducting their own training programs using the training curricula developed by DSHS or alternative curricula approved by DSHS must ensure that their instructors meet the minimum qualifications for instructors under this chapter.

(3) Other instructors

DSHS must approve all other instructors not described in subsection (1) and (2) of this section.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0360, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0365 Can DSHS deny or terminate a contract with an instructor or training entity? (1) DSHS may determine not to accept a bid or other offer by a person or organization seeking a contract with DSHS to conduct basic, modified basic, specialty, or nurse delegation core training classes using the training curricula developed by DSHS. The protest procedures under chapter 236-48 WAC, as applicable, are a bidder's exclusive administrative remedy. No administrative remedies are available to dispute DSHS' decision not to accept an offer that is not governed by chapter 236-48 WAC, except as may be provided through the contracting process.

(2) DSHS may terminate any training contract in accordance with the terms of the contract. The contractor's administrative remedies shall be limited to those specified in the contract.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0365, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0370 What is a guest speaker, and what are the minimum qualifications to be a guest speaker for basic and developmental disabilities specialty training? Guest speakers for basic and developmental disabilities specialty training teach a specific subject in which

they have expertise, under the supervision of the instructor. A guest speaker must have as minimum qualifications, an appropriate background and experience that demonstrates that the guest speaker has expertise on the topic he or she will teach. The instructor must select guest speakers that meet the minimum qualifications, and maintain documentation of this background. DSHS does not approve guest speakers.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0370, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0375 What are the minimum general qualifications for an instructor teaching a DSHS curriculum or DSHS-approved alternate curriculum as defined under chapter 388-112 WAC? An instructor teaching a DSHS curriculum or DSHS-approved alternate curriculum must meet the following minimum general qualifications:

(1) Twenty-one years of age; and

(2) Has not had a professional health care or social services license or certification revoked in Washington state (however, no license or certification is required).

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0375, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0380 What are the minimum qualifications for an instructor for basic or modified basic training? An instructor for basic or modified basic training must meet the following minimum qualifications in addition to the general instructor qualifications in WAC 388-112-0375:

(1) Education and work experience:

(a) Upon initial approval or hire, must have:

(i) A high school diploma and one year of professional or caregiving experience within the last five years in an adult family home, boarding home, supported living through DDD per chapter 388-820 WAC, or home care setting; or

(ii) An associate degree in a health field and six months professional or caregiving experience within the last five years in an adult family home, boarding home, supported living through DDD per chapter 388-820 WAC, or home care setting.

(2) Teaching experience:

(a) Must have one hundred hours of experience teaching adults on topics directly related to the basic training; or

(b) Must have forty hours of teaching while being mentored by an instructor who meets these qualifications, and attend a class in adult education that meets the requirements of WAC 388-112-0400.

(3) The instructor must be experienced in caregiving practices and capable of demonstrating competency with respect to the course content or units being taught;

(4) Instructors who will administer tests must have experience or training in assessment and competency testing; and

(5) If required under WAC 388-112-0075 or 388-112-0105, instructors must successfully complete basic or modified basic training prior to beginning to train others.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0380, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0385 What are the minimum qualifications for instructors for manager and caregiver mental health specialty? (1) Instructors for manager mental health specialty training: The minimum qualifications for instructors for manager mental health specialty, in addition to the general qualifications in WAC 388-112-0375 include:

(a) The instructor must be experienced in mental health caregiving practices and capable of demonstrating competency in the entire course content;

(b) Education

(i) Bachelor's degree, registered nurse, or mental health specialist, with at least one year of education in seminars, conferences, continuing education, or in college classes, in subjects directly related to mental health, such as, but not limited to, psychology. (One year of education equals twenty-four semester hours, thirty-six quarter hours, or one hundred ninety-two hours of seminars, conferences, and continuing education.)

(ii) If required under WAC 388-112-0160, successful completion of the mental health specialty training, prior to beginning to train others.

(c) Work experience - Two years full-time equivalent direct work experience with people who have a mental illness; and

(d) Teaching experience

(i) Two hundred hours experience teaching mental health or closely related subjects; and

(ii) Successful completion of an adult education class or train the trainer as follows:

(A) For instructors teaching alternate curricula, a class in adult education that meets the requirements of WAC 388-112-0400, or a train the trainer class for the curriculum they are teaching;

(B) For instructors teaching DSHS-developed mental health specialty training, successful completion of the DSHS-developed train the trainer.

(e) Instructors who will administer tests must have experience or training in assessment and competency testing.

(2) Instructors for caregiver mental health specialty training:

(a) Caregiver mental health specialty may be taught by a boarding home administrator (or designee), adult family home provider, or corporate trainer, who has successfully completed the manager mental health specialty training. A qualified instructor under this subsection may teach caregiver specialty to caregivers employed at other home(s) licensed by the same licensee.

(b) Caregiver mental health specialty taught by a person who does not meet the requirements in subsection (2)(a) must meet the same requirements as the instructors for manager mental health specialty in subsection (1).

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0385, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0390 What are the minimum qualifications for instructors for manager and caregiver dementia specialty? (1) The minimum qualifications for instructors for manager dementia specialty, in addition to the general qualifications under WAC 388-112-0375, include:

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(a) The instructor must be experienced in dementia caregiving practices and capable of demonstrating competency in the entire course content;

(b) Education

(i) Bachelor's degree, registered nurse, or mental health specialist, with at least one year of education in seminars, conferences, continuing education or college classes, in dementia or subjects directly related to dementia, such as, but not limited to, psychology. (One year of education equals twenty-four semester hours, thirty-six quarter hours, or at least one hundred ninety-two hours of seminars, conferences, or continuing education.)

(ii) If required under WAC 388-112-0160, successful completion of the dementia specialty training, prior to beginning to train others.

(c) Work experience - Two years full-time equivalent direct work experience with people who have dementia; and

(d) Teaching experience

(i) Two hundred hours experience teaching dementia or closely related subjects; and

(ii) Successful completion of an adult education class or train the trainer as follows:

(A) For instructors teaching alternate curricula, a class in adult education that meets the requirements of WAC 388-112-0400, or a train the trainer class for the curriculum they are teaching;

(B) For instructors teaching DSHS-developed dementia specialty training, successful completion of the DSHS-developed train the trainer.

(d) Instructors who will administer tests must have experience or training in assessment and competency testing.

(2) Instructors for caregiver dementia specialty training:

(a) Caregiver dementia specialty may be taught by a boarding home administrator (or designee), adult family home provider, or corporate trainer, who has successfully completed the manager dementia specialty training. A qualified instructor under this subsection may teach caregiver specialty to caregivers employed at other home(s) licensed by the same licensee.

(b) Caregiver dementia specialty taught by a person who does not meet the requirements in subsection (2)(a) must meet the same requirements as the instructors for manager dementia specialty in subsection (1).

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0390, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0395 What are the minimum qualifications for instructors for manager and caregiver developmental disabilities specialty? (1) The minimum qualifications for instructors for manager developmental disabilities specialty, in addition to the general qualifications under WAC 388-112-0375, include:

(a) Education and work experience:

(i) Bachelor's degree with at least two years of full-time work experience in the field of disabilities; or

(ii) High school diploma or equivalent, with four years full time work experience in the field of developmental disabilities, including two years full time direct work experience with people who have a developmental disability.

[Title 388 WAC—p. 641]

(b) Successful completion of developmental disabilities specialty training under WAC 388-112-0120; and

(c) Teaching experience:

(i) Two hundred hours of teaching experience; and

(ii) Successful completion of adult education or train the trainer as follows:

(A) For instructors teaching alternative curricula, a class in adult education that meets the requirements of WAC 388-112-0400, or a train the trainer class for the curriculum they are teaching;

(B) For instructors teaching DSHS-developed developmental disabilities specialty training, successful completion of the DSHS-developed train the trainer.

(d) Instructors who will administer tests must have experience in assessment and competency testing.

(2) Instructors for caregiver developmental disabilities specialty training:

(a) Caregiver developmental disabilities specialty may be taught by a boarding home administrator (or designee), adult family home provider, or corporate trainer, who has successfully completed the manager developmental disabilities specialty training. A qualified instructor under this subsection may teach caregiver specialty to caregivers employed at other home(s) licensed by the same licensee.

(b) Caregiver developmental disabilities specialty taught by a person who does not meet the requirements in subsection (2)(a) must meet the same requirements as the instructors for manager developmental disabilities specialty in subsection (1).

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0395, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0400 What must be included in a class on adult education? A class on adult education must include content, student practice, and evaluation of student skills by the instructor in:

- (1) Adult education theory and practice principles;
- (2) Instructor facilitation techniques;
- (3) Facilitating learning activities for adults;
- (4) Administering competency testing; and
- (5) Working with adults with special training needs (for example, English as a second language or learning and literacy issues).

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0400, filed 7/11/02, effective 8/11/02.]

SECTION XIV—PHYSICAL RESOURCES AND STANDARD PRACTICES FOR TRAINING

WAC 388-112-0405 What physical resources are required for basic, modified basic, specialty, or nurse delegation core classroom training and testing? (1) Classroom space used for basic, modified basic, specialty, or nurse delegation core classroom training must be accessible to trainees and provide adequate space for learning activities, comfort, lighting, lack of disturbance, and tools for effective teaching and learning such as white boards and flip charts. Appropriate supplies and equipment must be provided for

teaching and practice of caregiving skills in the class being taught.

(2) Testing sites must provide adequate space for testing, comfort, lighting, and lack of disturbance appropriate for the written or skills test being conducted. Appropriate supplies and equipment necessary for the particular test must be provided.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0405, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0410 What standard training practices must be maintained for basic, modified basic, specialty, or nurse delegation core classroom training and testing? The following training standards must be maintained for basic, modified basic, specialty or nurse delegation core classroom training and testing:

(1) Training, including all breaks, must not exceed eight hours within one day;

(2) Training provided in short time segments must include an entire unit, skill or concept;

(3) Training must include regular breaks; and

(4) Students attending a classroom training must not be expected to leave the class to attend to job duties, except in an emergency.

[Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0410, filed 7/11/02, effective 8/11/02.]

Chapter 388-145 WAC EMERGENCY RESPITE CENTERS

WAC

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388-145-0020 What definitions apply to this chapter?

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388-145-0140 What first aid and cardiopulmonary resuscitation (CPR) training is required?
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388-145-0370	What are the requirements for fire drills?
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388-145-0440	What steps must I take to ensure children's safety around outdoor bodies of water?
388-145-0450	What measures must I take for pest control?
388-145-0460	What are the requirements regarding pets and animals at a center?
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388-145-0540	What are the requirements for medical policies and procedures for a center?
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388-145-0600	Are there general menu requirements?
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388-145-0710	What are the general requirements for bedrooms?

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388-145-0720	What are the requirements for beds?
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DIAPER CHANGING AND BATHING FACILITIES

388-145-0740	What are the requirements for diapers and diaper-changing areas?
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TELEPHONE/LIGHTING/VENTILATION/WATER/WASTE DISPOSAL

388-145-0760	Do I need a telephone?
388-145-0770	What are the lighting requirements?
388-145-0780	What are the requirements for ventilation?
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LAUNDRY, SINKS, AND TOILETS

388-145-0810	What are the requirements for laundry facilities?
388-145-0820	What are the requirements for washing clothes?
388-145-0830	Do I need a housekeeping sink?
388-145-0840	What are the requirements for handwashing sinks?
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388-145-0860	Must a center have toilet training equipment for children?

INDOOR PLAY AREAS

388-145-0870	What are the requirements for indoor play areas?
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OUTDOOR PLAY AREAS

388-145-0880	What are the requirements for an outdoor play area?
388-145-0890	What are the size requirements for an outdoor play area?
388-145-0900	What are the requirements for playground equipment?

TRANSPORTATION

388-145-0910	Are there requirements to follow when I transport children?
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CLIENT RECORDS

388-145-0920	What does the department require for keeping client records?
388-145-0930	What written information is needed before a child is admitted to a center?

CLIENT PROTECTION

388-145-0940	What are the requirements for protecting a child under my care from abuse or neglect?
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388-145-1020	What types of physical restraint are acceptable?
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388-145-1040	What must I do following an incident that involved using physical restraint?
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STAFFING RATIO

388-145-1060 What is the ratio of child care staff to children at a center?

SUPERVISION OF CHILDREN

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388-145-1190 Is in-service training required for staff?

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388-145-1200 What are the requirements for an activity program?
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PURPOSE

WAC 388-145-0010 What is the purpose of this chapter? The department issues or denies a license on the basis of compliance with licensing requirements. This chapter defines general and specific licensing requirements for emergency respite centers. Unless noted otherwise, these requirements apply to people who want to be licensed or relicensed to provide facility-based emergency respite care.

The department is committed to ensuring that children who receive emergency respite care experience health, safety, and well-being. We want these children's experiences to be beneficial to them not only in the short term, but also in the long term. Our licensing requirements reflect our commitment to children.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0010, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0020 What definitions apply to this chapter? The following definitions are important to understand these rules:

"Abuse or neglect" means injury, sexual abuse, sexual exploitation, negligent treatment or mistreatment of a child where the child's health, welfare and safety are harmed.

"Capacity" means the maximum number of children that a facility is licensed to care for at a given time.

"Children" or "youth," means individuals who are:

- (1) Under eighteen years old, including expectant mothers under eighteen years old; or
- (2) Up to twenty-one years of age with developmental disabilities.

"Child-placing agency" means an agency licensed to place children for temporary care, continued care, or adoption.

"Compliance agreement" means a written licensing improvement plan to address specific skills, abilities, or other issues of a fully licensed facility to maintain and/or increase the safety and well-being of children in their care.

"DCCCEL" means the division of child care and early learning. DCCCEL licenses child care homes and child care centers.

"DCFS" means the division of children and family services.

"DDD" means the division of developmental disabilities.

"DSHS" or "department" means the department of social and health services (DSHS).

"DLR" means the division of licensed resources.

"DOH" means the department of health.

"ERC" or "emergency respite center" is an agency that may be commonly known as a crisis nursery that provides emergency or crisis care for children to prevent child abuse or neglect.

"Firearms" means guns or weapons, including but not limited to the following: BB guns, pellet guns, air rifles, stun guns, antique guns, bows and arrows, handguns, rifles, and shotguns.

"Hearing" means the department's administrative review process.

"I" refers to anyone who operates or owns emergency respite center.

"Individual with developmental disabilities" means an individual who meets the eligibility requirements in RCW 71A.10.020 and WAC 388-825-030 for services. A developmental disability is any of the following: Mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition described in WAC 388-825-030. These conditions must originate before the age of eighteen years; be expected to continue indefinitely; and result in a substantial handicap.

"Infants" means children under one year of age.

"License" means a permit issued by the department affirming that a facility meets the licensing requirements.

"Licensor" means a division of licensed resources (DLR) employee at DSHS who:

- (1) Approves licenses or certifications for group facilities; and
- (2) Monitors facilities to ensure that they continue to meet health and safety requirements.

"Nonambulatory" means not able to walk.

"Nonmobile" refers to children who are not yet walking, are unable to walk, or unable to use a wheelchair or other device to move about freely.

"Premises" means a facility's buildings and adjoining grounds that are managed by a person or agency in charge.

"Probationary license" means a license issued as a disciplinary measure to an individual or agency that has previously been issued a full license but is out of compliance with licensing standards.

"Respite" means brief, relief care provided to parents or legal guardians with the child care provider fulfilling some or all of the functions of the care-taking responsibilities of the parent or guardian.

"Severe developmental disabilities" means significant disabling, physical and/or mental condition(s) that cause a child to need external support for self-direction, self-support and social participation.

"Universal precautions" is a term relating to procedures designed to prevent transmission of bloodborne pathogens in health care and other settings. Under universal precautions (sometimes call standard precautions), blood or other potentially infectious materials of all patients should always be considered potentially infectious for HIV and other pathogens. Individuals should take appropriate precautions using personal protective equipment like gloves to prevent contact with blood.

"Washington state patrol fire protection bureau" is the name of the state agency commonly called the **"state fire marshal"** with authority and responsibility for the inspection of life and fire safety of facilities caring for six or more children.

"We" or **"our"** refers to the department of social and health services, including DLR licensors and DCFS social workers.

"You" refers to anyone who operates an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0020, filed 3/26/03, effective 4/26/03.]

GENERAL INFORMATION

WAC 388-145-0030 What is an emergency respite center? An emergency respite center is an agency that may be commonly known as a crisis nursery, which provides emergency or crisis care for nondependent children to prevent abuse and/or neglect for up to seventy-two hours.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0030, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0040 What services may be provided or arranged for by the emergency respite center? An emergency respite center may provide the following:

- (1) The provision of direct child care;
- (2) A family assessment;
- (3) Appropriate community service referrals; and/or
- (4) Family support services.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0040, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0050 Are there services an emergency respite center may not provide? The services provided by an emergency respite center may not substitute for those provided by:

- (1) Crisis residential centers;
- (2) HOPE centers; or
- (3) Any other services required under chapter 13.32A (Family reconciliation services) or 13.34 RCW (Child welfare).

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0050, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0060 What age children may a center serve? (1) Emergency respite centers may provide care for children from birth through seventeen years.

(2007 Ed.)

(2) There is one situation when an emergency respite center may provide care for a person eighteen through twenty years of age. That situation is when an eighteen through twenty-year old person is developmentally disabled and admitted with a sibling who is under eighteen.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0060, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0070 Who may place children at a center? A parent or legal guardian of a child may voluntarily place a child in an emergency respite center for up to seventy-two hours.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0070, filed 3/26/03, effective 4/26/03.]

APPLICATION

WAC 388-145-0080 Is a license required? (1) In most situations, a license is required to provide child care at an emergency respite center.

(2) The department does not require licenses for people providing care in any of the situations defined in RCW 74.15.020(2). Examples are relatives, school nurseries, and hospitals.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0080, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0090 How old do I have to be to apply for a license? You must be at least twenty-one years old to apply for a license to provide care to children at an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0090, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0100 What personal characteristics must a person have to provide care to children at a center? If a person is requesting a license or a position as an employee, volunteer, intern, or contractor in an emergency respite center, he/she must:

(1) Demonstrate an understanding, ability, physical health, emotional stability and personality suited to meet the physical, mental, emotional, and social needs of the children under his/her care.

(2) Be able to furnish the child with a nurturing, respectful, supportive, and responsive environment.

(3) Not have been disqualified by our background check (chapter 388-06 WAC) before having unsupervised access to children.

(4) Not have been found to have committed child abuse or neglect.

(5) Not have had a license denied or revoked from an agency that provides care to children or vulnerable adults, unless the department determines that the denial or revocation was not based on a factor that may pose a risk to the health, safety or welfare of children.

[Statutory Authority: RCW 74.15.030, 74.15.280. 05-11-008, § 388-145-0100, filed 5/4/05, effective 6/4/05. Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0100, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0110 What personal information may I be required to provide to be licensed? (1) The department may request additional information at any time and it may include, but is not limited to:

- (a) Substance and alcohol abuse evaluations and/or documentation of treatment;
 - (b) Psychiatric evaluations;
 - (c) Psycho-sexual evaluations; and
 - (d) Medical evaluations and/or medical records.
- (2) The applicant/licensee pays for any evaluation requested by the department.

(3) The applicant/licensee must give permission for the licenser to speak with the evaluator/provider before and after the evaluation.

(4) If an applicant or licensee refuses to comply with subsections (1), (2), or (3) of this section, then DLR may deny the application or revoke the license.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0110, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0120 How do I apply for a license? (1) To apply for an emergency respite center license, the person or legal entity responsible for the center must send the application form to your licenser at DLR.

(2) With the application form, you must send the following information:

(a) Written verification for each applicant and staff person of completion of:

- (i) A tuberculosis test or X ray unless you can demonstrate medical reasons prohibiting the test;
- (ii) First-aid and cardio-pulmonary resuscitation (CPR) training appropriate to the age of the children in care; and
- (iii) HIV/AIDS and bloodborne pathogens training including infection control standards.

(b) A completed background check form for each applicant, staff person, board member, intern or volunteer on the premises who:

- (i) Is at least sixteen years old; and
- (ii) Has unsupervised access to children (emergency respite centers must comply with chapter 388-06 WAC regarding background checks).

(3) If you, any staff person, board member, intern, or volunteer has lived in Washington state less than three years and will have unsupervised access to children, you must provide us with a completed FBI fingerprint form.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0120, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0130 What is required to document completed background checks on staff? The licensee of an emergency respite center must keep a log of all background check results of employees, volunteers, and interns on the premises of the center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0130, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0140 What first aid and cardiopulmonary resuscitation (CPR) training is required? (1) You and your staff at an emergency respite center must have the following current first-aid and CPR training:

- (a) Basic standard first aid; and

(b) Age-appropriate cardiopulmonary resuscitation (CPR).

(2) Approved first aid and CPR training must be in accordance with a nationally recognized standard.

(3) A person with first aid and CPR training must be on the premises of an emergency respite center at all times, when children are present.

(4) The requirement for CPR training may be waived for persons with a statement from their physician that the training is not advised for medical reasons. This person must not be the only person on the premises when children are present.

(5) You must keep records in your center showing who has completed current first aid and CPR training. This includes copies of the certificate of completion for the training for each staff person.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0140, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0150 What HIV/AIDS and blood-borne pathogens training is required? (1) You must provide or arrange for training for yourself and your staff at an emergency respite center on infection control, prevention, transmission, and treatment of HIV and AIDS and blood-borne pathogens.

(2) You must use infection control requirements and educational material consistent with the approved current curriculum "*Know - HIV/AIDS Prevention Education for Health Care Facility Employees*," published by the department of health, office on HIV/AIDS.

(3) Child care workers and anyone else providing direct care to children at an emergency respite center must use universal precautions (see definitions) when coming in contact with the bodily fluids or secretions of a child.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0150, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0160 How long do I have to complete the licensing application packet? (1) You must complete your licensing application with supporting documents, such as training certificates, within ninety days of first applying for your emergency respite center license.

(2) If you fail to meet this deadline and have not contacted your licenser, your licenser may consider your application withdrawn.

(3) If you are applying for a license renewal, you must send the application form to your licenser at least ninety days prior to the expiration of your current license.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0160, filed 3/26/03, effective 4/26/03.]

LICENSING AND PROGRAM APPROVAL

WAC 388-145-0170 Does the department need to approve the program I offer? (1) The department must approve the program that you have developed for children under your care at an emergency respite center.

(2) You must send to DLR a detailed written program description outlining educational, recreational, and any therapeutic services you will provide to children and their families.

(3) A sample of the schedule of daily activities for children under care must be included with the program description.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0170, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0180 May a facility have more than one type of license? (1) A facility-based emergency respite center licensed by the division of licensed resources may also be licensed as a child care center by the division of child care and early learning.

(2) The licensee must meet the requirements for both licenses and the have written approval for both licenses from each division.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0180, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0190 What hours may a center be open? An emergency respite center may choose to be open up to twenty-four hours a day, seven days a week.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0190, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0200 How does the department decide how many children a center may serve? (1) The department approves the number of children that an emergency respite center may serve based on an evaluation of these factors:

- (a) Physical accommodations in the center;
- (b) The number of staff, family members and volunteers available for providing care;
- (c) Your skills and the skills of your staff;
- (d) The ages and characteristics of the children you are serving;
- (e) The evaluation of fire safety by the Washington state patrol fire protection bureau; and
- (f) The evaluation of health and safety by the department of health.

(2) Based on the evaluation, the department may license you for the care of fewer children than your facility could house.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0200, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0210 Will the department grant exceptions to the licensing requirements? (1) At its discretion, the department may make exceptions to the licensing requirements for emergency respite centers. The exceptions:

- (a) Must regard only nonsafety requirements.
- (b) Must not compromise the safety and well being of the children receiving care.

(2) You must make a written request for an exception to the licensing requirements.

(3) After granting an exception to a licensing requirement, the department may:

- (a) Limit or restrict your license; and/or
- (b) Require you to enter into a compliance agreement to ensure the safety and well being of the children in your care.

(2007 Ed.)

(4) You must keep a copy of the approved exception and any compliance agreement to the licensing requirements for your files.

(5) You do not have appeal rights if the department denies your request for an exception to our requirements.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0210, filed 3/26/03, effective 4/26/03.]

CORRECTIVE ACTION

WAC 388-145-0220 Does the department issue probationary licenses? (1) The department may issue an emergency respite center a probationary license as part of a corrective action plan with a licensed provider.

(2) The department must base its decision about whether to issue a probationary license on the following:

- (a) Intentional or negligent noncompliance with the licensing rules;
- (b) A history of noncompliance with the rules;
- (c) Current noncompliance with the rules;
- (d) Evidence of a good faith effort to comply; and
- (e) Any other factors relevant to the specific situation.

(3) A probationary license may be issued for up to six months. At its discretion, the department may extend the probationary license for an additional six months.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0220, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0230 When is a license denied, suspended or revoked? (1) An emergency respite center license must be denied, suspended or revoked if the department decides that you cannot provide care for children in a way that ensures their safety, health and well-being.

(2) The department must deny, suspend, or revoke your license for any of the reasons that follow:

(a) Your facility fails to meet the health and safety requirements to receive a certificate of compliance as required by the department of health and/or Washington state patrol fire protection bureau.

(b) You or anyone on the premises have been disqualified by your background check (see chapter 388-06 WAC).

(c) You or anyone on the premises have been found to have committed child abuse or neglect, or you treat, permit or assist in treating children in your care with cruelty, indifference, abuse, neglect, or exploitation, unless the department determines that you do not pose a risk to a child's safety, well-being, and long-term stability.

(d) You or anyone on the premises had a license denied or revoked from an agency that provided care to children or vulnerable adults, unless the department determines that the denial or revocation was not based on a factor that may pose a risk to the health, safety or welfare of children.

(e) You try to get a license deceitfully, such as making false statements or leaving out important information on the application.

(f) You commit, permit or assist in an illegal act on the premises of an emergency respite center providing care to children.

(g) You are using illegal drugs, or excessively using alcohol and/or prescription drugs.

(h) You knowingly allowed employees or volunteers with false statements on their applications to work at your agency.

(i) You repeatedly lack qualified or an adequate number of staff to care for the number and types of children under your care.

(j) You have refused to allow our authorized staff and inspectors to have requested information or access to your facility, child and program files, and/or your staff and clients.

(k) You are unable to manage the property, fiscal responsibilities, or staff in your agency.

(l) You have failed to comply with the federal and state laws for any Native American children that you have under care.

[Statutory Authority: RCW 74.15.030, 74.15.280, 05-11-008, § 388-145-0230, filed 5/4/05, effective 6/4/05. Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230, 03-08-026, § 388-145-0230, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0240 Are there any other reasons that could potentially cause me to lose my license? (1) The department may suspend or revoke your emergency respite center license if you go beyond the conditions of your license by:

(a) Having more children than your license allows; or

(b) Having children with ages different than your license allows.

(2) The department also may suspend or revoke your license if you:

(a) Fail to provide a safe, healthy and nurturing environment for children under your care; or

(b) Fail to comply with any of our other licensing requirements.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230, 03-08-026, § 388-145-0240, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0250 What happens when a licensor is notified that a licensee has received a noncompliance support order from the division of child support? (1) The department must suspend an emergency respite care license, if the licensor receives a notice from the division of child support that the licensee is not in compliance with a support order under authority of RCW 43.20A.205 and 74.20A.320.

(2) In this situation, the suspension of a center license, for noncompliance of a support order, would be effective on the date the licensee receives a notice from the licensor.

(3) The license remains suspended until the licensee provides proof that he or she is in compliance with the child support order.

(4) The licensee does not have a right to an administrative hearing based on a suspension of the center license due to noncompliance of a child support order.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230, 03-08-026, § 388-145-0250, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0260 How will the department notify me if my license is denied, suspended, or revoked? (1) The department sends you a certified letter informing you of any decision to deny, suspend or revoke your emergency respite center license.

[Title 388 WAC—p. 648]

(2) In the letter, the department also informs you what you may do if you disagree with the decision of the department to deny, suspend or revoke your emergency respite center license.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230, 03-08-026, § 388-145-0260, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0270 What may I do if I disagree with the department's decision to deny, suspend or revoke my license? (1) You have the right to appeal any decision the department makes to deny, suspend, or revoke your emergency respite center license. The exception is outlined in WAC 388-145-0250 and deals with noncompliance of a child support order.

(2) Your right to appeal and the procedures for that process are outlined in RCW 43.20A.205 and 74.14.130, chapter 34.05 RCW, and chapter 388-02 WAC.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230, 03-08-026, § 388-145-0270, filed 3/26/03, effective 4/26/03.]

POSTING LICENSE AND REPORTING CHANGES

WAC 388-145-0280 Where do I post my license? You must post your emergency respite center license where the public can easily view it.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230, 03-08-026, § 388-145-0280, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0290 What changes to my center must I report to my licensor? (1) You must report to your licensor immediately any changes in the original emergency respite center licensing application. This includes changes in:

(a) Your location or designated space, including address;

(b) Your phone number;

(c) The maximum number, age ranges, and sex of children you wish to serve; or

(d) The structure of your facility or on the premises from events causing damage, such as a fire, or from remodeling.

(2) A license is valid only for the person or organization named on the license at a specific address. If you operate an emergency respite center, you must also report any of the following changes to your licensor:

(a) A change of your agency's executive director;

(b) The death, retirement, or incapacity of the person who holds the license;

(c) A change in the name of a licensed corporation, or the name by which your center is commonly known; or

(d) Changes in an agency's articles of incorporation and bylaws that apply to the operation or the license of the facility.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230, 03-08-026, § 388-145-0290, filed 3/26/03, effective 4/26/03.]

FIRE SAFETY

WAC 388-145-0300 Must I comply with the requirements of the Washington state patrol fire protection bureau to receive a license? (1) An emergency respite center must comply with the requirements for fire safety of the Washington state patrol fire protection bureau under WAC 212-12-210.

(2007 Ed.)

(2) The Washington state patrol fire protection bureau will issue a notice of approval for licensing to the licensing agency when you have met their requirements for fire safety.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0300, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0310 Do I need to notify the local fire department of the location of my center? You must notify the local fire authority of the location of your emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0310, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0320 Are local ordinances part of the licensing requirements? (1) Local ordinances (laws), such as zoning regulations and local building codes, are outside the scope of the licensing requirements for an emergency respite center.

(2) The department may require you to provide proof that you have met local ordinances.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0320, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0330 Are there other fire safety requirements for inside a center? An emergency respite center must comply with the fire safety requirements that follow.

(1) Every sleeping room used by children under care must have at least one operable window or door approved for emergency escape or rescue that must open directly into a public street, public alley, yard, or exit court.

(2) Centers with floors located more than four feet above or below grade (one-half story) must not be used for care of nonambulatory children.

(3) Emergency windows must:

(a) Be operable from the inside to provide a full, clear opening without the use of separate tools;

(b) Have a minimum net clear open area of 5.7 square feet;

(c) Have a minimum net clear open height dimension of twenty-four inches;

(d) Minimum net clear open width dimension of twenty inches;

(e) Have a finished sill height of not more than forty-four inches above the floor.

(4) No child may occupy a space that is accessible only by a ladder, folding stairs, or a trap door.

(5) Every bathroom door lock must be designed to permit the opening of the locked door from the outside.

(6) Every closet door latch must be designed to open from the inside.

(7) Open-flame devices and fireplaces, heating and cooking appliances, and products capable of igniting clothing must not be left unattended or used incorrectly.

(8) Fireplaces, wood stoves and other heating systems that have a surface hot enough to cause a burn must have a barrier to prevent access by children under age six years.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0330, filed 3/26/03, effective 4/26/03.]

(2007 Ed.)

WAC 388-145-0340 What are the requirements for smoke detectors? (1) Emergency respite centers licensed for sixteen or more residents must have an approved automatic and manual fire alarm system.

(2) Operation of any fire alarm activating device must automatically, without delay, activate off-site monitoring and signal a general alarm indication and sound an audible alarm throughout the building or affected part of the building.

(3) Emergency respite centers licensed for fewer than sixteen persons must have smoke detectors installed in all sleeping room, corridors, and in areas separating use areas from sleeping areas.

(4) Smoke detectors must be installed following the approved manufacturer's instructions.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0340, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0350 What are the requirements for a fire evacuation plan? (1) You must develop a written fire evacuation plan for your emergency respite center.

(2) The evacuation plan must include:

(a) An evacuation floor plan, identifying exit doors and windows;

(b) Action that the person discovering a fire must take;

(c) Methods for sounding an alarm on the premises;

(d) Ways to evacuate the building that ensures responsibility for children; and

(e) Action that staff must take while waiting for the fire department.

(3) The plan must be posted at each exit door.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0350, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0360 What fire prevention measures must I take? The department requires that you must take the following fire prevention measures for your emergency respite center:

(1) You must assure that furnace rooms are:

(a) Maintained free of lint, grease, and rubbish; and

(b) Suitably isolated, enclosed, or protected.

(2) Flammable or combustible materials must be stored away from exits and in areas that are not accessible to children. Combustible rubbish must not be allowed to collect and must be removed from the building or stored in closed, metal containers away from building exits.

(3) All trash must be removed daily from the building and thrown away in a safe manner outside the building. All containers used for the disposal of waste material must consist of noncombustible materials and have tops.

(4) All electrical motors must be kept free of dust.

(5) Open-flame devices capable of igniting clothing must not be left on, unattended or used in a manner that could result in an accidental ignition of children's clothing.

(6) Candles must not be used.

(7) All electrical circuits, devices and appliances must be properly maintained. Circuits must not be overloaded. Extension cords and multiplug adapters must not be used in place of permanent wiring and proper outlets.

(8) Fireplaces, woodstoves, and similar devices must be installed and approved according to the rules that were in effect at the time of installation (see the local building per-

mit). These devices must be properly maintained and must be cleaned and certified at least once a year or maintained according to the manufacturer's recommendations.

(9) Separate hazardous areas by at least a "one-hour" fire-resistant wall. Hazardous areas include rooms or spaces containing:

- (a) A commercial-type cooking kitchen;
- (b) A boiler;
- (c) A maintenance shop;
- (d) A janitor closet;
- (e) A woodworking shop;
- (f) A vehicle garage;
- (g) Flammable or combustible materials; or
- (h) Painting operations.

(10) The department does not require a fire-resistant wall when:

- (a) A kitchen contains only a domestic cooking range; and
- (b) Food preparation does not produce smoke or grease-laden vapors.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0360, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0370 What are the requirements for fire drills? (1) You must conduct monthly fire drills to test and practice the evacuation procedures.

(2) The monthly fire drill must be conducted on each shift, so that each person providing care to children participates in the drill.

(3) You must consult with and follow the Washington state patrol fire protection bureau protocol for "mock" fire drills, if you care for nonambulatory children.

(4) You must maintain a written record on the premises that indicates the date and time that drill practices were completed at your emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0370, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0380 What fire safety procedures do center staff need to know? You and your staff at an emergency respite center must be familiar with:

- (1) Safety procedures related to fire prevention; and
- (2) All aspects of a fire drill.
- (3) Your and your staff must be able to:
 - (a) Operate all fire extinguishers installed on the premises;
 - (b) Test smoke detectors (single station types);
 - (c) Conduct frequent inspections of the facility to identify fire hazards; and
 - (d) Correct any hazards noted during the inspection.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0380, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0390 What are the requirements for fire sprinkler systems? (1) Where a sprinkler system is required, a system complying with the uniform building code standards must be installed.

(2) A Washington state licensed fire sprinkler contractor must annually test and certify sprinkler systems installed in an emergency respite center for fire prevention.

[Title 388 WAC—p. 650]

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0390, filed 3/26/03, effective 4/26/03.]

HEALTH AND ENVIRONMENT

WAC 388-145-0400 Does an ERC need approval from the department of health to operate? (1) An emergency respite center must receive a certificate of compliance from the department of health before the department (DSHS) will issue an emergency respite center license.

(2) The department of health (DOH) conducts the health and safety survey. A registered nurse (RN) and/or a public health sanitarian may complete the survey.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0400, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0410 What are the physical structure safety requirements for a center? You must keep the equipment and the physical structures in your emergency respite center safe and clean for the children you serve. You must:

(1) Maintain your buildings, premises, and equipment in a clean and sanitary condition, free of hazards, and in good repair.

(2) Provide handrails for steps, stairways, and ramps, if required by the department.

(3) Have emergency lighting devices available and in operational condition.

(4) Furnish your center appropriately, based on the age and activities of the children under care.

(5) Have washable, water-resistant floors in your center bathrooms, kitchens, and any other rooms exposed to moisture. The department may approve washable, short-pile carpeting that is kept clean and sanitary for your facility's kitchens.

(6) Provide tamper proof or tamper resistant electrical outlets or blank covers installed in areas accessible to children under the age of six or other persons with limited mental capacity or who might be endangered by access to them.

(7) Have easy access to rooms occupied by children in case an emergency arises. Some examples are bedrooms, toilet rooms, shower rooms, and bathrooms.

(8) Have a written disaster plan for emergencies such as fire and earthquakes.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0410, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0420 What are the requirements for the location of a center? (1) Your center must be located on a well-drained site, free from hazardous conditions. Some examples of hazards are natural or man-made water hazards such as lakes or streams, steep banks, ravines, and busy streets.

(2) The safety of the children in care is paramount. You must discuss with the licensor any potential hazardous conditions, considering the children's ages, behaviors, and abilities.

(3) If the department decides that hazardous conditions are present at the emergency respite center, a supervision plan must be written for the children in care.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0420, filed 3/26/03, effective 4/26/03.]

(2007 Ed.)

WAC 388-145-0430 What are the requirements for emergency aid vehicle access to my center? (1) Your emergency respite center must be accessible to emergency vehicles.

(2) Your address must be clearly visible on the facility or mailbox so that firefighters or medics can easily find your center location.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0430, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0440 What steps must I take to ensure children's safety around outdoor bodies of water? (1) You must ensure children in your care at an emergency respite center are safe around bodies of water.

(2) On a daily basis, you must empty and clean any portable wading pool that children use.

(3) When they are swimming, wading, or near a body of water, children under twelve must be in continuous visual or auditory range at all times by an adult with current first aid and age appropriate CPR.

(4) You must ensure age and developmentally appropriate supervision of any child that uses hot tubs, swimming pools, spas, and other man-made and natural bodies of water.

(5) You must lock hot tubs and spas when they are not in use.

(6) You must place a fence designed to discourage climbing and have a locking gate around a pool. The pool must be inaccessible to children when not in use.

(7) A certified lifeguard must be on duty when children are using a public or private swimming pool.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0440, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0450 What measures must I take for pest control? You must make reasonable attempts, using the least toxic methods, to keep the premises of the emergency respite center free from pests. This includes rodents, flies, cockroaches, fleas, and other insects.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0450, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0460 What are the requirements regarding pets and animals at a center? (1) In an emergency respite center, you must not have any common household pets, exotic pets, other animals, birds, insects, reptiles, or fish that are dangerous or provide a risk to the children in care.

(2) Common household pets, exotic pets, animals, birds, insects, reptiles, and fish must:

(a) Be cared for in compliance with state regulations and local ordinances; and

(b) Be free from disease and cared for in a safe and sanitary manner.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0460, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0470 Are alcoholic beverages allowed at a center? You can not have alcohol on the premises of an emergency respite center. The staff of the center may not consume alcohol on the premises or during breaks.

(2007 Ed.)

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0470, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0480 Is smoking permitted around children? (1) You must prohibit smoking in the emergency respite center and in motor vehicles while transporting children.

(2) You may permit adults to smoke outdoors away from children.

(3) Nothing in this section is meant to interfere with traditional or spiritual Native American ceremonies involving the use of tobacco.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0480, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0490 May I have firearms at a center? The department prohibits firearms, ammunition, and other weapons on the premises of an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0490, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0500 May I use wheeled baby walkers? The department prohibits the use of wheeled baby walkers in an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0500, filed 3/26/03, effective 4/26/03.]

STORAGE OF MEDICATIONS AND CHEMICALS

WAC 388-145-0510 Are there requirements for the storage of medications? At an emergency respite center:

(1) You must keep all medications, including pet medications, vitamins and herbal remedies, in locked storage.

(2) You must store external medications separately from internal medications.

(3) You must store medications according to the manufacturer or pharmacy instructions.

(4) Pet and human medications must be stored in separate places.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0510, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0520 Are there requirements for storing dangerous chemicals or other substances? (1) At an emergency respite center, you must store the following items in a place that is not accessible to children, persons with limited mental capacity, or anyone who might be endangered by access to the following products:

(a) Cleaning supplies;

(b) Toxic or poisonous substances;

(c) Aerosols; and

(d) Items with warning labels.

(2) When containers are filled with toxic substances from a stock supply, you must label the containers filled from a stock supply.

(3) Toxic substances must be stored separately from food items.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0520, filed 3/26/03, effective 4/26/03.]

FIRST-AID SUPPLIES**WAC 388-145-0530 Are first-aid supplies required?**

(1) At an emergency respite center, first-aid supplies must be kept on hand for immediate use, including nonexpired syrup of ipecac that is to be used only when following the instruction of the poison control center.

(2) The following first-aid supplies must be kept on hand:

- (a) Barrier gloves and one-way resuscitation mask;
- (b) Bandages;
- (c) Scissors and tweezers;
- (d) Ace bandage;
- (e) Gauze;
- (f) Thermometer; and
- (g) A first-aid manual.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0530, filed 3/26/03, effective 4/26/03.]

MEDICAL CARE AND MEDICATION MANAGEMENT

WAC 388-145-0540 What are the requirements for medical policies and procedures for a center? (1) Emergency respite centers must have written policies and procedures about the control of infections. These policies must include, but are not limited to, the following areas:

- (a) Isolation;
- (b) Aseptic procedures;
- (c) Reporting communicable diseases;
- (d) Hygiene, including hand washing, using the toilet, diapering, and laundering.

(2) Emergency respite centers must maintain current written medical policies and procedures to be followed on:

(a) Prevention of the transmission of communicable diseases including:

- (i) Handwashing for staff and children;
- (ii) Management and reporting of communicable diseases.

(b) Medication management, including steps to be taken if medication is incorrectly administered;

- (c) First aid;
- (d) Care of minor illnesses;
- (e) Actions to be taken for medical emergencies;
- (f) Infant care procedures when infants are under care;

and

- (g) General health practices.

(3) You must arrange to have one of the following help you develop and periodically review your medical policies and procedures:

- (a) An advisory physician,
- (b) A physician's assistant, or
- (c) A registered nurse.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0540, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0550 Must all children accepted for care have current immunizations? Emergency respite centers may accept a child who is not current with immunizations for care at an emergency respite center.

[Title 388 WAC—p. 652]

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0550, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0560 What must I do to prevent the spread of infections and communicable diseases? (1) You must take precautions to guard against infections and communicable diseases infecting the children under care in an emergency respite center.

(2) Staff with a reportable communicable disease in an infectious stage, as defined by the department of health, must not be on duty until they have a physician's approval for returning to work.

(3) Each center that cares for medically fragile children must have an infection control program supervised by a registered nurse.

(4) Applicants for a license or adults authorized to have unsupervised access to children in a center must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test upon being employed or licensed unless:

(a) The person has evidence of testing within the previous twelve months;

(b) The person has evidence that they have a negative chest X ray since previously having a positive skin test;

(c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis.

(5) The department does not require a tuberculin skin test if:

(a) A person has a tuberculosis skin test that has been documented as negative within the past twelve months; or

(b) A physician indicates that the test is medically unadvisable.

(6) Persons whose tuberculosis skin test is positive must have a chest X ray within thirty days following the skin test.

(7) The department does not require retesting at the time of license renewal, unless the licensee or staff person believes they have been exposed to someone with tuberculosis or if testing is recommended by their health care provider.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0560, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0570 How do I manage medications for children? You must meet specific requirements for managing prescription and nonprescription medication for children under your care. The requirements are:

(1) Only you or another authorized care provider may give or have access to medications for the child under your care.

(2) Only you or another authorized care provider may give prescription and nonprescription medications. Written approval of the child's parent or legal guardian is required to give the child any medication.

(3) You must keep a record of all medications you give a child.

(4) You or another authorized care provider must contact a pharmacist or the department of health regarding the proper disposal of medications that are not returned to the parent or legal guardian of the child.

(5) You must give certain classifications of nonprescribed medications, only with the dose and directions on the

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manufacturer's label for the age and/or weight of the child needing the medication. These nonprescribed medications include but are not limited to:

- (a) Nonaspirin antipyretics/analgesics, fever reducers/pain relievers;
- (b) Nonnarcotic cough suppressants;
- (c) Decongestants;
- (d) Antacids and anti-diarrhea medication;
- (e) Anti-itching ointments or lotions intended specifically to relieve itching;
- (f) Shampoo for the removal of lice;
- (g) Diaper ointments and powders intended specifically for use in the diaper area of children; and
- (h) Sun screen (for children over six months of age).

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0570, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0580 May I accept medicine from a child's parent or guardian? The only medicine you may accept from the child's parent or legal guardian is medicine in the original container labeled with:

- (1) The child's first and last names;
- (2) The date the prescription was filled;
- (3) The medication's expiration date; and
- (4) Legible instructions for the administration of the drug (manufacturer's instructions or prescription label).

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0580, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0590 When may children take their own medicine? (1) You may permit children under your care to take their own medicine as long as:

- (a) They are physically and mentally capable of properly taking the medicine; and
 - (b) The child's parent or legal guardian approves in writing.
- (2) You must keep the written approval by the child's parent or legal guardian in your records.

(3) When children take their own medication, the medication and medical supplies must be kept locked or inaccessible to other children and unauthorized persons.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0590, filed 3/26/03, effective 4/26/03.]

FOOD/DIET/MENUS

WAC 388-145-0600 Are there general menu requirements? The department has menu requirements for emergency respite centers.

(1) Your program must be in compliance with the department of health standards in chapter 246-215 WAC on food service sanitation.

(2) You must prepare and date daily menus, including snacks, at least one week in advance.

(3) You must provide for the proper storage, preparation, and service of food to meet the needs of the program.

(4) A menu must specify a variety of foods for adequate nutrition and meal enjoyment.

(5) You must keep the menus on file for a minimum of six months so that we can review your menus.

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(6) You must post each person's dietary restrictions, if any, for staff to follow.

(7) You must post a schedule of mealtimes.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0600, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0610 How often must I feed children at a center? (1) You must provide all children a minimum of three meals in each twenty-four hour period. You may vary from this guideline only if you write to your licensor requesting a change and the request is approved by DLR.

(2) The time interval between the evening meal or snack and breakfast must not be more than fourteen hours.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0610, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0620 How do I handle a child's special diet? Unless a child is admitted to an emergency respite center with a written physician's order as medically necessary for the child, the following must not be served:

- (1) Nutrient concentrates, supplements, or amino acids;
- (2) Vitamins; or
- (3) Modified diets.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0620, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0630 Do you have special requirements for serving milk? (1) You must serve only pasteurized milk or a pasteurized milk product.

(2) You may not serve the following types of milk to any child under twenty-four months of age unless you have written permission by a physician, or parent or legal guardian:

- (a) Skim milk;
- (b) Reconstituted nonfat dry milk; and
- (c) One and two percent butterfat milk.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0630, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0640 What home canned foods may I use? You may not serve home canned foods to children at an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0640, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0650 What requirements must I meet for feeding babies? You must meet the following requirements for feeding babies:

(1) If more than one child is bottle-fed, all formulas must be in sanitized bottles with nipples and labeled with the child's name and date prepared.

(2) You must refrigerate filled bottles if the bottles are not used immediately. Contents must be discarded if not used within twenty-four hours.

(3) If you reuse bottles and nipples, you must sanitize them.

(4) Infants who are six months of age or over may hold their own bottles as long as an adult remains in the room, within eyesight. You must take bottles from the child when the child finishes feeding, or when the bottle is empty.

(5) You must not prop a bottle when feeding an infant.

[Title 388 WAC—p. 653]

(6) To prevent uneven heating, formula must not be warmed in a bottle used for feeding in a microwave oven.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0650, filed 3/26/03, effective 4/26/03.]

ROOM REQUIREMENTS

WAC 388-145-0660 Are there room requirements?

(1) You must provide rooms that are ample in size and properly furnished for the number of children you serve at an emergency respite center.

(2) With more than twelve children, you must provide at least one separate indoor recreation area. Its size and location must be sufficient for the age and number of the children using it to engage in recreational and informal education activities.

(3) You must provide a room or area that is used as an administrative office. In addition, suitable offices must be provided for social service staff. In facilities caring for fewer than thirteen children, these offices may be combined with the administrative office.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0660, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0670 What does the room temperature at a center need to be? (1) You must maintain the temperature within your emergency respite center facility at a reasonable level while occupied. This would normally be a minimum of sixty-eight degrees Fahrenheit during awake hours and a minimum of sixty-five degrees Fahrenheit during sleeping hours.

(2) You must consider the age and needs of the children under your care in determining appropriate temperature.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0670, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0680 What are the kitchen requirements? (1) You must provide facilities to properly store, prepare, and serve food to meet the needs of the children under your care at your emergency respite center.

(2) All food service facilities and food handling practices must comply with rules and regulations of the state board of health governing food service sanitation (see chapter 246-215 WAC). This includes food handler's permit for all staff.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0680, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0690 May I use the kitchen for activities for children? Children are not allowed in the kitchen of an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0690, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0700 May a room be used for more than one purpose? At your emergency respite center you may use a room for multiple purposes such as playing, dining, napping, and learning activities, provided that:

(1) The room is of sufficient size; and

(2) The room's usage for one purpose does not interfere with usage of the room for another purpose.

[Title 388 WAC—p. 654]

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0700, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0710 What are the general requirements for bedrooms? You must meet all the following requirements for bedrooms if you provide full-time care at an emergency respite center.

(1) An adult must be on the same floor or within easy hearing distance and accessibility to where children under six years of age are sleeping.

(2) Any room used for sleeping must be at least thirty-five square feet per child.

(3) Bedrooms must have both:

(a) Adequate ceiling height for the safety and comfort of the occupants (normally, seven and a half feet); and

(b) At least one window of not less than one-tenth of the required floor space that opens to the outside. This allows natural light into the bedroom and permits emergency access or exit.

(4) The number of beds allowed at an emergency respite center is established in consultation with the DOH surveyor for each facility.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0710, filed 3/26/03, effective 4/26/03.]

BEDS AND CRIBS

WAC 388-145-0720 What are the requirements for beds? (1) Children in overnight care must have their own bed at an emergency respite center. The bed must be at least twenty-seven inches wide with a clean and comfortable mattress in good condition.

(2) For each child in care, you must provide a pillow and pillowcase, blankets, and sheets.

(3) Pillows must be covered with waterproof material or be washable.

(4) Bedding must be clean.

(5) You must provide waterproof mattress covers or moisture resistant mattresses, if needed.

(6) You may use toddler beds with a standard crib mattress that is sufficient in length and width for the comfort of children.

(7) You must not allow children to use the loft style beds or upper bunks of double-deck beds if using them due to age, development or condition could hurt them. Examples: Preschool age children and children with disabilities.

(8) If a cot is used as the bed, the licensee must ensure the child's cot is of sufficient length and width, and constructed to provide adequate comfort for the child to sleep. The licensee must ensure that the cot surface is of a material that can be cleaned with a detergent solution, disinfected, and allowed to air dry.

(9) You must not use canvas cots.

(10) A mat may be used for napping but not as a substitute for a bed.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0720, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0730 Are there requirements for the use of cribs? (1) You must provide an infant with a crib that

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ensures the safety of the infant and complies with chapter 70.111 RCW, Infant Crib Safety Act.

(2) Cribs must have no more than two and three-eighths inches space between vertical slats when used for infants less than six months of age.

(3) Cribs, infant beds, bassinets, and playpens must:

(a) Have clean, firm, snug fitting mattresses covered with waterproof material that is easily sanitized; and

(b) Be made of wood, metal, or approved plastic with secure latching devices

(4) Crib bumpers, stuffed toys, and pillows must not be used in cribs, infant beds, bassinets, or playpens.

(5) You must follow the recommendation of the American Academy of Pediatrics, 1-800-505-CRIB, placing infants on their backs each time for sleep.

(6) The distance between each crib/bed must provide enough space for exiting and allow staff access to children. Normally, this would be thirty inches.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0730, filed 3/26/03, effective 4/26/03.]

DIAPER CHANGING AND BATHING FACILITIES

WAC 388-145-0740 What are the requirements for diapers and diaper-changing areas? At an emergency respite center, you must follow the requirements for diapers, diaper-changing rooms, and potty-chairs.

(1) You must separate diaper-changing areas from food preparation areas.

(2) You must sanitize diaper-changing areas between each use or you must use a nonabsorbent, disposable covering that is discarded after each use.

(3) For cleaning children, you must use either disposable towels or clean cloth towels that have been laundered between each use.

(4) You and any caregiver must wash hands before and after diapering each child.

(5) You must use disposable diapers, a commercial diaper service, or reusable diapers supplied by the child's family.

(6) Diaper-changing procedures must be posted at the changing areas.

(7) Diaper-changing areas must be adjacent to a hand-washing sink.

(8) The staff must be within arms-length of the child being diapered at all times while changing diapers. The use of safety belts is prohibited.

(9) Diaper-changing tables or surfaces must have a barrier or edge that is a minimum of four inches above the pad or six inches above the top of the table.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0740, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0750 What are the requirements for bathing facilities? Emergency respite centers must comply with the requirements that follow.

(1) Bathing facilities must be inaccessible to children when not in use.

(2) Preschool age and younger children must be supervised while using bathing facilities.

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(3) Bathing facilities must be equipped with a conveniently located grab bar or other safety device such as a non-skid pad.

(4) The ratio of bathing facilities to children in care must be 1:8.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0750, filed 3/26/03, effective 4/26/03.]

TELEPHONE/LIGHTING/VENTILATION/WATER/WASTE DISPOSAL

WAC 388-145-0760 Do I need a telephone? (1) You must have at least one telephone on the premises for incoming and outgoing calls. The telephone must be accessible for emergency use at all times.

(2) You must post emergency phone numbers next to the phone.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0760, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0770 What are the lighting requirements? (1) You must locate light fixtures and provide lighting that promotes good visibility and comfort for the children under your care at your emergency respite center.

(2) Emergency respite centers must have nonhazardous light fixture covers or shatter resistant (or otherwise made safe) light bulbs or tubes.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0770, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0780 What are the requirements for ventilation? (1) You must ensure that your physical facility is ventilated for the health and comfort of the persons under your care at the emergency respite center.

(2) A mechanical exhaust fan to the outside must ventilate toilets and bathrooms, and utility rooms with mop sinks that do not have windows opening to the outside.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0780, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0790 What are the requirements about drinking water? (1) You must provide the following:

(a) A public water supply or a private water supply approved by the local health authority at the time of licensing or relicensing; and

(b) Disposable paper cups, individual drinking cups or glasses, or angled jet type drinking fountains.

(2) You must not use bubbler type fountains or common drinking cups.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0790, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0800 What are the requirements for sewage and liquid wastes? Emergency respite centers must discharge sewage and liquid wastes into a public sewer system or into a functioning septic system.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0800, filed 3/26/03, effective 4/26/03.]

LAUNDRY, SINKS, AND TOILETS

WAC 388-145-0810 What are the requirements for laundry facilities? The department has specific requirements for laundry facilities at an emergency respite center.

(1) You must have separate and adequate facilities for storing soiled and clean linen.

(2) You must provide adequate laundry and drying equipment, or make other arrangements for getting laundry done on a regular basis.

(3) You must locate laundry equipment in an area separate from the kitchen and child care areas.

(4) Laundry equipment must be vented to the outdoors.

(5) You must make laundry equipment inaccessible to young children.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0810, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0820 What are the requirements for washing clothes? You must use an effective way to sanitize laundry contaminated with urine, feces, lice, scabies, or other potentially infectious materials at your emergency respite center. You must sanitize laundry through temperature control or the use of chemicals.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0820, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0830 Do I need a housekeeping sink? Facilities licensed to provide emergency respite care must have and use a housekeeping sink or DOH-approved method of drawing clean mop water and disposing of the wastewater.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0830, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0840 What are the requirements for handwashing sinks? (1) An emergency respite center must supply children with warm running water for handwashing. The water must be kept at a temperature range of not less than eighty-five degrees Fahrenheit and not more than one hundred and twenty degrees Fahrenheit.

(2) The children's handwashing facilities must be located in or adjacent to rooms used for toileting.

(3) The center must provide the child with soap and individual towels or other appropriate devices for washing and drying the child's hands and face.

(4) Handwashing sinks must be of appropriate height and size for children in care or your center must furnish safe, easily cleanable platforms impervious to moisture.

(5) An emergency respite center must provide a minimum of one handwashing sink:

(a) For every fifteen children normally on site during the day; and

(b) For every eight children normally on site overnight.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0840, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0850 What are the requirements for toilets? (1) An emergency respite center must provide a minimum of one indoor flush-type toilet:

(a) For every fifteen children normally on site during the day; and

(b) For every eight children normally on site overnight.

(2) Children eighteen months of age or younger and other children using toilet training equipment need not be included when determining the number of required flush-type toilet.

(3) If urinals are provided, the number of urinals must not replace more than one-third of the total required toilets.

(4) Privacy for toileting must be provided for children of the opposite sex who are six years of age and older and for other children demonstrating a need for privacy.

(5) A mounted toilet paper dispenser for each toilet must be provided.

(6) Toilets and urinals must be of appropriate height and size for children in care or your center must furnish safe, easily cleanable platforms impervious to moisture.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0850, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0860 Must a center have toilet training equipment for children? (1) An emergency respite center must have developmentally appropriate toilet-training equipment, when the center serves children who are not toilet trained.

(2) The equipment must be sanitized after each child's use.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0860, filed 3/26/03, effective 4/26/03.]

INDOOR PLAY AREAS

WAC 388-145-0870 What are the requirements for indoor play areas? (1) The emergency respite center's indoor premises must contain adequate area for child play and sufficient space to house a developmentally appropriate program for the number and age range of children served.

(2) You must provide a minimum of thirty-five square feet of usable floor space per child, not counting bathrooms, hallways, and closets.

(3) You may use and consider the napping area as child care space, if there are not beds or cots on the floor space.

(4) Any room used for napping or sleeping must have a window to allow natural light into the room.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0870, filed 3/26/03, effective 4/26/03.]

OUTDOOR PLAY AREAS

WAC 388-145-0880 What are the requirements for an outdoor play area? (1) You must provide a safe and securely-fenced or department-approved, enclosed outdoor play area at an emergency respite center.

(2) The fenced or approved enclosed outdoor play area must prevent child access to roadways and other dangers.

(3) The fence or enclosure must protect the play area from unauthorized exit or entry. Any fence or enclosure must be designed to discourage climbing.

(4) The outdoor play area must adjoin directly the indoor premises or be reachable by a safe route and method.

(5) The outdoor play area must promote the child's active play, physical development, and coordination.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0880, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0890 What are the size requirements for an outdoor play area? (1) You must ensure the play area at an emergency respite center contains a minimum of seventy-five usable square feet per child.

(2) If not all of the children are using the outdoor play area at the same time, you may reduce the outdoor play area size by the number of children normally using the play area at one time.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0890, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0900 What are the requirements for playground equipment? (1) You must provide a variety of age appropriate play equipment for climbing, pulling, pushing, riding, and balancing activities at an emergency respite center.

(2) You must arrange, design, construct, and maintain equipment and ground cover to prevent child injury.

(3) The quantity of outdoor play equipment must offer the child a range of outdoor play options.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0900, filed 3/26/03, effective 4/26/03.]

TRANSPORTATION

WAC 388-145-0910 Are there requirements to follow when I transport children? When you transport children under your care, you must follow these requirements.

(1) The vehicle must be kept in a safe operating condition.

(2) The driver must have a valid driver's license.

(3) There must be at least one adult other than the driver in a vehicle when:

(a) There are more than five preschool-aged children in the vehicle;

(b) Staff-to-child ratio guidelines or your contract require a second staff person; or

(c) The child's specific needs require a second adult person.

(4) The driver or owner of the vehicle must be covered under an automobile liability and insurance policy.

(5) Your vehicles must be equipped with seat belts, car seats and booster seats, and/or other appropriate safety devices for all passengers as required by law.

(6) The number of passengers must not exceed the vehicle's seat belts.

(7) All persons in the vehicle must use seat belts or approved child passenger restraint systems, as appropriate for age, whenever the vehicle is in motion.

(8) Buses approved by the state patrol are not required to have seat belts.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0910, filed 3/26/03, effective 4/26/03.]

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CLIENT RECORDS

WAC 388-145-0920 What does the department require for keeping client records? (1) Your records must be kept at your emergency respite center and contain, at a minimum, the following information:

(a) The child's name and birthdate;

(b) Daily attendance logs;

(c) A copy of any suspected child abuse and/or neglect referrals made to children's administration;

(d) Names, address and home and business telephone numbers of parents or persons to be contacted in case of emergency;

(e) Dates and illnesses or accidents while at the center;

(f) Medications and treatments given at the center;

(g) Facility and/or daily logs must have the signature of the person making the written entry;

(h) Health screening information including any allergy information; and

(i) Other information determined relevant by the department.

(2) Identifying and personal information about the child and their family must be kept confidential, unless permission has been given for release by the parent.

(3) You must keep information about the child and their families in a secure place.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0920, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0930 What written information is needed before a child is admitted to a center? Before accepting a child for care at an emergency respite center you must obtain the following written consent and information from the parent or guardian:

(1) Permission from the child's parent or guardian authorizing the placement of their child;

(2) Permission to seek emergency medical care or surgery on behalf of their child;

(3) Basic family information, including address, telephone numbers, and emergency contact; and

(4) Basic medical information, including current medication, known allergies, and at-risk behaviors of the child.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0930, filed 3/26/03, effective 4/26/03.]

CLIENT PROTECTION

WAC 388-145-0940 What are the requirements for protecting a child under my care from abuse or neglect? As part of ensuring a child's health, welfare and safety, you must protect children under your care from all forms of child abuse or neglect (see RCW 26.44.020(12) and chapter 388-15 WAC for more details).

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0940, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0950 What are the nondiscrimination requirements? You must follow all state and federal laws regarding nondiscrimination while providing services to children in your care.

[Title 388 WAC—p. 657]

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0950, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0960 Do I have to admit or retain all children at the center? An emergency respite center has the right to refuse to admit or retain a child who can not be served safely or who may pose a risk to other children.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0960, filed 3/26/03, effective 4/26/03.]

CLIENT RIGHTS

WAC 388-145-0970 Do I have responsibility for a child's personal hygiene? (1) You must provide or arrange for children under your care to have items needed for grooming and personal hygiene.

(2) You must assist these children in using these items, based on the child's developmental needs.

(3) Clothing must be clean and age-appropriate.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0970, filed 3/26/03, effective 4/26/03.]

WAC 388-145-0980 Do I have responsibility for a child's personal items at the center? You must provide separate space for the storage of personal items such as clothing and toys, for each child at your emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0980, filed 3/26/03, effective 4/26/03.]

DISCIPLINE

WAC 388-145-0990 What requirements must I follow when disciplining children? (1) You are responsible for disciplining children in your care. This responsibility may not be delegated to a child.

(2) Discipline must be based on an understanding of the child's needs and stage of development.

(3) Discipline must be designed to help the child under your care to develop inner control, acceptable behavior and respect for the rights of others.

(4) Discipline must be fair, reasonable, consistent, and related to the child's behavior.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-0990, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1000 What types of disciplinary practices are forbidden? (1) You must not use cruel, unusual, frightening, unsafe or humiliating discipline practices, including but not limited to:

- (a) Spanking children with a hand or object;
- (b) Biting, jerking, kicking, hitting, or shaking the child;
- (c) Pulling the child's hair;
- (d) Throwing the child;
- (e) Purposely inflicting pain as a punishment;
- (f) Name calling or using derogatory comments;
- (g) Threatening the child with physical harm;
- (h) Threatening or intimidating the child; or
- (i) Placing or requiring a child to stand under a cold water shower.

(2) You must not use methods that interfere with a child's basic needs. These include, but are not limited to:

- (a) Depriving the child of sleep;
 - (b) Providing inadequate food, clothing or shelter;
 - (c) Restricting a child's breathing;
 - (d) Interfering with a child's ability to take care of their own hygiene and toilet needs; or
 - (e) Providing inadequate medical or emergency dental care.
- (3) You must not use medication in an amount or frequency other than that prescribed by a physician or psychiatrist.
- (4) You must not give one child's medications to another child.
- (5) You must not use medication for behavior management unless a physician to control that child's behavior prescribes the medication.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1000, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1010 Does the department require a written statement describing my discipline methods? (1) You must provide a written statement describing the discipline methods you use with your application and reapplication for licensure.

(2) If your discipline methods change, you must immediately provide a new statement to your licensor describing your current practice.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1010, filed 3/26/03, effective 4/26/03.]

PHYSICAL RESTRAINT

WAC 388-145-1020 What types of physical restraint are acceptable? (1) You must use efforts other than physical restraint to redirect or deescalate a situation.

(2) If a child's behavior poses an immediate risk to physical safety, you may use a physical restraint on a child. The restraint must be reasonable and necessary to:

- (a) Prevent a child on the premises from harming himself/herself or others; or
 - (b) Protect property from serious damage.
- (3) You and the staff may use restraining techniques:
- (a) If your emergency respite center provides care to school-age children only; and

(b) Is approved by DLR for the use of physical restraint. You and your staff must be trained in accordance with the DLR behavior management policy before restraining a child in a nonemergency situation.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1020, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1030 What types of physical restraint are not acceptable for children? You must not use:

- (1) Physical restraint as a form of punishment or discipline;
- (2) Mechanical restraints, such as handcuffs and belt restraints;
- (3) Locked time-out rooms; or
- (4) Physical restraint techniques that restrict breathing, or inflict pain as a strategy for behavior control, or that might injure a child. These include, but are not limited to:

- (a) Restriction of body movement by placing pressure on joints, chest, heart, or vital organs;
- (b) Sleeper holds, which are holds used by law enforcement officers to subdue a person;
- (c) Arm twisting;
- (d) Hair holds;
- (e) Choking or putting arms around the throat; or
- (f) Chemical restraints, including but not limited to pepper spray.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1030, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1040 What must I do following an incident that involved using physical restraint? The director or program supervisor of an emergency respite center must review any incident with the staff who used physical restraint to ensure that the decision to use physical restraint and its application were appropriate.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1040, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1050 What incidents involving children must I report? (1) You or your staff at an emergency respite center must report any of the following incidents immediately to your local children's administration intake staff and the child's parent or legal guardian:

- (a) Any reasonable cause to believe that a child has suffered child abuse or neglect;
- (b) Any violations of the licensing or certification requirements;
- (c) Death of a child;
- (d) Any child's suicide attempt that results in injury requiring medical treatment or hospitalization;
- (e) Any use of physical restraint that is alleged to be improper, excessive, or results in injury;
- (f) Sexual contact between two or more children that is not considered typical play between preschool age children;
- (g) Any disclosures of sexual or physical abuse by a child in care;
- (h) Physical assaults between two or more children that result in injury requiring off-site medical treatment or hospitalization;
- (i) Unexpected or emergent health problems that require off-site medical treatment;
- (j) Any medication that is given incorrectly and requires off-site medical treatment; or
- (k) Serious property damage that is a safety hazard and is not immediately corrected.

(2) You or your staff must report immediately, any of the following incidents to the child's parent or legal guardian:

- (a) Suicidal/homicidal ideation, gestures, or attempts that do not require professional medical treatment;
- (b) Unexpected health problems that do not require professional medical treatment;
- (c) Any incident of medication administered incorrectly;
- (d) Physical assaults between two or more children that resulted in injury but did not require professional medical treatment;
- (e) Runaways; and
- (f) Use of physical restraints for routine behavior management.

(2007 Ed.)

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1050, filed 3/26/03, effective 4/26/03.]

STAFFING RATIO

WAC 388-145-1060 What is the ratio of child care staff to children at a center? At all times, emergency respite centers must have the following minimum staffing ratios:

- (1) At least two staff on duty when children are present; and
- (2) One child care staff providing visual or auditory supervision for every four children in care.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1060, filed 3/26/03, effective 4/26/03.]

SUPERVISION OF CHILDREN

WAC 388-145-1070 What are the requirements for supervision of children at a center? (1) Emergency respite centers must provide or arrange for care and supervision that is appropriate for the child's age, developmental level, and condition.

(2) In emergency respite centers, children must be within visual and auditory range at all times.

(3) Emergency respite centers must supervise children who help with activities involving food preparation, based on their age and skills.

(4) Preschool children and children with severe developmental disabilities must not be left unattended in a bathtub or shower at an emergency respite center.

(5) Staff, volunteers, and others caring for children at an emergency respite center must provide the children with:

- (a) Appropriate adult supervision;
- (b) Emotional support;
- (c) Personal attention; and
- (d) Structured daily routines and living experiences.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1070, filed 3/26/03, effective 4/26/03.]

STAFF POSITIONS AND QUALIFICATIONS

WAC 388-145-1080 What are the responsibilities of the director? (1) The director of an emergency respite center is responsible for the overall management of the center's facility and operation.

(2) The director serves as the administrator of the center.

(3) The director must ensure the emergency respite center complies with the licensing requirements contained in this chapter.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1080, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1090 Are there general qualifications for all staff in an emergency respite center? You, your staff, and other persons at an emergency respite center who have access to the children must be able to demonstrate the understanding, ability, personality, emotional stability, and physical health suited to meet the cultural, emotional, mental, physical, and social needs of the children in care.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1090, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1100 What are the minimum qualifications and training requirements for center staff?

Position	Qualifications	Background Check	TB Test	Food Handlers Permit	First Aid and CPR	HIV/AIDS and Bloodborne Pathogens Training
Director or program supervisor	<ul style="list-style-type: none"> •Twenty-one years of age; •Bachelor's degree; or •Five years of experience in child development, social service or related field. 	X	X	X	X	X
Primary child care worker	<ul style="list-style-type: none"> •Twenty-one years of age; •High school diploma or GED; •Two years of experience caring for children; or •Twenty hours training child development. 	X	X	X	X	X
Child care assistant	<ul style="list-style-type: none"> •Eighteen years of age; •High school diploma or GED; •One year of experience caring for children; or •Twenty hours training if obtained within first year of employment. 	X	X	X	X	X
Work study students	<ul style="list-style-type: none"> •Sixteen years of age; •Involved in an education-related program; and •Supervised by primary or child care assistant. 	X	X	X	X	X
Case manager	Bachelor's degree in social services, child development, or related field; recommended position, not required.	X	X	X	X	X
Volunteers	<ul style="list-style-type: none"> •Sixteen years of age. •Supervised at all times. 	X	X	X	Recommended training	X

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1100, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1110 May one person hold two positions at a center? (1) The director and program supervisor may be one and the same person when qualified for both positions.

(2) The director and program supervisor may also serve as child care staff when the role does not interfere with the director's or program supervisor's management and supervisory responsibilities.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1110, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1120 Who must be on the premises while children are in care at a center? (1) The director, program supervisor, or case manager at an emergency respite center must normally be on the premises during daytime hours when children are in care.

(2) If temporarily absent (for two hours or less) from the center, the director and program supervisor must leave a

competent, designated staff person in charge. This person must meet the qualifications of primary child care staff person.

(3) During evening, overnight, and weekend shifts, at least one of the staff on the premises must be a primary child care worker when children are present. The other staff may be a child care assistant. The director, program supervisor, or case manager must be on-call and able to respond by telephone within fifteen minutes.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1120, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1130 Are child care assistants allowed to provide care to a group of children without supervision? (1) You may assign a child care assistant to support lead child care staff at an emergency respite center.

(2) No person under eighteen years of age may be assigned sole responsibility for a group of children at an emergency respite center.

(3) Any child care assistant under twenty-one years old may care for a child or group of children without direct supervision for up to fifteen minutes.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1130, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1140 Are volunteers allowed to provide child care to children without supervision? The volunteer at an emergency respite center must care for a child only under the direct supervision of the primary child care staff person or program director.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1140, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1150 Do volunteers count in the staff-to-child ratio respite center? You may count the volunteer in the staff-to-child ratio when the volunteer meets the required staff qualifications at an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1150, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1160 Are professional consultants and case managers needed? (1) Emergency respite centers may have consultants and case managers available, as needed, to work with the staff, the children you serve, and the children's families. Any consultants or case managers must meet the full professional competency requirements in their respective fields. The consultants and case managers must have:

(a) The training, experience, knowledge and demonstrated skills in each area that he or she will be advising;

(b) The ability to ensure that your staff develop their skills and understanding needed to effectively manage their cases;

(c) Knowledge of mandatory child abuse and neglect reporting requirements; and

(d) Training and experience in early childhood education.

(2) Consultants and case managers may be hired as staff or operate under a contract with an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1160, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1170 What clerical, accounting and administrative services do I need? You must have sufficient clerical, accounting and administrative services to maintain proper records and carry out your program at an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1170, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1180 What support and maintenance staff do I need? You must have sufficient support and maintenance services to maintain and repair your facility and prepare and serve meals at an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1180, filed 3/26/03, effective 4/26/03.]

(2007 Ed.)

ON-GOING STAFF TRAINING

WAC 388-145-1190 Is in-service training required for staff? (1) You must offer in-service training programs for developing and upgrading staff skills.

(2) If you have five or more employees or volunteers, your training plan must be in writing.

(3) You must discuss with the staff your policies and procedures as well as the rules contained in this chapter.

(4) You must provide or arrange for your staff to have training for the services that you provide to children under your care.

(5) Your training on behavioral management must be approved by DLR and must include nonphysical age-appropriate methods of redirecting and controlling behavior, as described in the department's behavior management policy.

(6) Your training must include monthly practice of fire drills and disaster training for each staff.

(7) You must record the amount of time and type of training provided to staff.

(8) This information must be kept in each employee's file or in a separate training file.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1190, filed 3/26/03, effective 4/26/03.]

PROGRAM ACTIVITIES AND TOYS

WAC 388-145-1200 What are the requirements for an activity program? (1) You must provide an activity program at an emergency respite center that is designed to meet the developmental, cultural, and individual needs of the children served at an emergency respite center.

(2) You must ensure the emergency respite center's activity program allows time for children to have daily opportunities for small and large muscle activities and outdoor play.

(3) You must provide a written outline of planned activities, allowing flexibility for special events and specific child circumstances.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1200, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1210 What activities must I provide to children? (1) Activities must be designed for the developmental stages of the children you serve at an emergency respite center, allowing a balance between:

(a) Child-initiated and staff-initiated activities;

(b) Free play and organized events;

(c) Individual and group activities; and

(d) Quiet and active experiences.

(2) You must ensure that children at an emergency respite center are grouped to ensure the safety of children.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1210, filed 3/26/03, effective 4/26/03.]

WAC 388-145-1220 What types of toys must I provide? (1) You must provide safe and suitable toys and equipment for all children in your care at an emergency respite center.

(2) You must have toys that relate to the different developmental stages of the children you serve at an emergency respite center.

[Statutory Authority: RCW 74.15.280, 74.15.020 and 2001 c 230. 03-08-026, § 388-145-1220, filed 3/26/03, effective 4/26/03.]

Chapter 388-147 WAC

LICENSING REQUIREMENTS FOR PREGNANT AND PARENTING TEEN PROGRAMS AND FACILITIES

WAC

AUTHORITY

388-147-0010 What authority does the department of social and health services have to license residential programs for pregnant and parenting teens and their children?

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AUTHORITY

WAC 388-147-0010 What authority does the department of social and health services have to license residential programs for pregnant and parenting teens and their

children? (1) The rules are adopted under authority of chapter 74.15 RCW.

(2) The rules in this chapter are the minimum licensing requirements for residential programs for pregnant and parenting teens, age sixteen and seventeen and their children.

(3) The department issues or denies a license on the basis of compliance with the minimum licensing requirements contained in this chapter.

(4) Nothing in this chapter is intended to deny any individual access to services or the rights afforded him or her under other Revised Codes of Washington (RCW).

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0010, filed 12/9/04, effective 1/9/05.]

PURPOSE AND DEFINITIONS

WAC 388-147-0020 What is the purpose of this chapter? This chapter defines general and specific minimum licensing requirements for independent-living pregnant and parenting teen facilities. A program approved for licensing or relicensing under this chapter requires housing and services, as described in sections of the chapter. The licensing requirements in this chapter are intended to be for programs for teens age sixteen or older that are pregnant or parenting. A program for pregnant or parenting teens younger than age sixteen would require consultation with and approval from the department's licensing agent to be licensed under this chapter.

The department is committed to ensuring that the pregnant and parenting teens and their children who receive residential care experience health, safety, and well-being. Our licensing requirements reflect our commitment to children and youth.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0020, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0030 What definitions do I need to know to understand this chapter? The following definitions are important to understand these rules:

"Abuse or neglect" means the injury, sexual abuse, sexual exploitation, negligent treatment or mistreatment of a child/youth where the child/youth's health, welfare and safety are harmed.

"Agency" as defined in RCW 74.15.020 (1)(a) through (k).

"Assessment" means the appraisal or evaluation of a child's physical, mental, social and/or emotional condition.

"Capacity" means the maximum number of children that a home or facility is licensed to care for at a given time.

"Care provider" means any licensed or certified person or organization, or staff member of a licensed organization that provides twenty-four hour residential services to children and youth.

"Case manager" means an agency employee who coordinates and links the youth to appropriate services.

"Children" mean individuals who are under eighteen years old and are the children of the teen resident.

"Compliance agreement" means a written licensing improvement plan to address deficiencies in specific skills, abilities or other issues of a fully licensed facility in order to

maintain and/or increase the safety and well-being of children in care.

"Department" means the department of social and health services (DSHS).

"DLR" means the division of licensed resources.

"DOH" means the department of health.

"Firearms" means guns or weapons, including but not limited to the following: BB guns, pellet guns, air rifles, stun guns, antique guns, bows and arrows, handguns, rifles, and shotguns.

"Full licensure" means an entity meets the requirements established by the state for licensing or approved as meeting state minimum licensing requirements.

"Hearing" means the administrative review process.

"I" refers to anyone who is licensed, operates, or owns a facility for pregnant and parenting teens and their children.

"Infant" means a child less than one year of age.

"License" means a permit issued by the department affirming that a program/facility meets the minimum licensing requirements.

"Licensee" means the individual or agency that is responsible for the operation of the program and health and safety of the facility.

"Licensor" means a division of licensed resources (DLR) employee, children's administration of DSHS who:

(1) Approves licenses for pregnant and parenting teen programs/facilities; and

(2) Monitors facilities to ensure that they continue to meet minimum licensing requirements.

"Maternity service" means an agency which provides or arranges for care or services to expectant mothers, before or during confinement, or which provides care as needed to mothers and their infants after confinement, as defined in RCW 74.15.020. Maternity services, in this chapter refer to services to youth who are less than eighteen years.

"Nonambulatory" means not able to walk or traverse a normal path to safety without the physical assistance of another individual.

"Premises" means a facility's buildings and adjoining grounds that are managed by a person or agency in charge.

"Probationary license" means a license issued as part of a disciplinary action to an individual or agency that has previously been issued a full license but is out of compliance with the minimum licensing requirements.

"Provide care" to youth means the agency makes available residential services including case management to a client.

"Relative" means a person who is related to the child as defined in RCW 74.15.020 (4)(a)(i), (ii), (iii), and (iv) only.

"Resident" means the pregnant or parenting teen and her child or children.

"Service plan" means a description of the services to be provided or performed and who has responsibility to provide or perform the activities for a teen and the teen's child or children.

"Social service staff" means a clinician, program manager, case manager, consultant, contractor, or other staff person who is an employee of the agency or hired to develop and implement the child's individual service plans.

"Staff" means employees, interns, volunteers, or any individual operating under the auspices of the agency providing

ing services to pregnant and parenting teens and their children.

"Standard precautions" is a term relating to procedures designed to prevent transmission of blood borne pathogens in health care and other settings. Under standard precautions, blood or other potentially infectious materials of all people should always be considered potentially infectious for HIV and other pathogens. Individuals should take appropriate precautions using personal protective equipment like gloves to prevent contact with blood or other bodily fluids.

"Washington state patrol fire protection bureau" or **"WSP/FPB"** is the name for the agency popularly known as the state fire marshal.

"We" or **"our"** refers to the department of social and health services, including division of licensed resources (DLR) licensors.

"You" refers to the licensee or anyone who owns or operates a program/facility for pregnant and parenting teens and their children.

"Youth" means the pregnant or parenting teen resident, age sixteen or seventeen.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0030, filed 12/9/04, effective 1/9/05.]

APPLICATION PROCESS

WAC 388-147-0040 Is a license required to provide care to pregnant and parenting teens and their children? If you regularly provide residential care to a child or youth less than age eighteen who is not related to you, you must be licensed.

Note: See definition of relatives exempt from licensing RCW 74.15.030(2).

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0040, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0050 How old do I have to be to apply for a license? You must be at least twenty-one years old to apply for a license to provide residential and case management services to pregnant and parenting teens and their children.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0050, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0060 What personal characteristics are needed to be licensed? Individuals requesting a license or a position as an employee, volunteer, intern, or contractor must have the following specific personal characteristics:

(1) Able to demonstrate an understanding, ability, physical health, emotional stability and personality suited to meet the physical, mental, emotional, and social needs of the children and youth in care.

(2) Must not have been disqualified by the department's background check (chapter 388-06 WAC) prior to having unsupervised access to children.

(3) Have not had a license denied or revoked from an agency that regulates the care of children or vulnerable adults, unless the department determines that the individual does not pose a risk to a child's safety, well being, and long-term stability.

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(4) Must not have been found to have committed abuse or neglect of a child or a vulnerable adult, unless the department determines that the individual does not pose a risk to a child's safety, well being, and long-term stability.

(5) The department may require additional information from the applicant, employee, intern, or contractor. This information may be requested at any time and may include, but is not limited to:

(a) Substance and alcohol abuse evaluations and/or documentation of treatment;

(b) Psychiatric and psychological evaluations;

(c) Psycho-sexual evaluations; and

(d) Medical evaluations and/or medical records.

(6) Any evaluation requested under subsection (5) of this section will be at the applicant/licensees expense.

(7) The licensor must be given permission to speak with the evaluator/provider prior to and after the evaluation.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0060, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0070 What is required when completing an application for licensing? License applications are available from the division of licensed resources, children's administration.

(1) To apply for a license, the person or legal entity responsible for the facility must include with the application the following:

(a) Written verification for all applicant(s), staff, interns, volunteers and individuals who may have unsupervised access to children and youth in care of the following information:

(i) A tuberculosis (TB) test or an X ray, unless the individual can demonstrate a religious or a medical reason prohibiting the test;

Note: Written documentation from your physician that indicates you are free of the signs and symptoms of tuberculosis may be accepted for individuals with a religious or a medical prohibition to the TB test.

(ii) First-aid and cardio-pulmonary resuscitation (CPR) training appropriate to the age of the residents in care; and

(iii) HIV/AIDS and blood borne pathogens training including infection control standards.

(2) The completed background check forms on anyone on the premises having unsupervised access to children who is at least sixteen years old or older who is not a resident must be sent to the licensor. Note: See chapter 388-06 WAC.

(3) A completed FBI fingerprint form must be completed on a licensee, staff, employee, and any individual having unsupervised access to residents, who has lived outside Washington state within the last three years.

(4) Certificates of compliance from the department of health (DOH) and Washington state patrol fire protection bureau (WSPFPB) demonstrating the facility has met the requirements for health, fire and life safety are required prior to licensing. Both agencies perform inspections of the facility, including apartments, at licensing and relicensing of the facility. Proper notice to apartment residents is required.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0070, filed 12/9/04, effective 1/9/05.]

(2007 Ed.)

WAC 388-147-0080 How long does an applicant have to complete the licensing application packet? (1) An applicant must complete the licensing application with supporting documents, such as training certificates and certificates of compliance from the department of health and Washington state patrol fire protection bureau within ninety days of first applying for the license. If the applicant fails to meet this deadline and has not contacted the licensor, the application may be considered withdrawn.

(2) If a licensee is applying for a license renewal, the application forms must be sent to the licensor at least ninety days prior to the expiration of the current license.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0080, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0090 Will the department license or continue to license a facility if the facility does not meet the licensing requirements? (1) At its discretion, the department may make exceptions and license or continue to license a facility that does not meet the minimum licensing requirements.

(2) Exceptions are approved for nonsafety requirements only.

(3) The safety and well-being of the children and youth receiving care must not be compromised.

(4) The request for an exception to the licensing requirements must be in writing.

(5) The applicant or licensee must keep a copy of the approved exception to the licensing requirements for their files.

(6) Along with an exception to the licensing requirements, the department may limit or restrict a license issued and/or require the licensee to enter into a compliance agreement to ensure the safety and well-being of the children and youth in care.

(7) The applicant or licensee does not have appeal rights if the department denies your request for an exception to our requirements.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0090, filed 12/9/04, effective 1/9/05.]

CORRECTIVE ACTION

WAC 388-147-0100 Does the department issue a probationary license? (1) The department may, at its discretion, issue a probationary license as part of a corrective action plan with a licensed provider.

(2) The department will base its decision as to whether a probationary license will be issued on a consideration of the following:

(a) Intentional or negligent noncompliance with the licensing rules;

(b) A history of noncompliance with the rules;

(c) Current noncompliance with the rules;

(d) Evidence of a good faith effort to comply; and

(e) Any other factors relevant to the specific situation.

(3) A probationary license may be issued for up to six months. At its discretion, the department may extend the probationary license for an additional six months. A decision not to issue a probationary license is not subject to appeal.

(2007 Ed.)

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0100, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0110 When is a license denied, suspended or revoked? (1) A license must be denied, suspended or revoked if the department decides that the applicant or licensee cannot provide care for residents in a way that ensures their safety, health and well-being.

(2) The department must, also, disqualify an applicant or licensee for any of the reasons that follow. The applicant or licensee:

(a) Has been disqualified by the background check (see chapter 388-06 WAC).

(b) Has been found to have committed child abuse or neglect or treated, permitted or assisted in treating children or vulnerable adults in care with cruelty, indifference, abuse, neglect, or exploitation, unless the department determines that the applicant or licensee does not pose a risk to a child or youth's safety, well-being, and long-term stability.

(c) Tries to get a license by deceitful means, such as making false statements or omitting critical information on the application.

(d) Commits, permits, or assists in an illegal act on the premises of a facility providing care to children and youth.

(e) Uses illegal drugs, or excessively uses alcohol and/or prescription drugs.

(f) Knowingly allows employees or volunteers who made false statements or omit critical information on their applications to work at the agency or facility.

(g) Knowingly allows employees or volunteers who use illegal drugs, alcohol, or prescription drugs that affect their ability to perform their job duties to work at the agency or be on the premises of the facility when children/youth are present.

(h) Repeatedly lacks qualified or an adequate number of staff to care for the number and types of children and youth under care.

(i) Has refused to allow the department's authorized staff and inspectors to have requested information or access to the facility, youth or child, program files, and/or your staff. Any inspection requires appropriate tenant notice. Immediate access to client residence is in emergency situations only.

(j) Are unable to manage the property, fiscal responsibilities, or staff of the agency.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0110, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0120 Are there any other reasons that might cause me to lose my license? The department may suspend or revoke a license if the licensee:

(1) Exceeds the conditions of the facility license by:

(a) Having more youth or children residing at the facility than the license allows;

(b) Having youth or children residents with ages different than the license allows;

(c) Failing to provide a safe and healthy environment for youth and children under care; or

(d) Failing to comply with any of the other minimum licensing requirements.

(2) Fails to meet the health and safety requirements to receive a certificate of compliance as required by the depart-

ment of health or the Washington state patrol fire protection bureau.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0120, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0130 When is an employee or volunteer disqualified from having unsupervised access to a child or youth in a licensed facility? The department must disqualify an employee or volunteer of a licensed facility from having unsupervised access to a child or youth when he or she:

(1) Has a disqualifying background check result (see chapter 388-06 WAC);

(2) Has been found to have committed child abuse or neglect or have treated, permitted, or assisted in treating children, youth, or vulnerable adult with cruelty, indifference, abuse, neglect, or exploitation, unless the department determines that he or she does not pose a risk to a child or youth's safety, well being, and long-term stability;

(3) Attempted to become employed, volunteer, or otherwise have unsupervised access to children or youth by deceitful means, such as making false statements or omitting critical information on an application to work or volunteer at a licensed home, facility, or agency; or

(4) Used illegal drugs, alcohol, or prescription drugs that affected his or her ability to perform his or her job duties while on the premises when children or youth are present.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0130, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0140 How is the applicant or licensee notified if the department decides to modify, deny, suspend, or revoke a license? The department sends the applicant or licensee a certified letter informing him or her of the decision to modify, deny, suspend or revoke their license. In the letter, the department also tells the applicant or licensee what he or she needs to do if they disagree with the decision.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0140, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0150 What may an applicant or licensee do if he or she disagrees with the department's decision to modify, deny, suspend or revoke the license? The applicant or licensee has the right to appeal any decision the department makes to deny, modify, suspend, or revoke his or her license.

(1) The applicant or licensee may request an administrative hearing to disagree with the department's decision to modify, suspend, revoke or deny your license.

(2) The applicant or licensee must request an administrative hearing within twenty-eight days of receiving a certified letter with the department's decision (see chapter 34.05 RCW).

(3) The applicant or licensee must send a letter to the office of administrative hearings requesting an administrative hearing. The letter must have the following attachments:

(a) A specific statement of the applicant or licensee's reasons for disagreeing with the department decision and any laws that relate to the reasons; and

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(b) A copy of the certified letter from the department that the applicant or licensee is disputing.

(4) The administrative hearing will take place before an administrative law judge who is an employee of the office of administrative hearings.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0150, filed 12/9/04, effective 1/9/05.]

PROGRAM SERVICES

WAC 388-147-0160 Does the department need to approve the program offered for pregnant and parenting teens? The department must approve pregnant and parenting teen programs offered to youth prior to licensing.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0160, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0170 Is a program description required as part of the license application? As part of the application, the applicant/licensee must send to the licensing agency (DLR) a written statement that includes the program mission, goals, and a detailed written program description outlining case management and other services the program will provide or offer to pregnant and parent teens and their children.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0170, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0180 What must be included in a pregnant and parenting teen program? An agency licensed to provide a program for pregnant and parenting teens and their children must include:

- (1) Safe and stable housing;
- (2) An assessment of the family's need(s);
- (3) Referral to an authorized medical care provider for prenatal and postnatal medical care;
- (4) Case management services; and
- (5) The provision of direct services or referrals to services, as assessed and to the extent those services are available.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0180, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0190 What independent living skills may be offered? (1) The types of assistance, service, and support the pregnant and parenting teen program offers will vary based on the chronological age, the developmental stage, family resources, and the supervision needs of the individual youth.

(2) Assistance may be offered in the broad categories of:

(a) Parenting skills development and support (including instruction that includes the prohibition of spanking or the use of cruel or frightening discipline of her child by the teen parent);

(b) Skills for independence (budgeting, comparative shopping, cooking, cleaning, etc);

(c) Basic educational competencies (including assisting in developing or arranging for an educational plan for each youth in care who has not completed high school or the GED, support for regular school attendance, homework completion, and tutoring;

(d) Employment preparation (including volunteer experiences, job interview skills, resume development, appropriate work environment behavior, vocational training etc.);

(e) Interpersonal skills and health care (including education in nutrition, pregnancy prevention, sexually transmitted infections, substance abuse, health insurance, etc.);

(f) Housing (including skills needed to be a good roommate, options for housing, rental agreements, landlord/tenant relationships, etc.); and

(g) Developing significant support systems (identifying adults who can be a positive example and support in the future).

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0190, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0200 Is a residential facility for pregnant and parenting teens required to provide childcare?

(1) If the residential facility serves parents with children, the licensee or staff must assist the teen parent in arranging licensed childcare, when appropriate. An example is when teen parents are working or are in school and needs childcare.

(2) The childcare home or center used by teen parents must be licensed, when licensing is a legal requirement, as outlined in chapter 74.15 RCW.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0200, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0210 What are the requirements about nondiscrimination? Any licensed programs for pregnant or parenting teens must follow all state and federal laws regarding nondiscrimination while providing services to children and youth.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0210, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0220 Is participation in the program conditional on a teen's decision about keeping or relinquishing her child? Services to pregnant and parenting teens must not be contingent upon a teen's decision to keep or relinquish her child.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0220, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0230 What are your requirements for keeping client records? (1) Any identifying and personal information about a child/youth and the child/youth's family must be kept confidential.

(2) You must keep records about children/youth and their families in a secure place.

(3) If the information is available, your records must contain, at a minimum, the following:

(a) The child and youth parent's name and birth date;

(b) Information on the child's biological father;

(c) Name and telephone number of the social worker for each child/youth in care, if the child or youth is in the custody of the department of social and health services;

(d) Name, address, and telephone number of the teen's parent or person to be contacted in case of emergency;

(e) Appropriate medical history including any current medical problems, type of medical coverage and provider(s);

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(f) Other pertinent information related to the child and youth's physical health, current mental and emotional health, and dental records.

(4) The youth's records must contain a copy of the parent or legal guardian's consent to place or a court order that gives the licensed agency approval to house the youth.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0230, filed 12/9/04, effective 1/9/05.]

STAFF AND STAFF QUALIFICATIONS

WAC 388-147-0240 What personnel policies must a program have? (1) As an employer, you are responsible for complying with federal and state antidiscrimination laws related to employee personnel policies and procedures.

(2) You must keep a log with background check information, containing dates of request and completion of the checks on all staff, interns, volunteers, and contractors.

(3) If the program has five or more staff, volunteers, or interns you must have written policies covering qualifications, training, and duties for employees, interns, and volunteers.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0240, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0250 Must the facility license be posted? The licensee must post the agency license where the public can easily view it.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0250, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0260 What are the qualifications for an executive director? An executive director or person responsible for the agency administration, agency oversight, and fiscal operation of a program for pregnant and parenting teens must meet, at a minimum, the following requirements:

(1) Be able to communicate to the department the roles, expectations, and purpose of the program; and

(2) Have relevant education or four years of successful experience with similar duties and responsibilities for the administration, oversight, and fiscal management of a program or an agency.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0260, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0270 Is a supervisor or case consultant needed? The licensee must provide or arrange for social services by qualified persons who meet the education and training requirements that follow:

(1) One person who provides supervision or case consultation must have a master's degree in social work or a closely related field from an accredited school.

(2) The individual with the master's degree must have:

(a) The training, experience, knowledge and demonstrated skills in each area he or she will be supervising or advising; and

(b) The ability to ensure that staff develop the skills and understanding needed to effectively manage their cases.

(3) The person with a master's degree must consult, with any social service or case management staff having a bache-

lor's degree or less of formal education, one hour for every eighty hours the staff person works.

(4) Consultants may be hired as staff or operate under a contract.

(5) When case management is provided by another agency, the licensee must have a written agreement with the agency describing the scope of service they provide.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0270, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0280 What are the qualifications of a case manager? A social service or case manager for a pregnant or parenting teen program must have, at a minimum, the following:

- (1) A bachelor's degree in social services or closely related field from an accredited school; or
- (2) Five years of successful full-time experience in a relevant field.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0280, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0290 What are the responsibilities of the case manager? Case management services for pregnant and parenting teen programs must include the following:

- (1) An assessment of the teen's circumstances and needs;
- (2) Assist in the development of an individual or family services plan with attainable goals;
- (3) Assisting with independent living skills development;
- (4) The coordination of services;
- (5) Monitoring of the progress of service plan;
- (6) Appropriate recordkeeping; and
- (7) Client advocacy.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0290, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0300 What are the required ratios of case management staff to youth? The minimum ratio of case management staff to youth for pregnant and parenting teen programs is one staff person to fifteen teens.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0300, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0310 Is an on-site facilities manager required? All residential facilities for pregnant or parenting teens must have an on-site facility manager.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0310, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0320 What are the qualifications for an on-site facilities manager? The department requires that the on-site facilities manager for a pregnant and parenting teen program:

- (1) Be at least twenty-one years old;
- (2) Have the skills and abilities to work successfully with teens; and
- (3) Have effective communication and problem solving skills.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0320, filed 12/9/04, effective 1/9/05.]

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WAC 388-147-0330 What are the responsibilities of the on-site facilities manager? The responsibility of the on-site facility manager for a pregnant or parenting teen housing program includes:

- (1) Ensuring lease compliance by the residents; and
- (2) Responding to emergency situations, such as medical and fire emergencies when he or she is present at the facility.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0330, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0340 What clerical, accounting and administrative services are needed? The licensee must have sufficient clerical, accounting and administrative services to maintain proper records and carry out the pregnant and parenting teen program.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0340, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0350 What support and maintenance staff are needed? The licensee must have sufficient support and maintenance services to maintain and repair your facility.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0350, filed 12/9/04, effective 1/9/05.]

STAFF TRAINING

WAC 388-147-0360 What first aid and cardiopulmonary resuscitation (CPR) training is required? (1) If you have a facility that provides licensed care, you, your staff, interns, volunteers, and any individual who may at any time have unsupervised access, must have basic standard first-aid and age-appropriate cardiopulmonary resuscitation (CPR) training.

(2) The approved first aid and CPR training must be provided by a certified instructor in accordance with a nationally recognized standard.

(3) Records must be kept at the facility or readily available to the licensor showing who has completed current first aid and CPR training.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0360, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0370 What HIV/AIDS and blood-borne pathogens training is required? (1) Licensees, staff, and any individual who may have unsupervised contact with residents must have training on the transmission and prevention of HIV/AIDS and bloodborne pathogens. Such training must include infection control standards.

(2) The infection control requirements and educational material must be consistent with the current approved curriculum *Know-HIV/AIDS Prevention Education for Health Care Facility Employees*, published by the department of health, office on HIV/AIDS.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0370, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0380 What steps must be taken to prevent the spread of infections and communicable diseases? (1) The licensee must take precautions to guard against infections and communicable diseases infecting the children and

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youth residing at the facility by following the department of health regulations.

(2) Applicants for a license or adults authorized to have unsupervised access to residents at the facility must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test upon being employed, volunteering, or licensed unless:

(a) The person has evidence of testing within the previous twelve months;

(b) The person has evidence that they have a negative chest X ray since a previously positive skin test; or

(c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis.

(3) The department does not require a tuberculin skin test if:

(a) A person has a tuberculosis skin test that has been documented as negative within the past twelve months; or

(b) A physician indicates that the test is medically unadvisable.

(4) Persons whose tuberculosis skin test is positive must have a chest X ray within thirty days following the skin test.

(5) The department does not require retesting for license renewals unless a person believes he or she has been exposed to someone with tuberculosis or if testing is recommended by his or her health care provider.

(6) The licensee must keep the results of the TB test results in the personnel files available for review by DLR.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0380, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0390 Is in-service training required?

(1) The licensee must offer in-service training for developing and upgrading staff skills.

(2) If the pregnant and parenting teen program has five or more employees or volunteers, a training plan must be in writing.

(3) The licensee must discuss with staff the licensed agency's policies and procedures, mandatory reporting of suspected child abuse or neglect; as well as the rules contained in this chapter.

(4) The licensee must provide or arrange for staff to have training for the services that are provided to children and youth in the program.

(5) Training on behavioral management must be approved by DLR and must include nonphysical age-appropriate methods of redirecting and controlling behavior.

(6) The licensee must record the amount of time and type of training provided to staff.

(7) This information must be kept in each employee's file or in a separate training file.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0390, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0400 What types of disciplinary practices are forbidden at a facility? (1) This section applies to the discipline of teens at the facility and the children of the teens.

(2) The licensee or staff must not use cruel, unusual, frightening, unsafe or humiliating discipline practices, including but not limited to:

(a) Spanking children with a hand or object;

(b) Biting, jerking, kicking, hitting, or shaking the child;

(c) Pulling the child or youth's hair;

(d) Throwing the child or youth;

(e) Purposely inflicting pain as a punishment;

(f) Name calling, using derogatory comments;

(g) Threatening the child or youth with physical harm;

(h) Threatening or intimidating the child or youth; or

(i) Depriving the child or youth of sleep;

(j) Restricting a child or youth's breathing; or

(k) Interfering with a child or youth's ability to take care of his or her own hygiene and toilet needs.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0400, filed 12/9/04, effective 1/9/05.]

REPORTING REQUIREMENTS

WAC 388-147-0410 What are the reporting requirements?

(1) The licensee and staff of a licensed program for pregnant and parenting teens are mandatory reporters and must report any suspected child abuse or neglect to children's administration intake staff or law enforcement. (See RCW 26.44.020(12) and chapter 388-15 WAC for more details.)

(2) The licensee or staff must report the following incidents as soon as possible, and in not instance later than forty-eight hours, to children's administration intake staff:

(a) Death of a child or youth;

(b) Any violations of the licensing requirements where the health and safety of a child or youth is at risk and the violations are not corrected immediately or may compromise the continuing health and safety of children or youth;

(c) Any child or youth's suicide attempt that results in injury requiring medical attention or hospitalization;

(d) Any use of physical restraint that is alleged improperly applied or excessive;

(e) Sexual contact between two or more children that is not considered typical play between preschool age children;

(f) Any disclosures of sexual or physical abuse by a child or youth resident;

(g) Any physical assaults between two or more children or youth that result in injury requiring off-site medical attention or hospitalization;

(h) Any assaults of staff by children or youth that result in injury requiring off-site medical attention or hospitalization; or

(i) Any medication that is given incorrectly and requires off-site medical attention or hospitalization.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0410, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0420 What changes to a facility must the licensee report to the licensor? (1) A license is valid only for the person, organization, or agency named on the license and only for the specific address listed on the license.

(2) The licensee must report to the licensor immediately any changes in the original licensing application. Changes include any of the following:

(a) Changes in the location or designated space, including address;

(b) Changes in facility phone number;

(c) Changes in the maximum number, age ranges, and sex of children the licensee wishes to serve; and

(d) Changes in the structure of the facility or premises from events causing damage, such as a fire, or from remodeling.

(e) A change of the organization or agency's executive director or any staff changes;

(f) The death, retirement, or incapacity of the person who holds the license;

(g) A change in the name of a licensed corporation, or the name by which the facility is commonly known; or

(h) Changes in an agency's articles of incorporation and bylaws.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0420, filed 12/9/04, effective 1/9/05.]

HEALTH AND SAFETY

WAC 388-147-0430 How is the capacity determined for a facility? (1) The department licenses a facility for the number of youth and children based on the certification of occupancy from the Washington state patrol fire protection bureau;

(2) The department may issue a license to an applicant or licensee for the care of fewer youth and children than normally would reside at a facility based on an evaluation of the following factors:

(a) The number of staff and volunteers available for providing services;

(b) The skills of the staff and experience with the population of a pregnant and parenting teen program; and

(c) The ages and characteristics of the youth and children to be served.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0430, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0440 Are there general food service requirements? (1) The program must be in compliance with the department of health standards in chapter 246-215 WAC on food service sanitation when common food preparation areas are used.

(2) When a staff person is preparing or assisting in preparing food he or she must have a food handler's permit.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0440, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0450 What are the requirements for managing medications? (1) All medications must be inaccessible to children, including pet medications, vitamins and herbal remedies.

(2) Pet and human medications must be stored in separate places.

(3) Internal and external medications must be stored in separate places.

(4) Only the child's parent or another authorized care provider (example: Respite provider) is allowed to have access to medications for a child.

(5) The child's parent or another authorized care provider must give prescription and nonprescription medications:

(a) Only as specified on the prescription label; or

(b) As otherwise approved by a physician or another person legally authorized to prescribe medication.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0450, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0460 What are the requirements for transporting children and youth? When the licensee or staff transport children or youth, they must follow these requirements.

(1) The vehicle must be kept in a safe operating condition.

(2) The driver must have a valid driver's license.

(3) There must be at least one adult other than the driver in a vehicle when:

(a) There are more than five preschool-aged children traveling without their parent in the vehicle; or

(b) The child's specific needs require a second adult person.

(4) The driver or owner of the vehicle must be covered under an automobile liability insurance policy.

(5) The vehicles must be equipped with, seat belts, car seats and booster seats, and/or other appropriate safety devices for all passengers as required by law.

(6) The number of passengers must not exceed the vehicle's seat belts.

(7) All persons in the vehicle must use seat belts or approved child passenger restraint systems, as appropriate for age, whenever the vehicle is in motion.

(8) Buses approved by the state patrol are not required to have seat belts.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0460, filed 12/9/04, effective 1/9/05.]

BEDS, CRIBS, AND EQUIPMENT

WAC 388-147-0470 What are the requirements for beds? (1) Each resident must have his or her own bed that is at least twenty-seven inches wide with a clean and comfortable mattress in good condition, pillow, sheets, blankets, and pillowcases. Each resident's pillow must be covered with waterproof material or be washable.

(2) Bedding must be clean.

(3) Infants must have a crib that ensures the safety of the infant and complies with chapter 70.11 RCW, Infant Crib Safety Act.

(4) Cribs must have no more than two and three-eighths inches space between vertical slats when used for infants less than six months of age.

(5) Cribs, infant beds, bassinets, and playpens must:

(a) Have clean, firm, snug fitting mattresses covered with waterproof material that is easily sanitized; and

(b) Be made of wood, metal, or approved plastic with secure latching devices.

(6) Crib bumpers, stuffed toys and pillows must not be used in cribs, infant beds, bassinets, or playpens with an infant unless advised differently by the child's physician.

(7) The teen mother must follow the recommendation of the American Academy of Pediatrics, 1-800-505-CRIB, placing infants on their backs each time for sleep, unless advised differently by the child's physician.

(8) The teen mother may use toddler beds with a standard crib mattress that is sufficient in length and width for the comfort of children under six years of age.

(9) Children may not use the loft style beds or upper bunks of double-deck beds if using them due to age, development, or condition could hurt them. Examples: Preschool children, expectant mothers, and children with a disability.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0470, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0480 May wheeled baby walkers be used? The department prohibits the use of wheeled baby walkers in licensed facilities.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0480, filed 12/9/04, effective 1/9/05.]

RESIDENTIAL FACILITY

WAC 388-147-0490 What health and safety requirements are there? A residential facility for pregnant and parenting teens and their children is required to meet the health and fire safety requirements to receive a certificate of compliance from the department of health and the Washington state patrol fire protection bureau prior to licensing.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0490, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0500 Are local ordinances part of the licensing requirements? (1) The applicant or licensee is responsible for complying with local ordinances (laws), such as zoning regulations and local building codes.

(2) The department may require the applicant or licensee provide proof that the facility complies with local ordinances.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0500, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0510 What are the requirements regarding the location of a facility? (1) The address must be clearly visible on the facility or mailbox so that fire fighters or medics can easily find your location.

(2) The facility must be:

(a) Accessible to emergency vehicles; and

(b) Located on a well-drained site, free from hazardous conditions.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0510, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0520 What physical structure safety requirements must a facility meet? The licensee must keep the equipment and the physical structures in the facility safe and clean for the children/youth served. The licensee must:

(1) Maintain buildings, premises, and equipment in a clean and sanitary condition, free of hazards, and in good repair;

(2) Provide handrails for steps, stairways, and ramps; if required by the department of health or Washington state patrol fire protection bureau;

(3) Have emergency lighting devices, such as flashlights, available and in operational condition;

(2007 Ed.)

(4) Furnish the facility appropriately, based on the age and activities of the children and youth residing at the facility;

(5) Have washable, water-resistant floors in the apartments and facility bathrooms, kitchens, and any other rooms exposed to moisture. The department may approve washable, short-pile carpeting that is kept clean and sanitary for apartment and facility's kitchens;

(6) Provide tamper proof or tamper resistant electrical outlets or blank covers installed in areas accessible to children under the age of six or other persons with limited mental capacity or who might be endangered by access to them; and

(7) Have easy access to rooms occupied by children or youth in case an emergency arises. Some examples are bedrooms, toilet rooms, shower rooms, and bathrooms.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0520, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0530 What measures are required for pest control? The licensee must make reasonable attempts to keep the premises free from pests, such as rodents, flies, cockroaches, fleas, and other insects using the least toxic methods.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0530, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0540 What are the requirements regarding pets and animals in a facility? (1) Youth must not have any common household pets, exotic pets, animals, birds, insects, reptiles, or fish that are dangerous to children/youth on the premises.

(2) The department, at its discretion, may limit the type and number of common household pets, exotic pets, animals, birds, insects, reptiles or fish accessible to children if the department determines there are risks to the children/youth in care.

(3) The licensee must ensure that common household pets, exotic pets, animals, birds, insects, reptiles, and fish are free from disease and cared for in a safe and sanitary manner.

(4) Common household pets, exotic pets, animals, birds, insects, reptiles, and fish must be cared for in compliance with state regulations and local ordinances.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0540, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0550 Are alcoholic beverages or illegal drugs allowed at a facility? The facility must not have alcohol or illegal drugs on the premises. The staff of these facilities may not consume alcohol or illegal drugs on the premises or during breaks.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0550, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0560 Is smoking permitted around children or youth? (1) The licensee and staff must prohibit smoking in the living space of any facility caring for children/youth and in motor vehicles while transporting children/youth.

(2) The licensee may permit adults to smoke outdoors away from children/youth.

(3) Nothing in this section is meant to interfere with traditional or spiritual Native American or other religious ceremonies involving the use of tobacco.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0560, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0570 Are firearms allowed at a facility? The licensee must not permit firearms, ammunition, and other weapons on the premises of the facilities where children or youth reside.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0570, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0580 What are the requirements for storing dangerous chemicals or other substances? (1) The licensee must ensure that residents store the following items in a place that is not accessible to children or other persons with limited mental capacity or who might be endangered by access to these products:

- (a) Cleaning supplies;
- (b) Toxic or poisonous substances;
- (c) Aerosols; and
- (d) Items with warning labels.

(2) When containers are filled with toxic substances from a stock supply, the containers must be labeled.

(3) Toxic substances must be stored separately from food items.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0580, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0590 What first-aid supplies are needed? (1) The licensee must keep on hand for immediate use the following first aid supplies:

- (a) Barrier gloves and a one-way resuscitation mask;
- (b) Bandages and gauze;
- (c) Ace bandage;
- (d) Scissors and tweezers; and
- (e) A thermometer.

(2) The Poison Control Center's 1-800 number must be readily accessible to facility staff and teen parents.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0590, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0600 Is a telephone required at the facility? (1) The facility must have at least one telephone on the premises for incoming and outgoing calls. The telephone must be accessible for emergency use at all times.

(2) Emergency telephone numbers must be posted next to the telephone or in a specified location with easy access.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0600, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0610 What are the lighting requirements for the facility? The licensee must locate light fixtures and provide lighting that promotes good visibility and comfort for the children and youth residing at the facility.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0610, filed 12/9/04, effective 1/9/05.]

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WAC 388-147-0620 What are the requirements for laundry facilities? The department has specific requirements for on-site laundry facilities.

(1) The licensee must have separate and adequate facilities for storing soiled and clean linen.

(2) The licensee must locate laundry equipment in an area separate from the kitchen and childcare areas.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0620, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0630 What are the requirements for toilets, sinks, and bathing facilities? The licensee must meet certain requirements for toilets, sinks, and bathing facilities.

(1) The licensee must provide at least one indoor flush-type toilet, one nearby handwashing sink with hot and cold running water, and a bathing facility.

(2) Toilet and bathing facilities must allow privacy for children who are five years of age or older and opposite genders.

(3) Handwashing and bathing facilities must be provided with hot running water that does not exceed one hundred twenty degrees.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0630, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0640 What are the requirements about drinking water? The licensee must provide a public water supply or a private water supply approved by the local health authority at the time of licensing or relicensing.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0640, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0650 What are the requirements for sewage and liquid wastes? The licensee must ensure that sewage and liquid wastes are discharge into:

- (1) A public sewer system;
- (2) A functioning septic system; or
- (3) A department of health approved alternative system.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0650, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0660 Is a disaster plan required? (1) The licensee must ensure the facility has a disaster plan that addresses internal and external emergencies, such as a violent or threatening person on the premises, fire, earthquake, and power failure.

(2) Residents must be educated and familiar with the plan.

(3) The licensee must post a written disaster plan for easy access to staff and residents.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0660, filed 12/9/04, effective 1/9/05.]

FIRE SAFETY

WAC 388-147-0670 What fire safety procedures do case management and facility staff need to know? (1) Case managers and facility staff must be familiar with safety procedures related to fire prevention.

(2007 Ed.)

(2) The staff must be familiar with all aspects of the fire drill.

(3) The staff must be able to:

(a) Operate all fire extinguishers installed on the premises;

(b) Test smoke detectors (single station types); and

(c) Conduct frequent inspections of the facility to identify fire hazards and take action to correct any hazards noted during the inspection.

(4) If the facility has individual apartments for residents inspections of the apartments must be conducted with proper notice to apartment residents.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0670, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0680 What fire safety requirements must the licensee follow? A residential facility for pregnant or parenting teens and their children must comply with the regulations developed by the chief of the Washington state patrol through the director of the fire protection bureau (WSP/FPB). The regulations are the minimum requirements for protecting life and property against fire. Contact the WSP/FPB for specific requirements.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0680, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0690 What other requirements must I follow for smoke detectors? Facilities must have smoke detectors that are UL or Factory Mutual approved and comply with any other smoke detector requires of the Washington state patrol fire protection bureau.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0690, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0700 What fire safety instruction is required for children and youth residing in a facility? (1) The licensee or staff must:

(a) Conduct a fire drill at least once each month or as required under WAC 212-12-044 by WSPFPB, at varying times of the day and night so that staff on all shifts practice the procedures.

(b) Instruct children and youth who are capable of understanding and following emergency evacuation procedures how to exit the building in case of fire.

(c) Maintain a written record of such testing on the premises that indicates the date and time the test was completed.

(2) Any simulated fire drills for medically fragile or non-ambulatory children must meet WAC 212-12-005 as required by the WSP/FPB.

(3) If the use of a fire ladder is part of an evacuation plan it must be inspected annually to ensure it is in working order.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0700, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0710 What are the requirements for a fire or other emergency evacuation plan? (1) The licensee must develop a written emergency evacuation plan for the facility.

(2) The evacuation plan must include a floor plan, identifying exit doors and windows.

(2007 Ed.)

(3) The plan must be posted at each exit door.

(4) The licensee must ensure that the plan includes:

(a) Action to take by the person discovering a fire or other situation requiring emergency evacuation;

(b) Methods for sounding an alarm on the premises;

(c) Action to take for evacuating the building that ensures responsibility for the children;

(d) Action to take while waiting for the fire department or other emergency personnel; and

(e) If the use of a fire ladder is part of the evacuation plan it must be inspected at least annually to ensure it is in working order.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0710, filed 12/9/04, effective 1/9/05.]

WAC 388-147-0720 Are there different construction and fire safety requirements for facilities that have multiple licenses in the same building? (1) A facility with multiple Washington state licenses or certifications for the care of children or youth in the same building must comply with the most stringent construction and fire safety requirements for the physical structure, if children and youth share the same space.

(2) If the same facility has multiple Washington state licenses the licensee must notify the following of this:

(a) The Washington state patrol fire protection bureau inspector; and

(b) All of the licensing and certification agents.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 05-01-075, § 388-147-0720, filed 12/9/04, effective 1/9/05.]

Chapter 388-148 WAC

LICENSING REQUIREMENTS FOR CHILD FOSTER HOMES, STAFFED RESIDENTIAL HOMES, GROUP RESIDENTIAL FACILITIES, AND CHILD-PLACING AGENCIES

WAC

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GROUP CARE FACILITY—GROUP RECEIVING CENTERS—
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- 388-148-1255 What are the requirements for an activity program?
 388-148-1260 What activities must I provide to children?
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DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER

- 388-148-0285 Do I need a housekeeping sink? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0285, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.
 388-148-0360 Whom do I notify about medication changes and reactions? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0360, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.
 388-148-0450 What types of toys must I provide to children? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0450, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.
 388-148-0500 May I receive more than one in-home care license? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0500, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.
 388-148-0615 Are there specific fire safety requirements for the care of nonmobile children? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0615, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.
 388-148-0630 What fire prevention measures must I take? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0630, filed 8/28/01, effective 9/28/01.] Repealed by 04-

08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.

- 388-148-0635 What are the requirements for fire sprinkler systems? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0635, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.

- 388-148-0650 What requirements do you have regarding windows in staffed residential homes and group care facilities? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0650, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.

- 388-148-0735 When do I need a special care room? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0735, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.

- 388-148-0935 How long may a youth stay at a CRC? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0935, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.

- 388-148-1020 Must a staffed residential home operate in conjunction with another program? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1020, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.

- 388-148-1065 Do child-placing agency foster homes and group care facilities need to be licensed before placements? [Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1065, filed 8/28/01, effective 9/28/01.] Repealed by 04-08-073, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW.

PURPOSE AND DEFINITIONS

WAC 388-148-0005 What is the purpose of this chapter? The department issues or denies a license or certification on the basis of compliance with licensing requirements. This chapter defines general and specific licensing requirements for foster homes, staffed residential homes, group facilities, and child-placing agencies. We include licensing requirements for people who operate foster homes, group care programs and facilities, staffed residential homes, and child-placing agencies. In addition, we describe our requirements for specialized services offered in these homes and facilities, including: Maternity services, day treatment services, crisis residential centers, group receiving centers services for children with severe developmental disabilities and programs for medically fragile children. Unless noted otherwise, these requirements apply to people who want to be licensed, certified, relicensed and re-certified.

The department is committed to ensuring that the children who receive care experience health, safety, and well-being. We want these children's experiences to be beneficial to them not only in the short run, but also in the long term. Our licensing requirements reflect our commitment to children.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0005, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0005, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0010 What definitions do I need to know to understand this chapter? The following definitions are for the purpose of this chapter and are important to understand these rules:

"Abuse or neglect" means the injury, sexual abuse, sexual exploitation, negligent treatment or mistreatment of a child where the child's health, welfare and safety are harmed.

"Agency" is defined in RCW 74.15.020(1).

"Assessment" means the appraisal or evaluation of a child's physical, mental, social and/or emotional condition.

"Capacity" means the maximum number of children that a home or facility is licensed to care for at a given time.

"Care provider" means any licensed or certified person or organization or staff member of a licensed organization that provides twenty-four-hour care for children.

"Case manager" means the private agency employee who coordinates the planning efforts of all the persons working on behalf of a child. Case managers are responsible for implementing the child's case plan, assisting in achieving those goals, and assisting with day-to-day problem solving.

"Certification" means:

(1) Department approval of a person, home, or facility that does not legally need to be licensed, but wishes to have evidence that it meets the minimum licensing requirements; or

(2) Department licensing of a child-placing agency to certify that a foster home meets licensing requirements.

"Children" or **"youth,"** for this chapter, means individuals who are:

(1) Under eighteen years old, including expectant mothers under eighteen years old; or

(2) Up to twenty-one years of age and pursuing a high school, equivalent course of study (GED), or vocational program;

(3) Up to twenty-one years of age with developmental disabilities; or

(4) Up to twenty-one years of age if under the custody of the Washington state juvenile rehabilitation administration.

"Child-placing agency" means an agency licensed to place children for temporary care, continued care or adoption.

"Crisis residential center (CRC)" means an agency under contract with DSHS that provides temporary, protective care to children in a foster home, regular (semi-secure) or secure group setting.

"Compliance agreement" means a written licensing improvement plan to address deficiencies in specific skills, abilities or other issues of a fully licensed home or facility in order to maintain and/or increase the safety and well-being of children in their care.

"DCFS" means the division of children and family services.

"DDD" means division of developmental disabilities.

"Department" means the department of social and health services (DSHS).

"Developmental disability" is a disability as defined in RCW 71A.10.020.

"DLR" means the division of licensed resources.

"Firearms" means guns or weapons, including but not limited to the following: BB guns, pellet guns, air rifles, stun guns, antique guns, bows and arrows, handguns, rifles, and shotguns.

"Foster-adopt" means placement of a child with a foster parent(s) who intends to adopt the child, if possible.

"Foster home or foster family home" means person(s) licensed to regularly provide care on a twenty-four-hour basis to one or more children in the person's home.

"Full licensure" means an entity meets the requirements established by the state for licensing or approved as meeting state minimum licensing requirements.

"Group care facility for children" means a location maintained and operated for a group of children on a twenty-four-hour basis.

"Group receiving center" or "GRC" means a facility providing the basic needs of food, shelter, and supervision for more than six children placed by the department, generally for thirty or fewer days. A group receiving center is considered a group care program and must comply with the group care facility licensing requirements.

"Hearing" means the administrative review process.

"I" refers to anyone who operates or owns a foster home, staffed residential home, and group facilities, including group homes, child-placing agencies, maternity homes, day treatment centers, and crisis residential centers.

"Infant" means a child under one year of age.

"License" means a permit issued by the department affirming that a home or facility meets the minimum licensing requirements.

"Licensor" means:

(1) A division of licensed resources (DLR) employee at DSHS who:

(a) Approves licenses or certifications for foster homes, group facilities, and child-placing agencies; and

(b) Monitors homes and facilities to ensure that they continue to meet minimum health and safety requirements.

(2) An employee of a child-placing agency who:

(a) Attests that foster homes supervised by the child-placing agency meets licensing requirements; and

(b) Monitors those foster homes to ensure they continue to meet the minimum licensing standards.

"Maternity service" as defined in RCW 74.15.020.

"Medically fragile" means the condition of a child who has a chronic illness or severe medical disabilities requiring regular nursing visits, extraordinary medical monitoring, or on-going (other than routine) physician's care.

"Missing child" means:

(1) Any child up to eighteen years of age for whom Children's Administration (CA) has custody and control (not including children in dependency guardianship) and:

(a) The child's whereabouts are unknown; and/or

(b) The child has left care without the permission of the child's caregiver or CA.

(2) Children who are missing are categorized under one of the following definitions:

(a) **"Taken from placement"** means that a child's whereabouts are unknown, and it is believed that the child is being or has been concealed, detained or removed by another person from a court-ordered placement and the removal, concealment or detainment is in violation of the court order;

(b) **"Absence not authorized, whereabouts unknown"** means the child is not believed to have been taken from placement, did not have permission to leave the placement, and there has been no contact with the child and the whereabouts of the child is unknown; or

(c) **"Absence not authorized, whereabouts known"** means that a child has left his or her placement without permission and the social worker has some contact with the child or may periodically have information as to the whereabouts of the child.

"Multidisciplinary teams (MDT)" means groups formed to assist children who are considered at-risk youth or children in need of services, and their parents.

"Nonambulatory" means not able to walk or traverse a normal path to safety without the physical assistance of another individual.

"Out-of-home placement" means a child's placement in a home or facility other than the child's parent, guardian, or legal custodian.

"Premises" means a facility's buildings and adjoining grounds that are managed by a person or agency in charge.

"Probationary license" means a license issued as part of a disciplinary action to an individual or agency that has previously been issued a full license but is out of compliance with minimum licensing requirements and has entered into an agreement aimed at correcting deficiencies to minimum licensing requirements.

"Psychotropic medication" means a type of medicine that is prescribed to affect or alter thought processes, mood, sleep, or behavior. These include anti-psychotic, antidepressants and anti-anxiety medications.

"Relative" means a person who is related to the child as defined in RCW 74.15.020 (4)(a)(i), (ii), (iii), and (iv) only.

"Respite" means brief, temporary relief care provided to a child and his or her parents, legal guardians, or foster parents with the respite provider fulfilling some or all of the functions of the care-taking responsibilities of the parent, legal guardian, or foster parent.

"Secure facilities" means a crisis residential center that has locking doors and windows, or secured perimeters intended to prevent children from leaving without permission.

"Service plan" means a description of the services to be provided or performed and who has responsibility to provide or perform the activities for a child or child's family.

"Severe developmental disabilities" means significant disabling, physical and/or mental condition(s) that cause a child to need external support for self-direction, self-support and social participation.

"Social service staff" means a clinician, program manager, case manager, consultant, or other staff person who is an employee of the agency or hired to develop and implement the child's individual service and treatment plans.

"Staffed residential home" means a licensed home providing twenty-four-hour care for six or fewer children or expectant mothers. The home may employ staff to care for children or expectant mothers. It may or may not be a family residence.

"Standard precautions" is a term relating to procedures designed to prevent transmission of bloodborne pathogens in health care and other settings. Under standard precautions, blood or other potentially infectious materials of all people should always be considered potentially infectious for HIV and other pathogens. Individuals should take appropriate precautions using personal protective equipment like gloves to prevent contact with blood or other bodily fluids.

"Washington state patrol fire protection bureau" or **"WSP/FPB"** means the state fire marshal.

"We" or **"our"** refers to the department of social and health services, including DLR licensors and DCFS social workers.

"You" refers to anyone who operates a foster home, staffed residential home, and group facilities, including group homes, maternity programs, day treatment programs, crisis residential centers, group receiving centers, and child-placing agencies.

[Statutory Authority: RCW 74.15.030, 74.08.090, and chapters 74.13 and 74.15 RCW. 06-22-030, § 388-148-0010, filed 10/25/06, effective 11/25/06. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0010, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0010, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0015 Am I required to have a license to provide care to children? (1) If you regularly provide care on a twenty-four hour basis to a child who is not related to you, you must be licensed.

(2) The types of homes or facilities that need a license include:

- (a) Foster homes;
- (b) Group care programs;
- (c) Programs for medically fragile children and children with severe developmental disabilities;
- (d) Maternity services;
- (e) Day treatment programs;
- (f) Crisis residential centers;
- (g) Staffed residential homes;
- (h) Child-placing agencies; and
- (i) Group receiving centers.

Note: Homes and facilities offering maternity services, day treatment, crisis residential centers, group receiving centers, services to medically fragile children and/or children with severe developmental disabilities will need to follow the specific program requirements outlined in this chapter as well.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0015, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0015, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0020 When is a license not required if I provide care to children? The department does not require licenses for people providing care in any of the situations as defined in RCW 74.15.020(2).

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0020, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0020, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0025 How do you decide how many children I may serve in my home or facility? (1) The department approves the number of children that a home or facility may serve, based on an evaluation of these factors:

- (a) Physical accommodations in your home or facility;
- (b) The number of staff, family members and volunteers available for providing care;
- (c) Your skills and the skills of your staff;
- (d) The ages and characteristics of the children you are serving; and

(e) The certification of occupancy from the Washington state department of health if your facility is a group care program, or a staffed residential home licensed for six children.

(2) Based on the evaluation, the department may license you for the care of fewer children than you normally would serve in your category of care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0025, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0025, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—STAFF QUALIFICATIONS

WAC 388-148-0030 How old do I have to be to apply for a license to provide care to children? You must be at least twenty-one years old to apply for a license to provide care to children.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0030, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0035 What personal characteristics do I need to provide care to children? If you are requesting a license, certification, or a position as an employee, volunteer, intern, or contractor in a foster home, group care facility, staffed residential home, or child-placing agency you must have the following specific personal characteristics:

(1) You must demonstrate that you have the understanding, ability, physical health, emotional stability and personality suited to meet the physical, mental, emotional, and social needs of the children under your care.

(2) You must not have been disqualified by our background check (chapter 388-06 WAC) prior to having unsupervised access to children.

(3) You have not had a license denied or revoked from an agency that regulates the care of children or vulnerable adults, unless the department determines that you do not pose a risk to a child's safety, well being, and long-term stability.

(4) You must not have been found to have committed abuse or neglect of a child or vulnerable adult, unless the department determines that you do not pose a risk to a child's safety, well being, and long-term stability.

(5) You must have the ability to furnish the child with a nurturing, respectful, supportive, and responsive environment.

(6) The department may require you to give additional information. We may request this information at any time and it may include, but is not limited to:

(a) Substance and alcohol abuse evaluations and/or documentation of treatment;

(b) Psychiatric or psychological evaluations;

(c) Psycho-sexual evaluations; and

(d) Medical evaluations and/or medical records.

(7) Any evaluation requested under WAC 388-148-0035 (6)(a)-(d) will be at the applicant/licensees expense.

(8) The licensor must be given permission to speak with the evaluator/provider prior to and after the evaluation.

(9) Misrepresentation by a prospective employee, intern, or volunteer may be grounds for termination or denial of employment or volunteer service by that individual.

[Title 388 WAC—p. 680]

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0035, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0035, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—TRAINING REQUIRED

WAC 388-148-0040 What first-aid and cardiopulmonary resuscitation (CPR) training is required? (1) If you have a home or facility that provides licensed care, you, your staff, interns, volunteers, and any individual who may at any time be the sole caregiver, must have basic standard first aid and age-appropriate cardiopulmonary resuscitation (CPR) training.

(2) The approved first aid and CPR training must be in accordance with a nationally recognized standard.

(3) For licensed facilities and homes, a person with first aid and CPR training must be on the premises when children are present.

(4) The CPR training is not required for licensees with a statement from their physician that the training is not advised for medical reasons. However, another person with current CPR training must be on the premises when children are present.

(5) You must keep records in your home or facility showing who has completed current first-aid and CPR training.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0040, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0040, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0045 What HIV/AIDS and blood-borne pathogens training is required? (1) You must provide or arrange for training for yourself, your staff, and any individual who may at anytime be the sole caregiver, on the prevention and transmission of HIV/AIDS, and bloodborne pathogens. Such training must include infection control standards.

(2) You must use infection control requirements and educational material consistent with the current approved curriculum *Know - HIV/AIDS Prevention Education for Health Care Facility Employees*, published by the department of health, office on HIV/AIDS.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0045, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0045, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—APPLICATION AND LICENSING PROCESS

WAC 388-148-0050 How do I apply for a license? License applications are available from the division of licensed resources and licensed child placing agencies.

(1) To apply for a license, the person or legal entity responsible for your home or facility must include with the application the following:

(a) Written verification for each applicant(s), staff, interns, volunteers and individuals who may have unsupervised access to children in care of the following information:

(i) A negative tuberculosis test or an X ray, unless you can demonstrate a religious or a medical reason prohibiting the test;

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Note: Written documentation from your physician that indicates you are free of the signs and symptoms of tuberculosis may be accepted for individuals with a religious or a medical prohibition to the TB test.

(ii) First aid and cardio-pulmonary resuscitation (CPR) training appropriate to the age of the children in care; and

(iii) HIV/AIDS and bloodborne pathogens training including infection control standards.

(2) You must send a completed background check form to your licensur on anyone on the premises having unsupervised access to a child who:

(a) Is at least sixteen years old or older;

(b) Is not a foster child; nor an individual eighteen through twenty years old authorized to remain in foster care (see chapter 388-06 WAC).

(3) You must send a completed FBI fingerprint form on any individual in your home or facility who has lived outside Washington state within the last three years and meets WAC 388-148-0050 (2)(a)(b).

(4) A group care facility or staffed residential home licensed for six is required to meet the health and fire safety requirements to receive a certificate of compliance from the department of health and the Washington state patrol fire protection bureau.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-21-063, § 388-148-0050, filed 10/18/04, effective 11/18/04; 04-08-073, § 388-148-0050, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0050, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0055 How long do I have to complete the licensing application packet? (1) You must complete your licensing application with supporting documents, such as training certificates, within ninety days of first applying for your license. If you fail to meet this deadline and have not contacted your licensur, your licensur may consider your application withdrawn.

(2) If you are applying for a license renewal, other than as a foster home, you must send the application form to your licensur at least ninety days prior to the expiration of your current license.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0055, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0055, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0058 May I receive more than one in-home family license? (1) The department does not issue licenses for both a foster home and another kind of in-home family care, except in rare situations.

(2) In rare situations, a family that has demonstrated exceptional abilities in relation to meeting the special needs of children to be cared for may be granted approval to be licensed for foster care and another type of in-home family care. Approval may be granted if it appears to be in the best interest of the child and would not jeopardize the health and safety of children in the home.

(3) The following conditions apply to a home with more than one in-home family license:

(a) It must be clear that one type of care does not interfere with the health and safety of any child while providing the other type of care; and

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(b) The total number of children in all categories of care must not exceed te number permitted by the most stringent capacity standards for the licensed care of children.

(4) The approval for more than one in-home family license must be in writing and signed by the director of the division of licensed resources or designee and the appropriate authority of the other division.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0058, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0060 May my relative or I be certified by a child-placing agency to be a foster parent and be an employee of that same agency? (1) You or your relative(s), are not allowed to be certified by a child-placing agency as a foster home, if you or your relative is in an administrative or supervisory role, or directly involved in:

(a) Foster home certification;

(b) Placement;

(c) Case management; or

(d) Authorization of payment to yourself or your relative for that same child-placing agency.

(2) A foster parent certified by a child-placing agency who becomes employed by that agency, in one of the roles listed in WAC 388-148-0060(1) must be recertified through an agency other than their employer or licensed directly by DLR within six months of employment.

Note: Relative as defined under RCW 74.15.020 (4)(i) through (iv).

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0060, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0060, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0065 When may I be certified to provide care to children? When you meet the licensing requirements, you may apply for certification of your home or facility by the department rather than a license, if the following conditions apply:

(1) You are exempt from needing a license (per chapter 74.15 RCW); and

(2) You wish to serve department-funded children; or

(3) You are licensed by authority of an Indian tribe within the state under RCW 74.15.190.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0065, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0065, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0070 Is there a difference between licensing and certification? (1) The department has the sole legal authority to license or approve homes and facilities for the care of children in out-of-home placement.

(2) The department may license a child-placing agency, including a Tribal CPA, to operate foster home, staffed residential home, and/or group care facilities.

(3) The child-placing agency is only authorized to "certify" or attest to the department that the foster home meets the licensing requirements.

(4) The certification requirements are the same as the licensing requirements and are contained in this chapter.

(5) The department has the final approval for licensing the home or facility that the CPA will be supervising.

(6) The department's representative signs the license of the home or facility.

(7) A home "certified" by a child-placing agency (CPA) and licensed by the department must be supervised by that CPA to have a valid license.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0070, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0070, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0075 May I be licensed with the department and certified by a child-placing agency at the same time? You may not be licensed directly by the department to provide foster care to children and be certified and supervised by a child-placing agency, at the same time.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0075, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0075, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0080 What may I do if I disagree with the decision of a child-placing agency that I do not meet the licensing requirements? If you disagree with the child-placing agency's decision, you must abide by the child-placing agency's grievance process to challenge the decision.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0080, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—CORRECTIVE ACTION

WAC 388-148-0085 Will the department license or continue to license a home or facility if the home or facility does not meet the licensing requirements? (1) At its discretion, the department may make exceptions and license or continue to license a home or facility that does not meet the minimum licensing requirements.

(2) Exceptions are approved for nonsafety requirements only.

(3) The safety and well-being of the children receiving care must not be compromised.

(4) The request for an exception to the licensing requirements must be in writing.

(5) You must keep a copy of the approved exception to the licensing requirements for your files.

(6) Along with an exception to the licensing requirements, the department may limit or restrict a license issued to you and/or require you to enter into a compliance agreement to ensure the safety and well-being of the children in your care.

(7) You do not have appeal rights if the department in its discretion denies your request for an exception to the minimum licensing requirements.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0085, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0085, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0090 Does the department issue probationary license? (1) The department may issue a probationary license as part of a corrective action plan with a licensed provider.

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(2) The department will base its decision as to whether a probationary license will be issued on a consideration of the following:

(a) Intentional or negligent noncompliance with the licensing rules;

(b) A history of noncompliance with the rules;

(c) Current noncompliance with the rules;

(d) Evidence of a good faith effort to comply; and

(e) Any other factors relevant to the specific situation.

(3) A probationary license may be issued for up to six months. At its discretion, the department may extend the probationary license for an additional six months. A decision not to issue a probationary license is not subject to appeal.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0090, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0090, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0095 When are licenses denied, suspended or revoked? (1) A license must be denied, suspended or revoked if the department decides that you cannot provide care for children in a way that ensures their safety, health and well-being.

(2) The department must, also, disqualify you for any of the following reasons:

(a) You have been disqualified by your background check (see chapter 388-06 WAC).

(b) You have been found to have committed child abuse or neglect or you treat, permit or assist in treating children in your care with cruelty, indifference, abuse, neglect, or exploitation, unless the department determines that you do not pose a risk to a child's safety, well-being, and long-term stability.

(c) You or anyone living on the premises had a license denied or revoked from an agency that regulates care of children or vulnerable adults, unless the department determines that you do not pose a risk to children or vulnerable adults.

(d) You try to get a license by deceitful means, such as making false statements or omitting critical information on the application.

(e) You commit, permit or assist in an illegal act on the premises of a home or facility providing care to children.

(f) You are using illegal drugs, or excessively using alcohol and/or prescription drugs.

(g) You knowingly allowed employees or volunteers who made false statements or omit critical information on their applications to work at your agency.

(h) You knowingly allowed employees or volunteers who use illegal drugs, alcohol, or prescription drugs that affect their ability to perform their job duties to work at your agency or be on the premises when children are present.

(i) You repeatedly lack qualified or an adequate number of staff to care for the number and types of children under your care. Repeatedly means more than twice during a six-month period.

(j) You have refused to allow our authorized staff and inspectors to have requested information or access to your facility, child and program files, and/or your staff and clients.

(k) You are unable to properly manage the property, fiscal responsibilities, or staff in your agency.

(l) You have failed to comply with the federal and state laws for any Native American children that you have under care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0095, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0095, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0098 When is an employee or volunteer disqualified from having unsupervised access to a child in a licensed home, facility, or agency? The department must disqualify an employee or volunteer of a licensed home, facility, or agency from having unsupervised access to a child(ren) when he or she:

(1) Has a disqualifying background check (see chapter 388-06 WAC);

(2) Has been found to have committed child abuse or neglect or have treated, permitted, or assisted in treating children with cruelty, indifference, abuse, neglect, or exploitation;

(3) Had a license denied or revoked from an agency that regulates the care of children or vulnerable adults;

(4) Attempted to become employed, volunteer, or otherwise have unsupervised access to children by deceitful means, such as making false statements or omitting critical information on an application to work or volunteer at a licensed home, facility, or agency;

(5) Used illegal drugs, alcohol, or prescription drugs that affected their ability to perform their job duties while on the premises when children are present; or

(6) Has committed, permitted, or assisted in an illegal act on the premises of a home or facility providing care to children.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0098, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0100 Are there any other reasons that might cause me to lose my license? The department may suspend or revoke your home or facility license if you:

(1) Exceed the conditions of your home or facility license by:

(a) Having more children than the license allows;

(b) Having children with ages or genders different than the license allows;

(c) Failing to provide a safe, healthy and nurturing environment for children under your care; or

(d) Failing to comply with any of the other licensing requirements.

(2) Fail to meet the health and safety requirements to receive a certificate of compliance as required by the department of health and/or the Washington state patrol fire protection bureau.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0100, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0100, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0105 How do you notify me if you have modified, denied, suspended, or revoked my license? The department sends you a certified letter informing you of the decision to modify, deny, suspend or revoke your license. In the letter, the department also tells you what you need to do if you disagree with the decision.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0105, filed 8/28/01, effective 9/28/01.]

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WAC 388-148-0110 What may I do if I disagree with your decision to modify, deny, suspend or revoke my license? You have the right to appeal any decision the department makes to deny, modify, suspend, or revoke your license.

(1) You may request an administrative hearing to disagree with the department's decision to modify, suspend, revoke or deny your license.

(2) You must request an administrative hearing within twenty-eight days of receiving a certified letter with the department's decision (see chapter 34.05 RCW).

(3) You must send a letter to the office of administrative hearings, P.O. Box 42488, Olympia, Washington 98504-2488, 1-800-583-8271 requesting an administrative hearing. The letter must have the following attachments:

(a) A specific statement of your reasons for disagreeing with the department decision and any laws that relate to your reasons; and

(b) A copy of the certified letter from the department that you are disputing.

(4) The administrative hearing will take place before an administrative law judge employed by the office of administrative hearings.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0110, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0110, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0115 May I appeal the decision of the office of administrative hearings' administrative law judge? (1) The decision of the administrative law judge (ALJ) will become the final decision of the department, unless either you or the department files a petition for review with DSHS board of appeals within twenty-one days after the administrative law judge's initial decision is mailed to the parties.

(2) The procedure for requesting, or responding to, a petition for review with the board of appeals is in WAC 388-02-0560 through 388-02-0635.

(3) If either party asks for a review, the decision of the board of appeals review judge will be the department's final decision.

(4) If you disagree with the decision of the board of appeals, you may file a petition in superior court and ask for judicial review. The procedure for judicial review is in RCW 34.05.510 to 34.05.598.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0115, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—RECORD-KEEPING/REPORTING/PERSONNEL POLICIES/POSTING OF LICENSE

WAC 388-148-0120 What incidents involving children must I report? (1) You or your staff must report the incidents contained in WAC 388-148-0120(2), as soon as possible and in no instance later than forty-eight hours to your local:

(a) Children's administration intake staff, and

(b) The child's social worker or case manager.

(2) The incidents to be reported include:

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(a) Any reasonable cause to believe that a child has suffered child abuse or neglect;

(b) Any violations of the licensing or certification requirements where the health and safety of a foster child is at risk and the violations are not corrected immediately;

(c) Death of a child;

(d) Any child's suicide attempt that results in injury requiring medical treatment or hospitalization;

(e) Any use of physical restraint that is alleged improperly applied or excessive;

(f) Sexual contact between two or more children that is not considered typical play between preschool age children;

(g) Any disclosures of sexual or physical abuse by a child in care;

(h) Physical assaults between two or more children that result in injury requiring off-site medical attention or hospitalization;

(i) Physical assaults of foster parent or staff by children that result in injury requiring off-site medical attention or hospitalization;

(j) Any medication that is given incorrectly and requires off-site medical attention; or

(k) Serious property damage or other significant licensing requirement that is a safety hazard and is not immediately corrected or may compromise the continuing health and safety of children.

(3) You or your staff must report the following incidents as soon as possible or in no instance later than forty-eight hours, to the child's social worker, if the child is in the department's custody or to the case manager if placed with a child-placing agency program:

(a) Suicidal/homicidal ideations, gestures, or attempts that do not require professional medical treatment;

(b) Unexpected health problems outside the anticipated range of reactions caused by medications, that do not require professional medical attention;

(c) Any incident of medication incorrectly administered;

(d) Physical assaults between two or more children that result in injury but did not require professional medical attention;

(e) Any emergent medical or psychiatric care that requires off-site attention; and

(f) Use of prohibited physical restraints for behavior management as described in WAC 388-148-0485.

(4) Programs providing care to medically fragile children who have nursing care staff on duty may document the incidents described in WAC 388-148-0120 (3)(b)(c) in the facility daily logs, rather than contacting the social worker or case manager, if agreed to in the child's ISSP.

[Statutory Authority: RCW 74.15.030, 74.08.090, and chapters 74.13 and 74.15 RCW. 06-22-030, § 388-148-0120, filed 10/25/06, effective 11/25/06. Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0120, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0120, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0123 What are my reporting responsibilities when a child is missing from care? (1) As soon as you have reason to know a child in your care is missing as defined in WAC 388-148-0010, or has refused to return to or remain in your care, or whose whereabouts are otherwise

unknown, you or your staff are required to notify the following:

(a) The child's assigned social worker, if the child is in the department's custody;

(b) CA intake, if the social worker is not available or it is after normal business hours; or

(c) The case manager if the child is placed by a child-placing agency program.

(2) You or your staff are required to contact local law enforcement if the child is missing as defined in WAC 388-148-0010 within six hours. However, if one or more of the following factors are present, you must contact law enforcement immediately:

(a) The child has been, or is believed to have been, taken from placement as defined in WAC 388-148-0010;

(b) The child has been, or is believed to have been, lured from placement or to have left placement under circumstances that indicate the child may be at risk of physical or sexual assault or exploitation;

(c) The child is age thirteen or younger;

(d) The child has one or more physical or mental health conditions that if not treated daily will place the child at severe risks;

(e) The child is pregnant or parenting and the infant/child is believed to be with him or her;

(f) The child has severe emotional problems (e.g., suicidal ideations) that if not treated will place the child at severe risk;

(g) The child has a developmental disability that impairs the child's ability to care for him/herself;

(h) The child has a serious alcohol and/or substance abuse problem; or

(i) The child is at risk due to circumstances unique to that child.

After contacting local law enforcement, the Washington State Patrol's (WSP) Missing Children Clearinghouse must also be contacted and informed that the child is missing from care. The telephone number for the Clearinghouse is 1 (800) 543-5678.

(3) If the child leaves school or has an unauthorized absence from school, the caregiver should consult with the social worker to assess the situation and determine when law enforcement should be called. If any of the factors listed in subsections (2)(a) through (h) of this section are present, the caregiver and the social worker may decide it is appropriate to delay notification to law enforcement for up to four hours after the end of the school day to give the child the opportunity to return on their own.

(4) The caregiver will provide the following information to law enforcement and to the social worker when making a missing child report, if available:

(a) When the child left;

(b) Where the child left from;

(c) What the child was wearing;

(d) Any known behaviors or interactions that may have precipitated the child's departure;

(e) Any possible places the child may go to;

(f) Any special physical or mental health conditions or medications that affect the child's safety;

(g) Any known companions who may be aware of and involved in the child's absence;

- (h) Other professionals, relatives, significant adults or peers who may know where the child would go; and
- (i) A recent photo of the child.
- (5) The caregiver should obtain the number of the missing person report and provide that number to CA staff.

[Statutory Authority: RCW 74.15.030, 74.08.090, and chapters 74.13 and 74.15 RCW. 06-22-030, § 388-148-0123, filed 10/25/06, effective 11/25/06.]

WAC 388-148-0125 What are your requirements for keeping client records? (1) Any identifying and personal information about a child and the child's family must be kept confidential.

(2) You must keep records about children and their families in a secure place. For foster homes, if the child is in the department's custody, at the end of the child's placement, reports and information about the child or the child's family must be returned to the child's social worker.

(3) During a placement in your foster home, your records must be kept at your home and contain, if available, at a minimum, the following information:

- (a) The child's name, birth date, and legal status;
- (b) Name and telephone number of the social worker for each child in care;
- (c) Names, address and telephone numbers of parents or persons to be contacted in case of emergency;
- (d) Information on specific cultural needs of the child;
- (e) Medical history including any medical problems, name of doctor, type of medical coverage and provider;
- (f) Mental health history and any current mental health, chemical dependency, and behavioral issues, including medical and psychological reports when available;
- (g) Other pertinent information related to the child's health, including dental records;
- (h) Immunizations are not required to be current for children placed in:
 - (i) Receiving and interim care homes and facilities;
 - (ii) Crisis residential centers; and
 - (iii) A foster home licensed by a child-placing agency to provide emergency respite services to parents on a voluntary placement agreement.

Note: If a child's placement extends beyond thirty days, you must obtain the child's immunization records. If the child is not current with immunization, they must be updated as soon as medically possible.

- (i) Child's school records, report cards, school pictures, and individual education plans (IEP);
- (j) Special instructions including supervision requirements and suggestions for managing problem behavior;
- (k) Inventory of the child's personal belongings at the time of placement; and
- (l) The child's visitation plan.
- (4) During a child's placement in a home or facility, the child's record must be kept secure at the site and contain, at a minimum, the following information in addition to the information in subsection (3)(a) through (l) of this section:
 - (a) Written consent from the child placing agency, if any, for providing medical care and emergency surgery (unless that care is authorized by a court order);
 - (b) Names, addresses, and telephone numbers of persons authorized to take the child under care out of the facility;

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(c) A copy of the court order or voluntary placement agreement that gives approval to place the child;

(d) Case plans, such as children's administration's "individual service and safety plan (ISSP);" and

(e) Documentation of therapy treatment received by children with the signature of the person making the entry to the therapy or progress notes.

(5) If you operate a group care program, staffed residential home, or child-placing agency and have client files with information not returned to the department, you must keep them for six years following the termination or expiration of any contract you have with the department.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0125, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0125, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0127 What are the requirements for information kept in facility logs for staffed residential homes and group care programs? (1) Staffed residential homes and group care programs must document the following information for each shift:

- (a) Serious child health or safety issues;
- (b) Dates and illnesses or accidents while in care;
- (c) Medications and treatments given with the child's name;
- (d) After-hours telephone number of the supervisor;
- (e) On-call and relief staff on premises during emergencies; and
- (f) The signature of the staff person reviewing the log.
- (2) Staffed residential homes and group care programs must keep current:
 - (a) Medication logs;
 - (b) Incident logs, including a copy of any suspected child abuse and/or neglect referrals made to children's administration; and
 - (c) Daily or shift logs.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0127, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0130 What information may I share about a child or a child's family? (1) Information about a child or the child's family is confidential and must only be shared with people directly involved in the case plan for a child.

(2) You may discuss information about the child, the child's family and the case plan only with:

- (a) A representative of the department, including staff from DCFS and DLR; department of health and the office of the state fire marshal;
- (b) A child-placing agency case manager assigned to the child;
- (c) The child's assigned guardian ad litem or court-appointed special advocate; or
- (d) Others designated by the child's social worker.
- (3) You may check with your child's social worker for guidance about sharing information with the child's teacher, counselor, doctor, respite care provider, any other professional, or others involved in the case plan.

(4) Child-placing agencies and the department must share with the child's care provider any information about the child and child's family related to the case plan.

[Title 388 WAC—p. 685]

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0130, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0130, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0135 What changes to my home or facility must I report to my licensor? (1) You must report to your licensor immediately any changes in the original licensing application. Changes include any of the following:

(a) Changes in your location or designated space, including address;

(b) Changes in your phone number;

(c) Changes in the maximum number, age ranges, and sex of children you wish to serve;

(d) Changes in the structure of your facility or premises from events causing damage, such as a fire, or from remodeling;

(e) Addition of any new staff person, employee, intern, contractor, or volunteer, who might have unsupervised contact with the children in care; or

(f) Changes in household composition, such as:

(i) A marriage, separation or divorce;

(ii) Incapacity or serious physical or mental illness of a foster parent or member of the household;

(iii) The death of anyone in the household;

(iv) A change in employment status or significant change in income; or

(v) A change in who resides in the household or is on the premises for more than fourteen days.

(g) Any arrests or convictions that occur between the date of your license and the expiration date of your license for you or anyone sixteen years or older residing at your home.

(2) A license is valid only for the person or organization named on the license and only for the specific address listed on the license. If you operate a group facility or child-placing agency, you must also report any of the following changes to your licensor:

(a) A change of your agency's executive director or any staff changes;

(b) The death, retirement, or incapacity of the person who holds the license;

(c) A change in the name of a licensed corporation, or the name by which your facility is commonly known; or

(d) Changes in an agency's articles of incorporation and bylaws.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0135, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0135, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0140 What personnel policies must I have? (1) You must comply with federal and state antidiscrimination laws related to personnel policies and procedures.

You must keep a background check log that contains information on dates of request and completion of the checks.

(2) If you have five or more staff, volunteers, or interns you must have written policies covering qualifications, training, and duties for employees, interns, and volunteers.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0140, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0140, filed 8/28/01, effective 9/28/01.]

[Title 388 WAC—p. 686]

WAC 388-148-0145 Where do I post my license? (1) Foster home parents do not need to post their license.

(2) If you operate any other kind of home, facility, or agency you must post your license where the public can easily view it.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0145, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—HEALTH AND GENERAL SAFETY

WAC 388-148-0150 Are local ordinances part of the licensing requirements? (1) You are responsible for complying with local ordinances (laws), such as zoning regulations and local building codes.

(2) The department may require you to provide proof that you are complying with local ordinances.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0150, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0150, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0155 What physical structure safety requirements must my home or facility meet? You must keep the equipment and the physical structures in your home or facility safe and clean for the children you serve. You must:

(1) Maintain your buildings, premises, and equipment in a clean and sanitary condition, free of hazards, and in good repair;

(2) Provide handrails for steps, stairways, and ramps; if required by the department;

(3) Have emergency lighting devices available and in operational condition;

(4) Furnish your home or facility appropriately, based on the age and activities of the children under care.

(5) Have washable, water-resistant floors in your home or facility bathrooms, kitchens, and any other rooms exposed to moisture. The department may approve washable, short-pile carpeting that is kept clean and sanitary for your home or facility's kitchens.

(6) All homes and facilities must provide tamper proof or tamper resistant electrical outlets or blank covers installed in areas accessible to children under the age of six or other persons with limited mental capacity or who might be endangered by access to them.

(7) Have easy access to rooms occupied by children in case an emergency arises. Some examples are bedrooms, toilet rooms, shower rooms, and bathrooms.

(8) Except for foster homes, have posted a written disaster plan for emergencies such as fire and earthquakes.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0155, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0160 What measures must I take for pest control? You must make reasonable attempts to keep the premises free from pests, such as rodents, flies, cockroaches, fleas, and other insects using the least toxic methods.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0160, filed 8/28/01, effective 9/28/01.]

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WAC 388-148-0165 What are the requirements regarding the location of my home or facility? (1) Your address must be clearly visible on the home, facility, or mailbox so that firefighters or medics can easily find your location.

(2) Your home or facility must be accessible to emergency vehicles.

(3) Your home or facility must be located on a well-drained site, free from hazardous conditions. The safety of the children in care is paramount. You must discuss with the licensor any potential hazardous conditions, considering the children's ages, behaviors, and abilities.

(4) A licensing safety and supervision plan must be written if the department determines that hazardous conditions are present. Some examples of hazards are natural or man-made water hazards such as lakes or streams, steep banks, ravines, and busy streets.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0165, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0165, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0170 What steps must I take to ensure children's safety around outdoor bodies of water? (1) You must ensure children in your care or placed in your home or facility are safe around bodies of water.

(2) You must daily empty and clean any portable wading pool that children use.

(3) Children under twelve must be in continuous visual or auditory range at all times, when the children are swimming, wading, or boating, by an adult with current age appropriate first aid and CPR.

(4) You must ensure age and developmentally appropriate supervision of any child that uses hot tubs, swimming pools, spas, and around man-made and natural bodies of water.

(5) All safety devices and rescue equipment, such as personal flotation devices must meet state and federal water safety regulation.

(6) You must lock or secure hot tub and spa areas when they are not in use.

(7) You must place a fence designed to discourage climbing and have a locking gate around a pool or have another DLR approved safety device. The pool must be inaccessible to children when not in use.

(8) Foster homes with pools must have a written licensing safety and supervision plan.

(9) Individuals supervising children in foster homes and staffed residential homes licensed for five or fewer children must know how and be able to use rescue equipment or have a current life-saving certification, when children are using a pool on the premises.

(10) All group care facilities and staffed residential homes licensed for six children must have a person with current life-saving certification on-duty when children are using a pool at the facility.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0170, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0170, filed 8/28/01, effective 9/28/01.]

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WAC 388-148-0175 What are your requirements regarding pets and animals in my home or facility? (1) In a foster home, staffed residential home, or group care facility, you must not have any common household pets, exotic pets, animals, birds, insects, reptiles, or fish that are dangerous to the children in care.

(2) The department, at its discretion, may limit the type and number of common household pets, exotic pets, animals, birds, insects, reptiles or fish accessible to children if the department determines there are risks to the children in care.

(3) You must ensure that common household pets, exotic pets, animals, birds, insects, reptiles, and fish are free from disease and cared for in a safe and sanitary manner.

(4) Common household pets, exotic pets, animals, birds, insects, reptiles, and fish must be cared for in compliance with state regulations and local ordinances.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0175, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0180 Are alcoholic beverages or illegal drugs allowed at my home or facility? (1) In a foster home, you may have alcoholic beverages on the premises as long as they are inaccessible to children. If alcohol is on the premises of a foster home the issue must be addressed in the licensing safety and supervision plan.

(2) Licensed homes and facilities must not have illegal drugs on the premises.

(3) A group care facility or staffed residential home must not have alcohol or illegal drugs on the premises. The staff of these facilities may not consume alcohol or illegal drugs on the premises or during breaks.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0180, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0180, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0185 Is smoking permitted around children? (1) You must prohibit smoking in the living space of any home or facility caring for children and in motor vehicles while transporting children.

(2) You may permit adults to smoke outdoors away from children.

(3) Nothing in this section is meant to interfere with traditional or spiritual Native American or religious ceremonies involving the use of tobacco.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0185, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0185, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0190 May I have firearms in my home or facility? (1) Except for foster homes, you must not permit firearms, ammunition, and other weapons on the premises of homes or facilities that provide care to children.

(2) If you are licensed as a foster home, firearms, ammunition, and other weapons must be kept in locked container, gun cabinet, gun safe, or another storage area made of strong, unbreakable material when not in use.

(a) If the storage cabinet has a glass or another breakable front, the guns must be secured with a locked cable or chain placed through the trigger guards.

(b) Ammunition must be stored in a place that is separate from weapons or locked in a gun safe.

(c) Weapons and ammunition must be accessible only to authorized persons.

(3) You may allow a child to use a firearm only if:

(a) The child's social worker approves;

(b) Competent adults are supervising use; and

(c) The youth has completed an approved gun safety or hunter safety course.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0190, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0195 What are your requirements for storing dangerous chemicals or other substances? (1) You must store the following items in a place that is not accessible to preschool children or other persons with limited mental capacity or who might be endangered by access to these products:

(a) Cleaning supplies;

(b) Toxic or poisonous substances;

(c) Aerosols; and

(d) Items with warning labels.

(2) When containers are filled with toxic substances from a stock supply, you must label containers filled from a stock supply.

(3) Toxic substances must be stored separately from food items.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0195, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0200 Do I need first-aid supplies? (1)

You must keep first-aid supplies, and additional medications recommended by a child's physician, on hand for immediate use. You must keep the telephone number of the poison control center with the first aid supplies and you must post the number on or near your telephone.

(2) The following first-aid supplies must be kept on hand:

(a) Barrier gloves and one-way resuscitation mask;

(b) Bandages;

(c) Scissors and tweezers;

(d) Ace bandage;

(e) Gauze; and

(f) Thermometer.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0200, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0200, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0205 What requirements are there for the storage of medications? (1) You must keep all medications, including pet medications, vitamins and herbal remedies, in locked storage.

(2) Pet and human medications must be stored in separate places.

(3) You must store external medications separately from internal medications.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0205, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0210 What requirements do I need to follow when I transport children? When you transport children under your care, you must follow these requirements.

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(1) The vehicle must be kept in a safe operating condition.

(2) The driver must have a valid driver's license.

(3) There must be at least one adult other than the driver in a vehicle when:

(a) There are more than five preschool-aged children in the vehicle;

(b) Staff-to-child ratio guidelines or your contract require a second staff person; or

(c) The child's specific needs require a second adult person.

(4) The driver or owner of the vehicle must be covered under an automobile liability insurance policy.

(5) Your vehicles must be equipped with, seat belts, car seats and booster seats, and/or other appropriate safety devices for all passengers as required by law.

(6) The number of passengers must not exceed the vehicle's seat belts.

(7) Buses approved by the state patrol are not required to have seat belts.

(8) All persons in the vehicle must use seat belts or approved child passenger restraint systems, as appropriate for age, whenever the vehicle is in motion.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0210, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0210, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0215 May I use wheeled baby walkers? The department prohibits the use of wheeled baby walkers in foster homes and facilities.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0215, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—FIRE SAFETY

WAC 388-148-0220 What fire safety requirements must I follow to qualify for a license? (1) If you operate a group care facility or a staffed residential home licensed for six children, you must comply with the regulations developed by the chief of the Washington state patrol through the director of the fire protection bureau (WSP/FPB). The regulations are minimum requirements for protecting life and property against fire. They are contained in the current adopted fire code and Washington state amendments as adopted by the state of Washington. Contact the WSP/FPB for specific requirements.

(2) All foster homes and those staffed residential homes licensed for five or fewer children must have inspections by WSP/FPB or the local fire authority only if, either:

(a) The licensor request the inspections due to questions of fire safety; or

(b) Local ordinances or WSP/FPB require these inspections.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0220, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0220, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0225 What fire safety requirements are there for exits? (1) Group care facilities and staffed residential home licensed for six children must comply with the

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Washington state patrol protection bureau regulations regarding exits.

(2) All foster homes and those staffed residential home licensed for five or fewer children must comply with the fire safety requirements that follow concerning exits from homes.

(a) Exit doors and rescue windows must be easily and quickly opened from the inside without requiring a key or special instructions.

(b) Each home and facility must have at least one swinging exit door that is pivoted or hinged on the side.

(c) Each home or facility must have two means of exit, from the apartment, house, or facility, with at least one exit on each floor. The requirement for one of the two exits may be deleted if:

(i) A residential sprinkler system (complying with the WSP/FPB regulations and the currently adopted edition of the National Fire Protection Association (N.F.P.A.) #13) is provided throughout the entire building; and

(ii) The remaining exit is a door.

(d) Every occupied area must have access to one exit. Such exits may not be locked or blocked from the opposite side.

(e) Obstacles must not be placed in corridors, aisles, doorways, exit doors, stairways, ramps, or windows that could delay exiting in case of emergency.

(f) Barriers to exiting must be restricted to baby gates or DLR-approved electronic monitoring devices that do not delay exiting in case of emergency.

(g) Stoves or heaters must not block escape or exit routes.

(h) Flammable, combustible, or poisonous material must be stored away from exits and away from areas that are accessible to children under care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0225, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0225, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0230 Are there other fire safety requirements for inside a foster home or staffed residential home licensed for five or fewer children? All foster homes and those staffed residential homes licensed for five or fewer children must comply with the fire safety requirements that follow.

(1) Every bedroom used by children under care must have easy entry and exit, including one of these features:

(a) Two separate doors; or

(b) One door leading to an area with an exit; and

(c) A window that opens to the outside and is large enough for emergency personnel or rescuer access.

(2) No space may be lived-in by the children in care that is accessible only by a ladder, folding stairs, or a trap door.

(3) Every bathroom door lock must be designed to permit the opening of the locked door from the outside.

(4) Every closet door latch must be designed to be opened from the inside.

(5) Open-flame devices and fireplaces, heating and cooking appliances, and products capable of igniting clothing must not be left unattended or used incorrectly.

(6) Fireplaces, wood stoves and other heating systems that have a surface hot enough to cause a burn must have a barrier to prevent access by children under age six years.

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[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0230, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0230, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0235 What are the requirements for smoke detectors for foster homes and staffed residential homes licensed for five or fewer children? (1) All foster homes and those staffed residential homes licensed for five or fewer children must place a smoke detector in good working condition in each bedroom or in areas close to where children sleep, such as a hallway. If the smoke detector is mounted on the wall, it must be twelve inches from the ceiling and a corner.

(2) If a sleeping or napping room has a ceiling height that is at least twenty-four inches higher than its adjoining hallway, you must install a smoke detector in both the hallway and the sleeping or napping room.

(3) Smoke detectors must be tested twice a year to ensure they are in working order.

(4) Document date and time of test.

(5) If questions arise concerning fire danger, the local fire protection authority must be consulted.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0235, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0235, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0240 What are the requirements for fire extinguishers in homes and facilities? (1) All homes and facilities must have readily available at least one approved 2A10BC-rated or larger all purpose (ABC) fire extinguisher.

Note: Approved 2A10BC-rated means a fire extinguisher with an Underwriters' Laboratory label on the nameplate classifying the extinguisher as 2A10BC-rated. These extinguishers are usually multipurpose, five-pound dry chemical units.

(2) Approved fire extinguisher(s) must be located in the area of the normal path of exiting. The maximum travel distance to an extinguisher from any place on the premises must not exceed seventy-five feet. When the travel distance exceeds seventy-five feet, additional extinguisher(s) are required.

(3) Fire extinguishers must be ready for use at all times.

(4) Fire extinguishers must be kept on a shelf or mounted in a bracket so that the top of the extinguisher is not more than five feet above the floor.

(5) Fire extinguishers must receive a maintenance certification by a licensed firm specializing in this work, based on the manufacturer's recommended schedule. Maintenance means a thorough check of the extinguisher for:

(a) Mechanical parts;

(b) Extinguishing agent; and

(c) Expelling means.

(6) Exception: New fire extinguishers do not need to receive an additional certification test during the first year.

(7) For all foster homes and staffed residential homes licensed for five or fewer children, if local fire authorities require installation of a different type or size of fire extinguisher, those requirements apply instead of the departments, as long as at least the minimum size is maintained.

[Title 388 WAC—p. 689]

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0240, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0240, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0245 What fire escape measures must be taken for multilevel homes and facilities? (1) Multilevel homes and facilities must have a means of escape from an upper floor.

(2) If a fire ladder is needed to escape from an upper story window, it must be functional and stored in a location that is easily accessible.

(3) For all foster homes and those staffed residential homes licensed for five or fewer children, the local fire authority may be consulted to determine if a fire ladder is needed to ensure adequate safety.

(4) For group care programs and staffed residential homes licensed for six children fire escape measures from multilevel buildings is determined by the WSP/FPB representative.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0245, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0245, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0250 What fire safety instructions must I give to children residing in a home or staffed residential home licensed for five or fewer children? (1) You must instruct children, under your care, who are capable of understanding and following emergency evacuation procedures how to exit the building in case of fire.

(2) For foster homes and staffed residential homes licensed for five or fewer children, you must conduct fire drills at quarterly intervals or as required by WAC 212-12-044 by the WSP/FPB to test and practice evacuation procedures.

(3) Any simulated fire drills for medically fragile or non-ambulatory children must meet WAC 212-12-005 as required by the WSP/FPB.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0250, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0250, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0255 What are the requirements for a fire evacuation plan? (1) You must develop a written fire evacuation plan for your home or facility. The evacuation plan must include an evacuation floor plan, identifying exit doors and windows. Except in foster homes, the plan must be posted at each exit door.

(2) You must ensure that the plan includes:

- (a) Action to take by the person discovering a fire;
- (b) Methods for sounding an alarm on the premises;
- (c) Action to take for evacuating the building that ensures responsibility for the children;

(d) Action to take while waiting for the fire department; and

(e) If the use of a fire ladder is part of the evacuation plan it must be inspected at least annually to ensure it is in working order.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0255, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0255, filed 8/28/01, effective 9/28/01.]

[Title 388 WAC—p. 690]

GENERAL REQUIREMENTS—ROOM REQUIREMENTS

WAC 388-148-0260 What are the general requirements for bedrooms? You must meet all of the following requirements for bedrooms if you provide full-time care in a home or facility.

(1) An adult must be on the same floor or within easy hearing distance and access to where children under six years of age are sleeping. Infants under age one year must be on the same floor as an adult.

(2) You must use only bedrooms that have unrestricted direct access to hallways, corridors, living rooms, day rooms, or other such common use areas.

(3) You must not use hallways, kitchens, living rooms, dining rooms, and unfinished basements as bedrooms.

(4) For facilities licensed after December 31, 1986, bedrooms must have both:

(a) Adequate ceiling height for the safety and comfort of the occupants. Normally, this would be seven and a half feet; and

(b) A window that can open into the outside, allowing natural light into the bedroom and permitting emergency access or exit.

(5) Foster children must not share the same bedroom with children six years or older of a different gender.

(6) Children in care must not share the same bed.

(7) In group care facilities and staffed residential homes licensed for six children, single occupancy bedrooms must provide at least fifty square feet of floor space.

(8) In foster homes and staffed residential homes licensed for five or fewer children, single occupancy bedrooms must provide adequate floor space for the safety and comfort of the child. Normally, this would be at least fifty square feet of floor space, not including closets.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0260, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0260, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0265 What are additional requirements for bedrooms for more than one person? (1) You must not allow a child over one year of age to share a bedroom with an adult who is not the child's parent. A foster child over one year may share the bedroom of the foster parent(s) for close supervision due to the child's medical or developmental condition. A written recommendation of the child's physician is required.

(2) There must be no more than four persons to a bedroom.

(3) Multiple occupancy bedrooms must provide adequate floor space for safety and comfort of the children. Normally this would be at least fifty square feet of floor space per occupant, not including closets.

(4) When a mother and her infant sleep in the same room, the room must contain at least eighty square feet of usable floor space.

(5) You must allow only one mother and her newborn infant(s) to occupy a bedroom.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0265, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0265, filed 8/28/01, effective 9/28/01.]

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WAC 388-148-0270 What are the requirements for beds? (1) Each child in care must have a bed of his or her own.

(2) For each child in care, you must provide a bed at least twenty-seven inches wide with a clean and comfortable mattress in good condition, pillow, sheets, blankets, and pillowcases. Each child's pillow must be covered with waterproof material or be washable.

(3) Bedding must be clean.

(4) You must provide waterproof mattress covers or moisture resistant mattresses, if needed.

(5) You must provide an infant with a crib that ensures the safety of the infant and complies with chapter 70.111 RCW, Infant Crib Safety Act.

(6) Cribs must have no more than two and three-eighths inches space between vertical slats when used for infants under six months of age.

(7) Cribs, infant beds, bassinets, and playpens must:

(a) Have clean, firm, snug fitting mattresses covered with waterproof material that is easily sanitized; and

(b) Be made of wood, metal, or approved plastic with secure latching devices.

(8) Crib bumpers, stuffed toys and pillows must not be used in cribs, infant beds, bassinets, or playpens with an infant unless advised differently by the child's physician.

(9) You must follow the recommendation of the American Academy of Pediatrics, 1-800-505-CRIB, placing infants on their backs each time for sleep, unless advised differently by the child's physician.

(10) You may use toddler beds with a standard crib mattress that is sufficient in length and width for the comfort of children under six years of age.

(11) You must not allow children to use the loft style beds or upper bunks of double-deck beds if using them due to age, development or condition could hurt them. Examples: Preschool children, expectant mothers, and children with a disability.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0270, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0270, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS— TELEPHONE/LIGHTING/VENTILATION/WATER/ LAUNDRY/SEWAGE

WAC 388-148-0275 Do I need a telephone at my home or facility? The department has two requirements for the telephone that you must meet at your home or facility.

(1) You must have at least one telephone on the premises for incoming and outgoing calls. The telephone must be accessible for emergency use at all times.

(2) You must post emergency phone numbers next to the phone, or at a specified place for easy access.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0275, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0275, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0280 What are the lighting requirements for my home or facility? (1) You must locate light fixtures and provide lighting that promotes good visibility and comfort for the children under your care.

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(2) In addition, group care facilities must have nonbreakable light fixture covers or shatter resistant light bulbs or tubes.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0280, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0290 What does the room temperature for my home or facility need to be? You must maintain the temperature within your home or facility at a reasonable level while occupied. You must consider the age and needs of the children under your care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0290, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0300 How must I ventilate my home or facility? You must ensure that your physical facility is ventilated for the health and comfort of the persons under your care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0300, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0300, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0305 What are the requirements for laundry facilities? The department has specific requirements for laundry facilities at your home or facility.

(1) You must have separate and adequate facilities for storing soiled and clean linen.

(2) You must provide adequate laundry and drying equipment, or make other arrangements for getting laundry done on a regular basis.

(3) Except for foster homes, you must locate laundry equipment in an area separate from the kitchen and child care areas.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0305, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0305, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0310 What are the requirements for washing clothes? You must use an effective way to sanitize laundry contaminated with urine, feces, lice, scabies, or other potentially infectious materials. You must sanitize laundry through temperature or chemicals.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0310, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0315 What are the requirements for toilets, sinks, and bathing facilities? You must meet certain requirements for toilets, sinks, and bathing facilities.

(1) You must provide at least one indoor flush-type toilet, one nearby handwashing sink with hot and cold running water, and a bathing facility.

(2) You must comply with all of the following requirements for toilet and bathing facilities:

(a) Toilet and bathing facilities must allow privacy for children who are five years of age or older and opposite genders.

(b) Toilet, urinals, and handwashing sinks must be the appropriate height for the children served, or have a safe and easily cleaned step stool or platform that is water-resistant.

[Title 388 WAC—p. 691]

(c) Handwashing and bathing facilities must be provided with hot running water that does not exceed one hundred twenty degrees.

(d) All bathing facilities must have a conveniently located grab bar unless we approve other safety measures, such as nonskid pads.

(e) You must provide potty-chairs and toilet training equipment for toddlers. You must regularly maintain this equipment and keep it in sanitary condition. You must put potty-chairs, when in use, on washable, water-resistant surfaces.

(f) In group care facilities, whenever urinals are provided, the number of urinals must not replace more than one-third of the total number of required toilets.

(g) You must provide soap and clean towels, disposable towels or other approved hand-drying devices to the persons under your care.

(h) In programs providing care to expectant mothers:

(i) Bathing facilities must have adequate grab bars in convenient places; and

(ii) Except in foster homes, all sleeping areas must have at least one toilet and handwashing sink on the same floor.

(3) The following ratios of persons normally on the premises to bathrooms at the facilities shall apply:

	Toilets	Handwashing Sinks	Bathing Facilities
Group care facilities and SRH licensed for six children	Two minimum and 1:8 ratio	Two minimum and 1:8 ratio	One minimum and 1:8 ratio
Foster homes and staffed residential homes licensed for five or fewer children	One minimum	One minimum	One minimum

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0315, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0315, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0320 What are the requirements about drinking water? You must provide the following:

(1) A public water supply or a private water supply approved by the local health authority at the time of licensing or relicensing; and

(2) Disposable paper cups, individual drinking cups or glasses, or angled jet type drinking fountains.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0320, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0320, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0325 What are the requirements for sewage and liquid wastes? You must discharge sewage and liquid wastes into a public sewer system or into a functioning septic system, or department of health approved alternative system.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0325, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0325, filed 8/28/01, effective 9/28/01.]

[Title 388 WAC—p. 692]

GENERAL REQUIREMENTS—MEDICAL CARE AND MEDICATION MANAGEMENT

WAC 388-148-0330 Am I required to obtain a child's health history? (1) You may obtain the health history from the social worker or child-placing agency making the placement for all children that are accepted into your home or facility.

(2) The health history must include:

(a) The date of the child's last physical examination;

(b) Allergies;

(c) Any special health problems;

(d) A history of immunizations;

(e) Clinical and medical diagnoses and treatment plans; and

(f) All currently prescribed medications.

(3) When leaving the home or facility, the health history of the child must go with the child to the next placement for continuity of care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0330, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0335 When must I get an EPSDT exam for a child under my care? (1) An early and periodic screening, diagnosis and treatment (EPSDT) exam must be completed for any child in care more than thirty days, who within the past year, has not had a physical exam by a physician, a physician's assistant, or an advanced registered nurse practitioner (ARNP).

(2) In consultation with the child's social worker and physician, you must schedule an EPSDT exam by a physician, a physician's assistant, or an advanced registered nurse practitioner (ARNP) according to the published frequency schedule.

Note: You may contact the child's social worker for information on this.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0335, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0335, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0340 What are the requirements for immunizations for children? (1) Contact the child's social worker before beginning any immunization schedule to avoid duplication of immunizations.

(2) You may accept a child who has not received all immunizations on a conditional basis if immunizations are started as soon as medically possible.

(3) If you are providing care and have minor children of your own who are on the premises of a home or facility, your children must have proof of current immunizations.

(4) The department may give conditional approval for any of your own children who have not received all immunizations as long as their immunizations are started soon as medically possible.

(5) The department may grant exceptions to this requirement for immunizations for your children in two situations:

(a) You, as parent or guardian, have signed a statement indicating your religious, philosophical or personal objections to the requirement; or

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(b) You have a physician's statement indicating that a valid medical reason exists for not obtaining immunizations for your own child.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0340, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0340, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0345 What must I do to prevent the spread of infections and communicable diseases? You must take precautions to guard against infections and communicable diseases infecting the children under care in your home or facility.

General communicable diseases and infections

(1) In each home or facility, other than a foster home, staff with a reportable communicable disease or notifiable disease condition, as defined by the department of health, in chapter 246-101 WAC, in an infectious stage must not be on duty until they have a physician's approval for returning to work.

(2) Each home or facility, other than a foster home, that cares for medically fragile children and children with a severe developmental disability must have an infection control program supervised by a registered nurse.

(3) Foster homes and staffed residential homes licensed for five or fewer children who are medically fragile may use other alternatives, such as in-home nursing services, to consult on infection control procedures.

Tuberculosis

(4) Applicants for a license or adults authorized to have unsupervised access to children in a home or facility must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test upon being employed or licensed unless:

(a) The person has evidence of testing within the previous twelve months;

(b) The person has evidence that they have a negative chest X ray since a previously positive skin test;

(c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis.

(5) The department does not require a tuberculin skin test if:

(a) A person has a tuberculosis skin test that has been documented as negative within the past twelve months; or

(b) A physician indicates that the test is medically unadvisable.

(6) Persons whose tuberculosis skin test is positive must have a chest X ray within thirty days following the skin test.

(7) The department does not require retesting for license renewals unless a person believes they have been exposed to someone with tuberculosis or if testing is recommended by their health care provider.

(8) The facility must keep the results of the applicant and employees TB test results in the personnel file available for review by DLR.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0345, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0345, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0350 What are the requirements for obtaining consent for medical care for children under my

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care? (1) In general, the department is the legal custodian of a child in foster care. The department has the authority to consent to emergent and routine medical services on behalf of the child. The department delegates some of that authority to out-of-home placement providers (both foster parents and facility-based programs). You must contact the child's social worker or children's administration intake (emergency placements) for specific information for each child.

(2) In case of medical emergency, contact children's administration intake as soon as possible.

(3) If you care for children in the custody of another agency, tribal court or other court you must follow the direction of that agency or court regarding permission to provide consent for medical care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0350, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0350, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0352 What are the requirements for the management of medication for children in my care?
General medication management requirements

(1) Medication must not be used for behavior control, unless prescribed for that purpose by a physician or another person legally authorized to prescribe medication.

(2) Only you or another authorized care provider (such as a respite provider) are allowed to have access to medications for a child under your care.

(3) You or another authorized care provider must give prescription and nonprescription medications:

(a) Only as specified on the prescription label; or

(b) As otherwise approved by a physician or another person legally authorized to prescribe medication.

(4) If you care for children in the custody of another agency, tribal or other court you must follow the direction of that agency or court regarding giving or applying prescription and nonprescription medications.

(5) Foster homes must keep a record of all prescription medication given to a foster child.

(6) All licensees, except foster homes, must keep a record of all prescription and nonprescription medications given to children in care.

Nonprescription medications

(7) You or another authorized care provider may give the following nonprescription medications according to product instructions, without prior approval of the department:

(a) Nonaspirin antipyretics/analgesics, fever reducers/pain relievers;

(b) Nonnarcotic cough suppressants;

(c) Decongestants;

(d) Antacids and anti-diarrhea medication;

(e) Anti-itching ointments or lotions intended specifically to relieve itching;

(f) Shampoo for the removal of lice;

(g) Diaper ointments and powders intended specifically for use in the diaper area of children;

(h) Sun screen for children over six months; and

(i) Antibacterial ointments.

Note: Other nonprescription medications may be given with a physician's standing order, if the order is child specific.

Prescription medications

(8) Children taking prescription medications, internally, must have the prescribing physician's written authorization before any other medications, herbal supplements, remedies, vitamins, or minerals are given.

(9) You must notify the child's social worker of changes in prescribed medications.

(10) Except for foster homes, the disposal of any prescription medication must be documented and contain the following information:

- (a) What medication was disposed;
- (b) The name of the child the medication was prescribed for;
- (c) The amount disposed;
- (d) The name of the individual disposing of the medication; and
- (e) The name of the individual witnessing the disposal.

Note: You may consult with a pharmacist on the proper disposal of medications that are no longer being taken or have expired.

Psychotropic medications

(11) Care providers must not consent to giving or stopping a psychotropic medication. Consent to begin or to stop a psychotropic medication for a child can only be given by one of these:

- (a) The child's parent;
- (b) Dependency guardians based on the authority of the dependency guardianship court order;
- (c) A court order; or
- (d) The child's social worker, if:
 - (i) The child is legally free and in the permanent custody of the department; or
 - (ii) It is impossible to obtain informed parental consent after normal work hours, on weekends, or on holidays.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0352, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0355 May I accept medicine from a child's parent or guardian? (1) The only medicine you may accept from the child's parent, guardian, or responsible relative is medicine in the original container labeled with:

- (a) The child's first and last name;
- (b) The date the prescription was filled;
- (c) The medication's expiration date; and
- (d) Legible instructions for administration (manufacturer's instructions or prescription label) of the medication.

(2) You must notify the child's social worker when you receive a prescription from a child's parent or guardian.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0355, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0355, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0365 When may children take their own medicine? (1) You may permit children under your care to take their own medicine as long as:

- (a) They are physically and mentally capable of properly taking the medicine; and
- (b) You must keep the written approval by the child's social worker in your records.

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(2) When a child is taking their own medication, the medication and medical supplies must be kept locked or inaccessible to unauthorized persons.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0365, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0365, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—FOOD/DIET/INFANT CARE

WAC 388-148-0370 What food and meal guidelines must I follow? (1) Food served to children in your care must meet the needs of the children.

(2) For an educational and social environment during mealtimes, children must not be routinely separated from the adults and/or required to have separate menus unless ordered by the child's health care provider.

(3) You must provide the facilities for proper storage, preparation, and service of food to meet the needs of the program.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0370, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0375 How often must I feed children?

(1) You must provide all children a minimum of three meals in each twenty-four-hour period. You may vary from this guideline only if you have written approval from the child's physician and social worker.

(2) The time interval between the evening meal and breakfast must not be more than fourteen hours.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0375, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0375, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0380 How do I handle a child's special diet? You must have approval of the child's social worker and written instructions by a physician, parent or guardian before serving nutrient concentrates, nutrient supplements, vitamins, and modified diets (therapeutic and allergy diets).

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0380, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0380, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0385 Are there special requirements for serving milk? You must follow these requirements for serving milk:

(1) Serve only pasteurized milk or a pasteurized milk product.

(2) Not serve the following types of milk to any child less than twenty-four months of age unless you have written permission by a physician:

- (a) Skim milk;
- (b) Reconstituted nonfat dry milk; and
- (c) One and two percent butterfat milk.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0385, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0385, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0390 What home-canned foods may I use? (1) In all homes and facilities, except foster homes, you

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may serve only home-canned high-acid foods with a pH of less than 4.6 such as canned fruits, jams, jellies, and pickles.

(2) In foster homes, all home-canned foods must be preserved following published procedures that are approved by the extension service.

(3) You must be able to provide the printed procedure that you followed.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0390, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0395 What requirements must I meet for feeding babies? You must meet the following requirements for feeding babies:

(1) In group care settings, all formulas must be in sanitized bottles with nipples and labeled with the child's name and date prepared if more than one child is bottle-fed.

(2) You must refrigerate filled bottles if bottles are not used immediately and contents must be discarded if not used within twenty-four hours.

(3) If you reuse bottles and nipples, you must sanitize them.

(4) If breast milk is provided by anyone other than a baby's biological mother, approval must be obtained from the child's social worker.

(5) Infants who are six months of age or over may hold their own bottles as long as an adult remains in the room and within observation range. You must take bottles from the child when the child finishes feeding or when the bottle is empty, or when the child falls asleep.

(6) You must not prop bottles while feeding infants.

(7) To prevent uneven heating, formula must not be warmed in a microwave oven in the bottle that will be used for feeding the baby.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0395, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0395, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0400 What are the requirements for diapers and diaper-changing areas? In a foster home or group care program you must follow the requirements for diapers, diaper-changing rooms and toilet-training equipment.

(1) You must separate diaper-changing areas from food preparation areas.

(2) You must sanitize diaper-changing areas and toilet-training equipment between each use or you must use a non-absorbent, disposable covering that is discarded after each use.

(3) For cleaning children, you must use either disposable towels or clean cloth towels that have been laundered between each use.

(4) You and any caregiver must wash hands before and after diapering each child.

(5) In group care programs, you must use disposable diapers, a commercial diaper service, or reusable diapers supplied by the child's family.

(6) In group care programs, diaper-changing procedures must be posted at the changing areas.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0400, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0400, filed 8/28/01, effective 9/28/01.]

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GENERAL REQUIREMENTS—CLOTHING AND PERSONAL HYGIENE

WAC 388-148-0405 Do I have responsibility for a child's clothing? You must provide or arrange for appropriate clothing for the children under your care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0405, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0410 May a child take personal belongings after being discharged from a home or facility? You must permit a child who is discharged from your home or facility to take with them the personal belongings they brought with them or acquired while in care. This includes clothing, personal mementos, bicycles, gifts, and any saved money or regular allowance. There are two ways this may occur:

(1) The child may take these belongings upon leaving your home or facility; or

(2) If it is impossible for the child to take their belongings at the time they leave, you are required to secure the child's belongings for up to thirty days and cooperate with the child's social worker to transfer the belongings to the child, as soon as possible.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0410, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0415 Do I have responsibility for a child's personal hygiene? You must provide or arrange for children under your care to have items needed for grooming and personal hygiene. You must assist these children in using these items, based on the child's developmental needs.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0415, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—CLIENT RIGHTS

WAC 388-148-0420 What are the requirements for protecting a child under my care from abuse and neglect? As part of ensuring a child's health, welfare and safety, you must protect children under your care from all forms of child abuse and neglect (see RCW 26.44.020(12) and chapter 388-15 WAC for more details).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0420, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0422 What are the requirements for privacy for children in out-of-home placements? (1) In general, children in out-of-home placement have the right to privacy of personal mail and phone calls.

(2) The department and its delegates may censor the child's mail and monitor telephone calls to the extent necessary and in the manner specified by the court order for the child's safety or well-being.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0422, filed 4/5/04, effective 5/6/04.]

[Title 388 WAC—p. 695]

WAC 388-148-0425 What are the requirements about nondiscrimination? You are expected to follow all state and federal laws regarding nondiscrimination while providing services to children in your care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0425, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0425, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0430 May I take a foster child to church services, temple, mosque or synagogue? (1) You may have a child attend church services, temple, mosque, or synagogue, if the child chooses to participate.

(2) You must respect the religious backgrounds or preferences of the children under your care.

(3) Children have the right to practice their own faith.

(4) Children have the right not to practice your faith without consequences.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0430, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0430, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0435 Do I have to admit or retain all children? (1) A foster home or other program has the right to refuse to admit or retain a child in a program.

The exceptions to this requirement are the individual programs that have contracts that specify a child can not be denied admission.

(2) A joint decision may be made by the provider and the placement agency to serve the child elsewhere, for the health and safety of the child or others.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0435, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0440 What must I consider in assigning work to children in my home or facility? (1) Children may do regular household tasks without payment.

(2) Children may do work assignments other than household tasks that are appropriate to their age and physical conditions and receive monetary compensation if this is part of their service plan.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0440, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0445 What toys and activities must I provide to children? You must provide children with safe and suitable toys and activities that contribute to developing their physical, mental, social, and emotional skills. Activities must be designed for the developmental stages of the children you serve.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0445, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0445, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0455 Do I need permission to travel on an overnight trip or out-of-state with my foster child? Contact the child's social worker with the agency having legal custody of the child for written permission prior to overnight trips, out-of-state, or out-of-country travel.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0455, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0455, filed 8/28/01, effective 9/28/01.]

[Title 388 WAC—p. 696]

GENERAL REQUIREMENTS—SUPERVISION

WAC 388-148-0460 What requirements do you have for supervising children? (1) For all homes and facilities you must provide or arrange for care and supervision that is appropriate for the child's age, developmental skill level, and condition.

(2) Preschool children and children with severe developmental disabilities must not be left unattended in a bathtub or shower.

(3) Foster parents and facility staff must provide the children in their care with appropriate adult supervision, emotional support, personal attention, and structured daily routines and living experiences.

(4) Except group receiving centers, children in group care must be supervised during sleeping hours by at least one awake staff when:

(a) There are more than six children in care; and

(b) The major focus of the program is behavioral rather than the development of independent living skills such as a teen parent program or responsible living skills program; or

(c) The youth's behavior poses a risk to self or others.

(5) In foster homes and staffed residential homes, children must be supervised during sleeping hours by at least one awake staff only when it is part of the child's written supervision plan.

(6) Adequate supervision should be arranged and maintained during times of crisis when one or more family members or staff members may be unavailable to provide the necessary supervision or coverage for other children in care.

(7) When special supervision is required and agreed upon between the department and the agency or foster parent, the agency or foster parent provides the necessary supervision. This supervision may require auditory or visual supervision at all times.

(8) When a child has exhibited behavior in a previous placement or the placement agency believes the child poses a risk to other children the agency must inform the provider and jointly develop a plan to address the risk.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0460, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0460, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—DISCIPLINE

WAC 388-148-0465 What requirements must I follow when disciplining children? (1) You are responsible for disciplining children in your care. This responsibility may not be delegated to a child.

(2) Discipline must be based on an understanding of the child's needs and stage of development.

(3) Discipline must be designed to help the child under your care to develop inner control, acceptable behavior and respect for the rights of others.

(4) Discipline must be fair, reasonable, consistent, and related to the child's behavior.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0465, filed 8/28/01, effective 9/28/01.]

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WAC 388-148-0470 What types of disciplinary practices are forbidden? (1) You must not use cruel, unusual, frightening, unsafe or humiliating discipline practices, including but not limited to:

- (a) Spanking children with a hand or object;
- (b) Biting, jerking, kicking, hitting, or shaking the child;
- (c) Pulling the child's hair;
- (d) Throwing the child;
- (e) Purposely inflicting pain as a punishment;
- (f) Name calling, using derogatory comments;
- (g) Threatening the child with physical harm;
- (h) Threatening or intimidating the child; or
- (i) Placing or requiring a child to stand under a cold water shower.

(2) You must not use methods that interfere with a child's basic needs. These include, but are not limited to:

- (a) Depriving the child of sleep;
- (b) Providing inadequate food, clothing, living space, or shelter;
- (c) Restricting a child's breathing;
- (d) Interfering with a child's ability to take care of their own hygiene and toilet needs; or
- (e) Providing inadequate medical or dental care.

(3) You must not use methods that deprive a child of necessary services. These include, but are not limited to, contacting:

- (a) The assigned social worker;
- (b) The assigned legal representative;
- (c) Parents or other family members who are identified in the service plan; or
- (d) Individuals providing the child with therapeutic activities as part of the child's service plan.

(4) You must not use medication in an amount or frequency other than that prescribed by a physician or psychiatrist.

(5) You must not use medications for a child that have been prescribed for someone else.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW, 04-08-073, § 388-148-0470, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0470, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0475 Do you require a written statement describing my discipline methods? (1) You must provide a written statement with your application and reapplication for licensure describing the discipline methods you use.

(2) If your discipline methods change, you must immediately provide a new statement to your licensor describing your current practice.

[Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0475, filed 8/28/01, effective 9/28/01.]

GENERAL REQUIREMENTS—PHYSICAL RESTRAINT

WAC 388-148-0480 When may a child be restrained? (1) You must use efforts other than physical restraint to redirect or deescalate a situation, unless the child's behavior poses an immediate risk to physical safety.

(2) When a child's behavior poses an immediate risk to physical safety you may use physical restraint. The restraint must be reasonable and necessary to:

(a) Prevent a child from harming him or herself, or others; or

(b) Protect property from serious damage.

(3) If a group care program is approved by DLR for the use of physical restraint, the licensee and staff must be trained in the appropriate use of restraining techniques in accordance with the children's administration's behavior management policy before restraining a child.

(4) Medication prescribed by a physician to control behavior must be only given as prescribed.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW, 04-08-073, § 388-148-0480, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0480, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0485 What types of physical restraint are not acceptable for children? Homes and facilities must follow these requirements. You must not:

(1) Use physical restraint as a form of punishment or discipline.

(2) Use mechanical restraints, such as handcuffs and belt restraints, unless ordered by the child's physician, such as a belt restraint for an infant with reflux who must be secured to a wedge.

(3) Use physical restraint techniques that restrict breathing, inflict pain as a strategy for behavior control, or that is likely to cause injury that is more than transient to a child. These include, but are not limited to:

- (a) Restriction of body movement by placing pressure on joints, chest, heart, or vital organs;
- (b) Sleeper holds, which are holds used by law enforcement officers to subdue a person;
- (c) Arm twisting;
- (d) Hair holds;
- (e) Choking or putting arms around the throat; or
- (f) Chemical restraints, including but not limited to pepper spray.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW, 04-08-073, § 388-148-0485, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0485, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0487 Are there requirements for time-out or quiet rooms? (1) Locked time-out or quiet rooms are prohibited in foster homes and staffed residential homes licensed for five or fewer children.

(2) Locked time-out or quiet rooms are prohibited in group care facilities and staffed residential homes licensed for six unless, the group facility or staffed residential home:

(a) Has approval from the Washington state patrol fire protection bureau or a certificate of compliance stating that the facility is in compliance with the fire codes with Washington state amendments;

(b) Has approval from the DLR licensor stating the facility is in compliance with the children's administration's behavior management guidelines; and

(c) Has current written approval of the DLR director.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW, 04-08-073, § 388-148-0487, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0488 Are time-delay mechanisms allowed on windows and doors of a facility or staffed residential home licensed for six? The use of time-delay mechanisms

animals that meet the fire codes with Washington state amendments of the Washington state patrol fire protection bureau for fire and life safety may be approved for group care facilities and staffed residential homes licensed for six children, if:

(1) There is an exterior door(s) that ensures egress when the building needs to be evacuated;

(2) The time-delay mechanism(s) automatically unlocks when the fire alarm goes off;

(3) The licensee has approval from the DLR licensor stating that the program is in compliance with the children's administration's behavior management guidelines; and

(4) The licensee has current written approval of the DLR director.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0488, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0490 What must I do following an incident that involved using physical restraint? (1) In foster homes, the foster parent must send a copy of the documented use of physical restraint to the child's social worker and licensor within forty-eight hours; or if the foster home is supervised by a child-placing agency to the case manager.

(2) The CPA case manager must furnish a copy of the incident report to the child's DCFS social worker and DLR licensor.

(3) For group care programs and all staffed residential homes, the director or program supervisor must:

(a) Review any incident with the staff who used physical restraint to ensure that the decision to use physical restraint and its application were appropriate; and

(b) Report the incident if it meets criteria in WAC 388-148-0120.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0490, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0490, filed 8/28/01, effective 9/28/01.]

FOSTER HOME REQUIREMENTS

WAC 388-148-0505 What services must a foster parent be able to provide? (1) Foster parents must be able to meet the child's basic needs and have the knowledge and skills to:

(a) Protect and nurture children in a safe, healthy environment with unconditional positive support;

(b) Support relationships among children and their parents, siblings, and kin;

(c) Meet the developmental needs of the child by:

(i) Helping the child cope with separation and loss;

(ii) Helping the child build positive attachments to appropriate adults;

(iii) Building self-esteem;

(iv) Giving positive guidance;

(v) Supporting cultural identity;

(vi) Using discipline appropriate to the child's age and stage of development;

(vii) Supporting intellectual and educational growth;

(viii) Encouraging and modeling positive social relationships and responsibilities; and

(ix) Helping the child gain age appropriate skills for independence.

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(2) Foster parents must support the permanent placement plan for the child, focusing first on the birth family reuniting, and then, on options leading to a permanent placement.

(3) Foster parents are encouraged to participate as members of the child's treatment team.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0505, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0510 What educational support must I provide to children under my care? If you operate a foster home, you must:

(1) Assist the child to attend school on a regular basis if this is part of the child's service plan;

(2) Provide a suitable study area for the children under your care; and

(3) Provide opportunities to learn appropriate skills for the development of self-sufficiency.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0510, filed 8/28/01, effective 9/28/01.]

FOSTER HOMES—FOSTER PARENT QUALIFICATIONS/TRAINING/CAPACITY ALLOWED

WAC 388-148-0515 What is the minimum age to be a foster parent? You need to be at least twenty-one years old to be a foster parent.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0515, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0520 What are the training requirements for foster parents and prospective foster parents? At least one foster parent must:

(1) Attend required orientation and preservice training programs that the department sponsors, or that your licensed child-placing agency offers; and

(2) Complete all other required DLR-approved training after licensing.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0520, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0520, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0525 How many children may my foster home serve? (1) The department may restrict the number, age range, or gender of children a foster home is licensed to serve up to the maximum listed below. The age of the foster and birth applicant or licensee's children, and the physical and emotional condition of the children are considered in making this decision. These requirements are for all foster homes, including those that only have foster children for a short time (sometimes called a "receiving home").

(2) In a two-parent household, the [total] maximum number of children in your home may be no more than six children, including your own children.

(3) In a single parent household, the maximum number of children in your home may be no more than four children, including your own children.

(4) A home may at the discretion of the department be licensed for the care of at least one child when the foster parent(s) have more of their own children than specified in sub-

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section (2) and (3) of this section, if they meet the other licensing requirements.

(5) You may have only two children under two years of age in your home at a time. This includes foster children and your own children.

(6) The capacity restrictions in this section may at the discretion of the department be exceeded in extraordinary situations, such as to place a sibling group, to place a child with a relative, or because the foster family has demonstrated exceptional abilities in relation to the special needs of a foster child, if this appears to be in the best interest of the child and would not jeopardize the health and safety of the other children in the home. Approval to exceed the capacity restrictions must be in writing and signed by the DLR manager or designee.

(7) The department may license a foster home for up to three medically fragile foster children that are severe enough to need semi-skilled maintenance or supportive services if:

(a) Your training and/or experience qualifies you to provide proper care;

(b) The children's treatment requires nursing service oversight; and

(c) The maximum number of medically fragile children in your home is three or fewer; and

(d) You have a written plan on how you will evacuate children in case of fire or other emergency.

(8) The department may license a foster family for up to two nonmobile children.

(9) While providing respite care, you may only exceed the number of children you are licensed to serve with prior approval by the DLR director or designee.

(10) The department may license a foster home to serve up to four children with developmental disabilities as defined in RCW 71A.10.020, at any one time.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0525, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0525, filed 8/28/01, effective 9/28/01.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffective changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

FOSTER HOMES—FOSTER PARENT EMPLOYMENT AND RESPITE

WAC 388-148-0530 May I be employed if I am a foster parent? (1) If you are a single parent or both parents of a two-parent household are employed outside the home, you must give the child-placing agency or the department a written outline of your plan for supervising the children under your care while you are working.

(2) At least one parent must be available to respond to school crisis.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0530, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0535 Do I need to have income separate from foster care payments? You must have sufficient regular income, at least, an amount that meets current TANF standards for the number of persons in your home, to main-

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tain your own family, without the foster care payments made for the children in care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0535, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0535, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0540 When may I use respite care? (1) Foster families may arrange for respite (brief temporary relief) care with the consent of the child's social worker.

(2) Respite care may be arranged in advance or on an emergency basis.

(3) Respite care may be arranged to support the care a foster parent is providing or to provide substitute care in the absence of foster parents.

(4) Respite care given outside the foster parent's home must be provided by licensed providers.

(5) While providing respite, licensees must not exceed their licensed capacity and must maintain compliance with the licensing requirements.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0540, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0540, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0541 Excluding respite care, who may provide care to a foster child in the foster home when the foster parent is away from the home? (1) Occasionally, and for less than twenty-four hours, the foster parent, at their own expense, may use a friend or a relative as a substitute caregiver in the foster home, without verifying criminal and founded child abuse/neglect history when the foster parent has no reason to suspect the substitute caregiver:

(a) Has a criminal or founded child abuse or neglect history that would disqualify them from caring for a department child; or

(b) Would be a risk to the foster child while in the substitute's care.

(2) The foster parent must:

(a) Be familiar and comfortable with the individual who will be caring for the foster child;

(b) Meet with the substitute caregiver and review the expectations regarding supervision and discipline of the foster child, including the requirement that no physical discipline is used on foster children;

(c) Be responsible for providing the caregiver any special care instructions;

(d) Provide information on how to be contacted by the substitute caregiver; and

(e) Ensure the child has a safety plan.

(3) If the care by the friend or relative is a regular arrangement, the foster parents must have written approval of the social worker for the arrangement and provide the social worker with evidence from the substitute caregiver of:

(a) Current first aid and age-appropriate CPR training;

(b) HIV/AIDS and bloodborne pathogens training;

(c) A nondisqualifying background check; and

(d) A tuberculosis test.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0541, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0542 May a foster child be supervised by someone under eighteen in the foster home? (1) A foster parent, at their own expense, may use a friend or relative who is sixteen or seventeen to supervise (baby sit) a foster child under the following conditions:

(a) The foster parent knows the youth babysitter to be reliable and mature enough to provide appropriate care to the foster child.

(b) The youth babysitter has completed a background check within the past year. Exception: For occasional care of less than twenty-four hours, the verification of the background check is not required, as provided in WAC 388-148-0541 (1)(a)(b).

(c) The youth babysitter must not be responsible for more than three children.

(2) If the care by the youth babysitter is a regular arrangement, the foster parents must have the written approval of the social worker and provide the social worker with evidence from the youth babysitter of:

(a) Current first aid and age-appropriate CPR training;

(b) HIV/AIDS training including bloodborne pathogens training;

(c) A nondisqualifying background check; and

(d) A tuberculosis test.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0542, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0545 May I place my foster child with another family temporarily? Foster parents must not place a child in another home temporarily or otherwise without the written consent of:

(1) The child's social worker; or

(2) The child placing agency case manager, if any.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0545, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0550 May my foster children participate in routine activities without a licensed provider supervising the activity? Contact the child's social worker for prior approval for your foster child's participation in routine activities without a licensed provider supervising the activity, such as clubs, social outings with classmates or friends.

Note: The social worker with the agency having legal custody of the child is the contact person.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0550, filed 8/28/01, effective 9/28/01.]

REQUIREMENTS FOR ALL LICENSES, EXCEPT FOSTER HOMES—PROGRAM AND SERVICES

WAC 388-148-0555 Do I need a social summary for children under my care? (1) Except for foster homes and group receiving centers, all programs must develop a written diagnostic social summary for each child accepted for care.

(2) The social summary must serve as the basis of the child's admission to care.

(3) If a child needs to be accepted for emergency care, such as placement in a crisis residential center, the department does not require the social study to be completed prior to admission. In these cases, if the child remains in care

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beyond thirty days, a summary must be completed as soon as possible.

(4) The study must contain the following information for the child:

(a) Copies of psychological or psychiatric evaluations, if any, on the child under care.

(b) A narrative description of the child's background and family that identifies the immediate and extended family resources;

(c) The child's interrelationships and the problems and behaviors that have required care away from his or her own home;

(d) The child's primary and alternate permanency plan;

(e) Previous placement history, if any; and

(f) An evaluation of the child's need for the particular services and type of care you provide.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0555, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0555, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0560 Do I need a treatment plan for children under my care? (1) Except group receiving centers, all group care programs, staffed residential homes, and foster homes of child-placing agencies that have contracts or agreements with the department to provide treatment or therapeutic services to dependent children, must assist in developing and implementing a written treatment plan for each child by the thirtieth day in care.

(2) The treatment plan must:

(a) Identify the service needs of the child, parent or guardian;

(b) Describe the treatment goals and strategies for achieving those goals;

(c) Include a running account of the treatment received by the child and others involved in the treatment plan, such as any group treatment or individual counseling; and

(d) Be updated at least quarterly to show the progress toward meeting goals and list barriers to the permanent plan.

(3) A social service staff person must review and sign approving the child's treatment plan.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0560, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0560, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0565 Do you need to approve the program that I offer for children under my care? (1) The department must approve the program that you have developed for children under your care.

(2) You must send to DLR a detailed written program description outlining educational, recreational, and therapeutic services you will provide to children and their families. A sample of the schedule of daily activities for children under care must be included.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0565, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0570 What education and vocational instruction must I provide to the children under my care?

(1) If you operate a staffed residential home or a group care program, you must meet the following requirements for pro-

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viding education and vocational instruction to the children under your care. You must:

(a) Develop or arrange for an educational plan for each child in care who has not completed high school and/or the GED (high school equivalency examination);

(b) Support each child participating in their education plan; and

(c) Provide suitable study areas for children under your care.

(2) If the instruction is given on your premises, you must:

(a) Have the program certified by the office of the superintendent of public instruction and provide classrooms separate from the living area;

(b) Send the department a written description of how you will provide an educational program for children under your care; and

(c) Provide or arrange for independent living skills education for developing self-sufficiency for the children under your care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0570, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0575 What medical policies and procedures must I have? (1) If you operate a staffed residential home or a group care program, you must have written policies and procedures about the control of infections. These must include, but are not limited to, the following areas:

(a) Isolation;

(b) Aseptic procedures;

(c) Reporting communicable diseases;

(d) Hygiene, including hand washing, using the toilet, diapering, and laundering.

(2) Group care facilities must maintain current written medical policies and procedures to be followed on:

(a) Prevention of the transmission of communicable diseases including:

(i) Handwashing for staff and children;

(ii) Management and reporting of communicable diseases.

(b) Medication management;

(c) First aid;

(d) Care of minor illnesses;

(e) Actions to be taken for medical emergencies;

(f) Infant care procedures when infants are under care; and

(g) General health practices.

(3) If you are licensed as a group home or as a facility that can care for thirteen or more persons at once, you must arrange to have one of the following help you develop and periodically review your medical policies and procedures:

(a) An advisory physician,

(b) A physician's assistant, or

(c) A registered nurse.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0575, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0580 What nursing services must I provide? (1) If you operate a staffed residential home or facility caring for chronically ill children or medically fragile children, you must arrange for regular nursing visits.

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(a) These must include at least monthly visits unless a different agreement is specified in the individual child's treatment plan.

(b) The nurse must be registered and currently licensed in the state of Washington.

(2) The nurse's name, address and telephone number must be readily available to the staff at your home or facility.

(3) The nurse must assist the agency in setting up a program that provides for regular medical check-ups and follow-up for special health care needs specified by the child's physician or your staff.

(4) The nurse must advise and assist nonmedical staff at your home or facility in maintaining child health records, meeting daily health needs and caring for children with minor illnesses and injuries.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0580, filed 8/28/01, effective 9/28/01.]

ALL LICENSES EXCEPT FOSTER HOMES AND GROUP RECEIVING CENTERS—SOCIAL SERVICE STAFF QUALIFICATIONS AND STAFFING RATIOS

WAC 388-148-0585 What social service staff do I need? (1) Except for foster homes, group receiving centers, and juvenile detention facilities, you must provide or arrange for social services by qualified persons who meet the education and training requirements that follow:

(a) One person who provides social services must have a master's degree in social work or a closely related field from an accredited school.

(b) Social service staff without a master's degree in social work or closely related field must have a bachelor's degree in social work or a closely related field from an accredited school. A person with a master's degree must consult with any social service staff who has only a bachelor's degree one hour for every twenty hours the staff person works.

(2) When social services are provided by another agency, you must have a written agreement with the agency describing the scope of service they provide.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0585, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0585, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0590 What clerical, accounting and administrative services do I need for my home or facility?

You must have sufficient clerical, accounting and administrative services to maintain proper records and carry out your program.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0590, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0595 What support and maintenance staff do I need for my home or facility? If you operate a home or facility other than a foster home, you must have sufficient support and maintenance services to maintain and repair your facility, prepare and serve meals.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0595, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0600 Do I need professional consultants for my program? (1) Except for foster homes, you must have consultants available as needed, to work with your staff, the children you serve, and the children's families. The consultants that are used by your program must meet the full professional competency and requirements and academic training in their respective fields. The consultant or consultants must have:

(a) A master's degree from a recognized school of social work or closely related field;

(b) The training, experience, knowledge and demonstrated skills in each area that he or she will be supervising or advising; and

(c) The ability to ensure staff develop their skills and understanding needed to effectively manage their cases.

(2) Consultants may be hired as staff or operate under a contract with the program.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0600, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0600, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0605 Is in-service training required? If you have employees in your home or facility, you must offer in-service training programs for developing and upgrading staff skills.

(1) If you have five or more employees or volunteers, your training plan must be in writing.

(2) You must discuss with the staff your policies and procedures as well as the rules contained in this chapter.

(3) You must provide or arrange for your staff to have training for the services that you provide to children under your care.

(4) Your training on behavioral management must be approved by DLR and must include nonphysical age-appropriate methods of redirecting and controlling behavior, as described in children's administration's guidelines on behavior management.

(5) You must record the amount of time and type of training provided to staff.

(6) This information must be kept in each employee's file or in a separate training file.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0605, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0605, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0610 What are the required ratios of social service staff to children under care? You must meet the minimum ratios of social service staff to children under care as shown in the chart below:

Type of Facility	Minimum Ratio of Full-Time Social Service Staff to Children Under Care
Day treatment program	1 to 15
Group homes	1 to 25
Child-placing agency	1 to 25
Maternity services	1 to 25
Regular and secure crisis residential centers	1 to 5

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0610, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0610, filed 8/28/01, effective 9/28/01.]

GROUP CARE FACILITIES AND STAFFED RESIDENTIAL HOMES LICENSED FOR SIX CHILDREN—FIRE SAFETY REQUIREMENTS

WAC 388-148-0620 What safety features do I need for hazardous areas? The department requires hazardous areas in a group care facility or a staffed residential home licensed for six children meet the facility fire and life safety requirements as developed by the chief of the Washington state patrol through the director of the fire protection bureau.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0620, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0620, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0625 What other requirements must I follow for smoke detectors? (1) Group care facilities and staffed residential homes licensed for six children must have smoke detectors that are UL or Factory Mutual approved.

(2) Smoke detectors must have a strobe and be in compliance with the Americans with Disabilities Act (ADA).

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0625, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0625, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0640 What fire safety procedures do staff of a group care facility and a staffed residential home licensed for six children need to know? You and your staff at a group care facility and a staffed residential home licensed for six children must be familiar with safety procedures related to fire prevention.

(1) You and your staff must be familiar with all aspects of the fire drill.

(2) You and your staff must be able to:

(a) Operate all fire extinguishers installed on the premises;

(b) Test smoke detectors (single station types); and

(c) Conduct frequent inspections of the home or facility to identify fire hazards and take action to correct any hazards noted during the inspection.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0640, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0640, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0645 What are the requirements for fire drills and testing smoke detectors? (1) You must conduct a fire drill in your staffed residential home licensed for six children or group care facility at least once each month at varying times of the day and night so that staff on all shifts practice the procedures.

You must maintain a written record on the premises that indicates the date and time that all drill practices were completed.

(2) Single-station smoke detectors must be tested monthly or in a manner specified by the manufacturer. You must maintain a written record of such testing on the premises that indicates the date and time the test was completed.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0645, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0645, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0655 Are there different construction and fire safety requirements for facilities that have multiple licenses in the same building? (1) A facility with multiple Washington state licenses or certifications for the care of children in the same building must comply with the most stringent construction and fire safety requirements for the physical structure, if children share the same space.

(2) If the same facility has multiple Washington state licenses the licensee must notify:

(a) The Washington state patrol fire protection bureau inspector; and

(b) All of the licensing and certification agents.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0655, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0655, filed 8/28/01, effective 9/28/01.]

GROUP CARE FACILITIES AND STAFFED RESIDENTIAL HOMES—FOOD AND MEALS

WAC 388-148-0660 Do mealtimes need to be established? Group care facilities and staffed residential homes must establish and post a schedule of mealtimes.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0660, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0660, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0665 Do you have general menu requirements? The department has menu requirements for group care facilities that care for children.

(1) If you operate a facility other than a foster home or a staffed residential home you must prepare and date daily menus, including snacks, at least one week in advance.

(2) You must provide for the proper storage, preparation, and service of food to meet the needs of the program.

(3) Your program must be in compliance with the department of health standards in chapter 246-215 WAC on food service sanitation.

(4) A menu must specify a variety of foods for adequate nutrition and meal enjoyment.

(5) You must keep the menus on file for a minimum of six months so that we can review your menus.

(6) You must post each person's dietary restrictions, if any, for staff to follow.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0665, filed 8/28/01, effective 9/28/01.]

GROUP CARE—PROGRAM REQUIREMENTS AND SERVICES

WAC 388-148-0670 What types of group care programs are licensed to provide care to children? (1) The following types of programs may be licensed as group care to provide care for children on a twenty-four-hour basis:

(a) Group residential programs;

(b) Independent living skills programs;

(c) Maternity services;

(d) Services to children with severe developmental disabilities and medically fragile children;

(e) Crisis residential centers and secure crisis residential centers;

(f) Group receiving centers; and

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(g) Day treatment programs. Day treatment programs are considered group care programs under this chapter, though they are not twenty-four-hour residential programs.

(2) If your group care facility provides services named in WAC 388-148-0670 (1)(c) through (g) you will need to comply with the licensing requirements specific to those programs. A license may be issued for that specific type of care, such as a crisis residential center in addition to the group care license.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0670, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0670, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0680 What basic elements must a group care program include? (1) Your group care program must provide a safe and healthy group living environment that meets the developmental needs of the children in your care, including:

(a) A clean, homelike environment;

(b) Basic necessities such as adequate food, appropriate clothing and recreational opportunities;

(c) Safety;

(d) An age-appropriate environment with necessary structure, routine, and rules to provide for a healthy life, growth and development.

(2) Your program must be staffed with employees who are competent to provide for the safety and needs of the children in your care.

(3) Your program must have a written statement that includes your mission, goals, and a description of the services you provide.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0680, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0685 Who may a group care program provider serve? (1) If you are a group care program provider, you may serve children who are at least six years of age and meet one of the following conditions:

(a) Have behavior that cannot be safely or effectively managed in foster care;

(b) Need temporary placement awaiting a more permanent placement;

(c) Need emergency placement during a temporary disruption of a current placement;

(d) Have emotional, physical, or mental disabilities;

(e) Need a transitional living setting;

(f) Need respite care from a licensed provider; or

(g) Are age sixteen or older and need to acquire independent living skills.

(2) If your group care program serves children with severe developmental disabilities, medically fragile children, maternity services, or is a group receiving center or meets RCW 74.15.020 (2)(m), the children may be younger than six years of age.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0685, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0685, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0690 What services must I provide if I have a group care license? You must provide specialized services that are needed by the group that you serve. These

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services may be provided through your own program or through using other community resources.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0690, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0695 Must I give a child an allowance? Group care facilities, except group receiving centers, must give the children under their care allowances based on age, needs and ability to handle money. These facilities must keep track of allowances given to children in a ledger.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0695, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0695, filed 8/28/01, effective 9/28/01.]

GROUP CARE—STAFF QUALIFICATIONS AND STAFFING RATIOS

WAC 388-148-0700 What are the qualifications for an executive director for a group care program or child-placing agency? A group care program, child-placing agency executive director, or person responsible for the agency administration, agency oversight, and fiscal operation must meet, at a minimum, the requirements that follow.

- (1) Be able to communicate to the department the roles, expectations and purposes of the program;
- (2) Work with representatives of other agencies; and
- (3) Have appropriate education and four years of successful experience with similar duties and responsibilities for the administration oversight, and fiscal management of an agency.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0700, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0700, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0705 Do I need an on-site program manager or social service staff at each group care facility? Each group care facility must have an on-site program manager, social service staff, or person with the equivalent training and experience of an on-site program manager at each facility during business hours.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0705, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0705, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0710 What are the responsibilities of the on-site program manager or social service staff for a group care facility? The on-site program manager or social service staff has the following responsibilities:

- (1) Coordinates the day-to-day operations of the program;
- (2) Supervises the child care staff;
- (3) Oversees the completion of each child's plan of care and treatment.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0710, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0710, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0715 What qualifications must the on-site program manager, or social service staff for a group care program or a CPA program manager have? (1) Each on-site program manager or social service staff for group care

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and CPA program manager must have the following qualifications:

- (a) A bachelor's degree in a social services or closely related field from an accredited school; or
- (b) Five years of successful full-time experience in a relevant field; and
- (c) Supervisory abilities that promote effective staff performance; and
- (d) Relevant experience, training, and demonstrated skills in each area that he or she will be supervising or managing.

(2) The same person may have the responsibilities of the executive director and the group care on-site program manager, social service staff or a CPA program manager, if that person meets the qualifications for both positions.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0715, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0715, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0718 What are the responsibilities for child care staff at a group care program? The child care staff responsibilities at a group care program includes care, supervision, and behavior management of the children under care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0718, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0720 What are the qualifications for child care staff and case aides? The department requires child care staff and case aides:

- (1) Be at least twenty-one years old;
- (2) Exception: Child care staff may be eighteen to twenty years old if enrolled and participating in an internship or practicum program with an accredited college or university; and supervised by staff twenty-one years or older;
- (3) Have a high school diploma or GED;
- (4) Have one year of experience working with children;
- (5) Have the skills and abilities to work successfully with the challenging behaviors of children in care; and
- (6) Have effective communication and problem solving skills.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0720, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0720, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0722 What are the qualifications for health care staff for a group care program or a child-placing agency caring for medically fragile children? (1) The health care staff, such as a licensed practical nurse (LPN) and nurse assistant certified, must meet the full professional competency requirements in their respective field when working in a group care facility or a CPA program for medically fragile children.

(2) The health care staff must maintain their certification or licensure as required by the department of licensing.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0722, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0725 What is the ratio of child care staff to children in group care facilities? The department

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has specific requirements for the ratio of child care staff to children in group care.

(1) The ratio for group care is at least one child care staff member on site for every eight children during waking and sleeping hours.

Note: Crisis residential centers, group receiving centers, staffed residential homes, maternity programs, and programs for children with severe developmental disabilities have different requirements.

(2) At least two adults, including at least one child care staff person, must be on site whenever more than eight children are on the premises.

(3) To keep the proper ratio of staff to children, the executive director, health care staff, on-site program manager, support staff and maintenance staff may serve temporarily as child care staff if they meet all other child care staff qualifications and training.

(4) During sleeping hours of youth, at least one staff person must be awake in all group home programs when:

(a) There are more than six youth in care; and

(b) The major focus of the program is behavioral change rather than the development of independent living skills, such as teen parent and independent living skills programs; or

(c) The youth's behavior poses a safety risk to self or others.

(5) When only one child care staff is on site, a second staff must be on call.

(6) You must have relief staff so that all staff can have the equivalent of two days off a week.

(7) If you have more than one program in one building, such as a group care program and a crisis residential center, you must follow the most stringent staffing ratio requirements.

(8) For juvenile detention facilities certified as meeting the minimum licensing requirements, at least one child care staff member must be on duty for every ten children in care during the sleeping and waking hours.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0725, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0725, filed 8/28/01, effective 9/28/01.]

GROUP CARE—ROOM REQUIREMENTS

WAC 388-148-0730 Are there room requirements for group care facilities? You must meet the following room requirements to operate a group care facility.

(1) You must provide rooms that are ample in size and properly furnished for the number of children you serve.

(2) You must have a comfortably furnished living room.

(3) You must have a dining room area that is ample in size and suitably furnished for your residents.

(4) Juvenile detention facilities, certified as meeting the licensing requirements, are not required to meet these first three standards, (WAC 388-148-0730 (1)(2)(3)).

(5) With more than twelve children, you must provide at least one separate indoor recreation area. Its size and location must be sufficient for the age and number of the children to engage in recreational and informal education activities.

(6) You must provide a room or area that is used as an administrative office. In addition, suitable offices must be provided for social service staff. In facilities caring for fewer

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than thirteen children, these offices may be combined with the administrative office.

(7) You must provide a space that can be used as a visiting area.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0730, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0730, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0740 What are the kitchen requirements? (1) You must provide facilities to properly store, prepare, and serve food to meet the needs of the children under your care.

(2) All food service facilities and food handling practices in day treatment programs and group care facilities must comply with rules and regulations of the state board of health governing food service sanitation (see chapter 246-215 WAC).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0740, filed 8/28/01, effective 9/28/01.]

SPECIFIC PROGRAM REQUIREMENTS—MATERNITY SERVICES

WAC 388-148-0745 Who may provide maternity services? The following programs, homes, facilities, and agencies that may provide or arrange for maternity services include:

- (1) Foster homes;
- (2) Staffed residential homes;
- (3) Group homes for new mothers with infants;
- (4) Independent living programs; and
- (5) Child placing agencies.

Note: The rules in WAC 388-148-0745 through 388-148-0795 apply exclusively to licensing requirements for agencies providing or arranging maternity service.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0745, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0750 What maternity services must I provide? If you operate a licensed program for expectant mothers and new mothers with infants, you must provide or arrange for the following services:

(1) Information and referral services to every expectant and new mother who applies for care.

(2) Individual or group counseling sessions, if necessary, about the following topics:

- (a) Pregnancy counseling;
- (b) Independent living education;
- (c) Infant and child care training;
- (d) Living arrangements;
- (e) Medical care planning;
- (f) Legal issues;
- (g) Vocational or educational guidance;
- (h) Plans for the child;
- (i) Financial, emotional or psychological problems;
- (j) Relations with parents and birth father; and
- (k) Home management and consumer education.

(3) An expectant mother's delivery in a licensed hospital or licensed birthing facility.

(4) Postpartum medical examinations, as prescribed by a physician, to a new mother.

- (5) Child care, as needed.
- (6) Case management services.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0750, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0750, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0755 How are maternity services delivered? (1) Maternity services must not be contingent upon a parent's decision to keep or relinquish her child.

(2) If you do not directly provide maternity services to an expectant or new mother in your facility, you must either:

- (a) Arrange for these services through formal agreements with other community agencies; or
- (b) Assist the clients in your program to get these services.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0755, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0760 Do you need to approve daily activities that I offer to expectant or new mothers? The department must approve the program of daily activities that you've developed for expectant or new mothers, whether your program is residential or nonresidential.

(1) The department requires that you provide us with a written program description about the daily activities you offer. The program description must outline educational, recreational, and therapeutic services that you intend to provide to expectant mothers and new mothers with infants.

(2) You must also provide us with a schedule of typical daily activities for the mothers under your care.

Exception: Foster homes are not required meet the standard in this section.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0760, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0765 What types of health education must I offer expectant and new mothers? You need to offer or arrange health education for expectant and new mothers that includes the following areas:

- (1) Hygiene;
- (2) Suitable preparation for childbirth;
- (3) The physiological changes during pregnancy;
- (4) Examinations and childbirth procedures;
- (5) Postnatal and pediatrics care;
- (6) Contraception and family planning;
- (7) Nutritional requirements for mother and child;
- (8) Child health and development; and
- (9) Psychological and emotional changes during and after pregnancy.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0765, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0765, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0770 Is a group care program required to provide child care? (1) If your program serves parents with children, you must provide or assist the parent in arranging for licensed child care when appropriate. An example is when parents are working or are in school and need child care.

- (2) The child care home or facility must be licensed.

[Title 388 WAC—p. 706]

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0770, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0775 Do expectant and new mothers need to be under a physician's care? A program providing maternity services to expectant and new mothers must provide or assist them in obtaining a physician's care for pre- and post-natal care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0775, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0775, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0780 What are my responsibilities if a specialist is required? You must provide or arrange for consultation regarding prenatal care by specialists meeting their full professional qualifications when the physician requests prenatal consultants.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0780, filed 8/28/01, effective 9/28/01.]

MATERNITY SERVICES—STAFF QUALIFICATIONS AND STAFFING RATIOS

WAC 388-148-0785 What is the proper ratio of staff to children in home or group care facilities offering maternity services? Residential programs provide twenty-four-hour care to expectant mothers and to new mothers with infants.

(1) These programs must employ sufficient numbers of residential staff to meet the physical, safety, health and emotional needs of the residents. Residential staff are in charge of supervising the day-to-day living situation for youth.

Note: Child care staff may carry out any maintenance tasks that do not detract from their primary function.

(2) When youth are on the premises, the ratio of staff to residents must be as follows:

(a) At least one residential staff member must be on duty for every eight mothers.

(b) When more than eight mothers are on the premises, at least two adults, including at least one child care staff must be on duty.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0785, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0785, filed 8/28/01, effective 9/28/01.]

MATERNITY SERVICES—ROOM REQUIREMENTS

WAC 388-148-0790 Do you have room requirements for facilities offering maternity services? (1) If you have a residential program for expectant mothers or new mothers with infants, you must meet the room requirements for group facilities (WAC 388-148-0730).

(2) If your facility offers medical clinics, you must have a separate, adequately equipped examination room with adequate nursing equipment.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0790, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0795 How is capacity determined for a maternity services facility? We count the number of mothers and children in determining capacity. The space

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required for a mother and infant bedroom needs to be considered when determining the capacity of a group care facility providing maternity services is determined by the department of health representative.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0795, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0795, filed 8/28/01, effective 9/28/01.]

DAY TREATMENT PROGRAMS—PROGRAM AND SERVICES

WAC 388-148-0800 What is the purpose of day treatment programs? (1) A day treatment program must provide educational and therapeutic group experiences for emotionally disturbed children who are not in need of residential care. These services are provided during part of the twenty-four-hour day, usually during a five-day week.

(2) Day treatment is for children who are:

(a) Unable to adjust to school programs due to disruptive behavior, family stress, learning disabilities or other serious emotional disabilities; and/or

(b) Have intensive needs, which can not be adequately met through out-patient community mental health services.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0800, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0800, filed 8/28/01, effective 9/28/01.]

DAY TREATMENT PROGRAMS—STAFF QUALIFICATIONS AND STAFFING RATIOS

WAC 388-148-0805 What staff must my day treatment program have? (1) Your day treatment program must have an executive director to manage the financial and administrative operations of the program and an on-site program manager to supervise the child care staff and the treatment program at the facility.

Note: The executive director and on-site program manager may be the same person if that person is qualified for both positions.

(2) Either the executive director or on-site program manager must be on the premises while the children are in care. Another competent person may be left in charge during the director's and/or program supervisor's temporary absence.

(3) The qualifications for executive director and on-site program manager are outlined in WAC 388-148-0700 and 388-148-0715, respectively.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0805, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0805, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0810 What consultants must my day treatment program have? If you operate a day treatment program, you must use psychiatrists, psychologists, teachers, and group counselors for children under care as follows. Your day treatment program must:

(1) Receive regular consultation from a child psychiatrist;

(2) Provide or arrange for a psychologist for psychological testing and related services if the child's school does not provide these services;

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(3) Provide or arrange for teaching by certified teachers qualified by training or experience in remedial education; and

(4) Use group counselors who are qualified by training or by experience in the care of emotionally disturbed children.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0810, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0810, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0815 What is the ratio of counselor and teaching staff to children in a day treatment program? There must be one counselor or teacher for every six children who are in a day treatment program.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0815, filed 8/28/01, effective 9/28/01.]

GROUP CARE PROGRAMS FOR MEDICALLY FRAGILE CHILDREN AND CHILDREN WITH SEVERE DEVELOPMENTAL DISABILITIES—PROGRAM AND SERVICES

WAC 388-148-0820 What type of care is offered for medically fragile children and children with severe developmental disabilities? Specialized group care programs are designed to provide residential care to children who need intensive personal care due to medical fragility and/or severe developmental disabilities. The children may require skilled health care, physical therapy, or other forms of therapy.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0820, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0825 Who provides services for medically fragile children and children with severe developmental disabilities? Individuals and agencies are licensed to provide services to medically fragile children and children with severe developmental disabilities, including staffed residential homes, group homes and child-placing agencies.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0825, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0830 What services must be provided for medically fragile children and children with severe developmental disabilities? (1) If you care for medically fragile children and children with severe developmental disabilities you must ensure the following services are provided, if prescribed by a physician:

(a) An individualized treatment plan suited to the unique needs of each child in care; and

(b) Care by physicians, including surgeons, general and family practitioners, and specialists in the child's particular diagnosis on either a referral, consultative, or ongoing treatment basis.

(2) You must also provide the following nursing services, if prescribed by a physician, if you care for medically fragile children, or children with severe developmental disabilities unless these children are in a foster home:

(a) Sufficient licensed nursing staff to meet the nursing care needs of the children; or

(b) Regular nursing consultation that includes at least one weekly on-site visit by a registered nurse.

[Title 388 WAC—p. 707]

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0830, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0830, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0835 Do I need to have a multidisciplinary care plan for medically fragile children and children with severe developmental disabilities? If you operate a program licensed for the care of medically fragile children and children with severe developmental disabilities, you must maintain a multidisciplinary plan of care for each child in care.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0835, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0840 What must the multidisciplinary care plan for a medically fragile child or a child with severe developmental disabilities include? The multidisciplinary care plan must address the social service, medical, nutritional, rehabilitative, and educational needs of each medically fragile child or child with severe developmental disabilities.

- (1) The plan must describe:
 - (a) The care given for each child;
 - (b) The goals to be accomplished; and
 - (c) The professional services responsible for each element of care.

(2) The care plan must be reviewed, evaluated, and updated annually by professional staff involved in the care of the child to reevaluate each child's condition, progress, prognosis and need for ongoing care and services.

(3) You must record progress reports in the child's record on a quarterly basis.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0840, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0845 What are the requirements for nurses in programs who care for medically fragile children or children with severe developmental disabilities? If nursing services are prescribed by a physician, the department has several requirements for programs that care for medically fragile children or children with severe developmental disabilities.

(1) The registered nurse's name, address, and telephone number must be readily available.

(2) The agency or program must have the nurse assist in implementing a regular health care program that both:

- (a) Oversees the health of all children; and
- (b) Provides follow-up care of special health needs identified by the child's physician or facility or program staff.

(3) The agency or program must have the nurse advise and assist nonmedical personnel in maintaining medical records, meeting daily health needs, and caring for children with minor illnesses and injuries.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0845, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0850 When do I use a nurse? You must use a nurse to consult with you at your home or facility if you have infants, medically fragile children or children with severe developmental disabilities under your care and meet these specific conditions:

[Title 388 WAC—p. 708]

(1) If you have four or more infants, you must arrange for monthly on-site visits with a registered nurse that is trained or experienced in the care of young children.

(2) You must have a written agreement with the registered nurse about your infant care program.

(3) If you have children with severe developmental disabilities requiring nursing services, you must have a registered nurse on staff or under contract.

(4) The nurse must advise you and your staff on your infant care program and your child health program.

(5) You must document the nurse's on-site visits.

(6) The nurse's name and telephone number must be posted or otherwise available in your home or facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0850, filed 8/28/01, effective 9/28/01.]

GROUP CARE PROGRAMS FOR MEDICALLY FRAGILE CHILDREN OR CHILDREN WITH SEVERE DEVELOPMENTAL DISABILITIES—ROOM REQUIREMENTS

WAC 388-148-0855 Do I need to provide a therapy room for children with severe developmental disabilities?

(1) If you care for children with severe developmental disabilities, you must provide them with a room for physical and occupational therapy, if these services are prescribed by a physician. The room must be adequate for storing equipment used during therapy sessions.

(2) If you do not have a room for physical and occupational therapy, you must arrange for these therapies outside of your facilities.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0855, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0860 Are there room requirements for group care facilities for medically fragile children less than age six? If you operate a group care program that serves medically fragile children less than age six, you must follow these additional room requirements.

(1) If you are licensed to care for thirteen or more children, you must provide separate, safe play areas for children less than one year or children not walking. The department must approve the rooms or areas.

(2) Children less than one year must be cared for in rooms or areas separate from older children.

(3) No more than eight children less than one year of age may be in the room at a time.

(4) Handwashing facilities must be available nearby.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0860, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0860, filed 8/28/01, effective 9/28/01.]

GROUP CARE PROGRAMS FOR MEDICALLY FRAGILE CHILDREN AND CHILDREN WITH SEVERE DEVELOPMENTAL DISABILITIES—FOOD AND MEALS

WAC 388-148-0865 What food requirements exist for medically fragile children and children with severe developmental disabilities? There may be specific food requirements if you operate a home or facility that cares for

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medically fragile children and children with severe developmental disabilities:

(1) All modified diets must be planned, reviewed, and approved by a dietitian. You must use the services of a dietitian who meets current registration requirements of the American dietetic association.

(2) You must follow the dietary plan for each child as prescribed by the child's physician. You must document in the child's file that staff are following the physician's order.

[Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0865, filed 8/28/01, effective 9/28/01.]

GROUP CARE PROGRAMS FOR MEDICALLY FRAGILE CHILDREN AND CHILDREN WITH SEVERE DEVELOPMENTAL DISABILITIES—RECORD-KEEPING

WAC 388-148-0870 What additional record-keeping requirements exist for medically fragile children and children with severe developmental disabilities? (1) In addition to meeting standard requirements for keeping records (see WAC 388-148-0120 through 388-148-0140), you must also keep the following information for any medically fragile child and child with a severe developmental disability:

(a) Information you received upon admission including family background, current diagnosis and medical status, an inventory of personal belongings, medical history, and a report of a physical examination and diagnosis by a physician;

(b) Information about the child's daily care including treatment plans, medications, observations, medical examinations, physicians' orders, allergic responses, consent authorizations, releases, diagnostic reports, and revisions of assessments;

(c) Upon discharge, a summary including diagnoses, treatments, and prognosis by the person responsible for providing care, and any instructions and referrals for continuity of care; and

(d) Evidence of meeting criteria for eligibility for services from the division of developmental disabilities.

(2) If the child has died, you must also have the following information:

(a) The time and date of death;

(b) Apparent cause of death;

(c) Notification of the physician and relevant others (including the coroner if necessary); and

(d) Regarding the disposal of the child's body and how the child's personal effects will be dealt with.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0870, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0870, filed 8/28/01, effective 9/28/01.]

CRISIS RESIDENTIAL CENTERS—PROGRAM/LEVELS OF SECURITY/PLACEMENT AND SERVICES

WAC 388-148-0875 What types of crisis residential centers may be licensed? (1) A facility may be licensed as a regular crisis residential center (CRC) or a secure crisis residential center.

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(2) A foster home may be licensed as a family CRC. The foster home licensed, as a CRC, must meet the licensing standards for foster homes outlined in this chapter.

(3) Family CRCs and regular CRCs are not locked facilities, but are operated in a way that reasonably assures that youth placed there will not run away.

Note: Regular CRCs are also known as semi-secure CRCs, as referred to in RCW 13.32A.030(16).

(4) A secure facility is designed and operated to prevent a youth from leaving without permission of the staff.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0875, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0875, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0880 What levels of secure CRCs exist? The department licenses three types of secure crisis residential centers (CRCs): Level one, level two, and level three. Level one is the most secure facility and level three is the least secure facility.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0880, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0880, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0885 What are the requirements for a level-one secure CRC? A level-one crisis residential center (CRC) must meet each of these requirements:

(1) Be a free-standing facility, separate unit, or separate building within a campus with windows and exterior doors that prevent exit.

(2) Meet or exceed the current state building code when locking doors and windows prevent exit.

(3) Ensure that no youth is kept in a locked room that isolates the youth from the general population and/or staff.

(4) Maintain a recreation area, within the secured facility or secured on the property of the facility, that can support youth's vigorous physical activity. Any fences used to secure the recreation area must meet or exceed the specifications of the level-two CRC referenced in WAC 388-148-0890(3).

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0885, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0885, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0890 What are the requirements for a level-two secure CRC? A level-two secure crisis residential center (CRC) must meet each of these requirements:

(1) Be a free-standing facility, separate unit, or separate building within a campus that prevents unauthorized entering and exiting with a nonscalable fence around the perimeter of the facility property;

(2) Not prevent exit by locking facility doors or windows;

(3) Design the nonscalable fence so that it does not cause injury, such as avoiding use of electrification, razor wire or concertina wire;

(4) Ensure that no youth is kept in a locked room that isolates him or her from the general population and/or staff; and

(5) Maintain a recreation area surrounded by a nonscalable fence that can support youth's vigorous physical activity.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0890, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030, 01-18-037, § 388-148-0890, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0892 What are the requirements for a level three secure CRC? A level-three secure crisis residential center (CRC) must meet each of these requirements:

- (1) Be a free-standing facility, separate unit or separate building within a campus with exterior doors that have special egress-control devices;
- (2) Meet or exceed the current state building code for facilities with special egress-control devices; and
- (3) Maintain a recreation area, within the secured facility or secured on the property of the facility, that can support youth's vigorous physical activity. Any fences used to secure the recreation area must meet or exceed the specifications of the level-two secure CRC referenced in WAC 388-148-0890(3).

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0892, filed 4/5/04, effective 5/6/04.]

WAC 388-148-0895 May a juvenile detention center operate as a separate secure CRC program? (1) A juvenile detention center may operate a separate secure crisis residential center (CRC) program. The physical facility must be operated so that no direct communication or physical contact can be made between a resident of the secure crisis residential center and a person held in the detention facility.

- (2) Staff assigned to the secure crisis residential center youth must not be simultaneously assigned to the juvenile detention center residents on the same shift.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0895, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0895, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0900 What youth may a CRC serve?

All CRCs

A crisis residential center (CRC) provides emergency, temporary residence to youth ages twelve through seventeen who meet one of the following criteria:

- (1) Are beyond the control of their parents or guardians and behave in a way that endangers any person's welfare;
- (2) Need assistance getting food, shelter, health care, clothing, educational services, and/or resolving family conflicts;
- (3) Need temporary protective custody; or
- (4) Have parents who are not able or willing to continue efforts to keep the family together.

Secure CRCs

- (5) Youth ordered by the court to serve time for contempt on CHINS, ARP, or truancy orders may be ordered into a secure CRC that is colocated with a detention facility.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0900, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0900, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0905 Can law enforcement officers place youth in secure CRCs? Law enforcement officers may place youth in secure crisis residential centers (CRCs), when available, when youth:

- (1) Are runaways;
- (2) Are in dangerous situations; or
- (3) Are in violation of curfew.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0905, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0905, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0910 What hours do CRCs have to be open? Crisis residential centers (CRC) must be open twenty-four hours a day, seven days a week.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0910, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0915 What steps must be taken after a youth is admitted into a CRC?

All CRCs

- (1) The director or designee of a crisis residential center (CRC) must immediately notify the parents of the youth who has been admitted.

- (2) If the director or designee of any CRC is unable to contact the youth's parents within, forty-eight hours, he or she must:

- (a) Contact the department and request that the case be reviewed for dependency filing under chapter 13.34 RCW or "child in need of services" filing under chapter 13.32A RCW; and

- (b) Document the contact with the department in the youth's case record.

Secure CRCs

- (3) Within the first twenty-four hours after admitting a youth to a secure crisis residential center, and each twenty-four hours after, the director or designee must assess the youth's risk of running.

- (4) The secure CRC director or designee must determine what type of CRC, regular or secure, would be best for the youth.

- (5) The secure CRC director or designee must use the following criteria in making the decision, considering the safety, health and welfare of the youth and others:

- (a) The youth's age and maturity;
- (b) The youth's physical, mental, and emotional condition upon arrival at the center;
- (c) The circumstances that led to the youth's placement at the facility;
- (d) The youth's behavior;
- (e) The youth's history of running away;
- (f) The youth's willingness to cooperate in conducting the assessment;
- (g) The youth's need for continued assessment, protection, and intervention services in a CRC; and
- (h) The likelihood the youth will remain at a CRC.

- (6) The secure CRC director or designee must put the decision about the youth's status in writing in the youth's file.

- (7) After a youth is admitted, the secure CRC director or designee must ensure that a youth is assessed for any health needs requiring immediate attention.

- (8) By the first school day after admission, the crisis residential center staff must:

- (a) Notify the youth's school district about the youth's placement; and

- (b) Assess the youth for any educational needs as a part of the assessment process for inclusion in the discharge summary.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0915, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0915, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0920 What if a youth seems unlikely to remain in a regular CRC? If a crisis residential center (CRC) director or designee decides that a youth is unlikely to stay in a regular facility, he or she must make reasonable efforts to transfer the youth to a secure facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0920, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0925 What happens when no space exists at a secure CRC? If space is not available in a secure crisis residential center (CRC), the director or designee of the secure CRC may transfer a different youth from that facility to a regular CRC as long as the youth:

- (1) Has been in the secure facility for at least twenty-four hours; and
- (2) Is considered likely to remain at a regular CRC facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0925, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0930 How is a youth transferred from one type of CRC to another? After deciding that a youth needs to be transferred from one type of crisis residential center (CRC) to another, the director or designee initiating the change must take these steps:

- (1) Obtain the department's agreement with the transfer decision.
- (2) Communicate with the CRC where the youth is being relocated:
 - (a) Assure mutual agreement with the transfer decision; and
 - (b) Make sure that space for the youth is available to support the transfer.
- (3) Document all communication related to the transfer into the youth's file.
- (4) The CRC director or designee initiating the transfer must establish and maintain the following written documents:
 - (a) Transfer procedures for the transfer of youth to another crisis residential center; and
 - (b) Protocols/agreements with the other crisis residential center's director for youth transfers.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0930, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0940 What does a youth's orientation to a CRC need to include? (1) As part of admission to a crisis residential center (CRC), the CRC staff must give an orientation to youth that includes, but is not limited to:

- (a) A description of the CRC's program and services;
 - (b) The physical facility;
 - (c) The department-approved policy that states that youth may not have guns and other weapons, alcohol, tobacco, and drugs within the facility; and
 - (d) The department-approved policy on client visitation that includes access to the youth's attorney.
- (2) Written documentation of this orientation must be in each youth's file.

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[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0940, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0945 What intervention services must be provided or arranged for by the CRC? (1) Crisis residential centers (CRCs) must provide or arrange, at a minimum, the following services:

- (a) Assessment of the family in order to develop a treatment plan for the youth;
 - (b) Family counseling focused on communication skills development and problem solving;
 - (c) Individual and/or group counseling; and
 - (d) Referrals to transition the family to community-based services.
- (2) Intervention services must be documented, in writing, in the youth's case record.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0945, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0950 What behavior management practices are required for a CRC? (1) Crisis residential centers (CRC) must follow the department's behavioral management policy as specified in the general licensing requirement section of this chapter (see WAC 388-148-0465 through 388-148-0490).

(2) A CRC must develop policies and procedures when the behavior management practices include use of physical restraint, including:

- (a) Who may authorize the use of physical restraint; and
 - (b) Under what circumstances physical restraint may be used, including time limitations, reevaluation procedures, and supervisory monitoring.
- (3) Written policies and procedures about using physical restraint must be submitted to the department for approval before the policies and procedures are implemented.
- (4) All staff must be trained in behavior management techniques prior to using physical restraint.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0950, filed 8/28/01, effective 9/28/01.]

CRISIS RESIDENTIAL CENTERS—MULTIDISCIPLINARY TEAM

WAC 388-148-0955 What is the purpose of a multidisciplinary team in a CRC? (1) Crisis residential centers (CRC) must have multidisciplinary teams available as a service to youth and their families, if they request the service.

(2) The purpose of the multidisciplinary team is to evaluate the youth and the youth's family and when agreed to by the family, assist the with any of the following services:

- (a) Developing a plan for accessing available social and health-related services;
 - (b) Obtaining referrals to a chemical dependency specialist and/or county-designated mental health professional;
 - (c) Recommending no further intervention because the youth and family have worked out the problems that were causing family conflicts; and
 - (d) Reconciling the youth and family.
- (3) Members of multidisciplinary teams may include:
- (a) Educators;
 - (b) Law enforcement personnel;

[Title 388 WAC—p. 711]

- (c) Court personnel;
- (d) Family therapists or mental health providers;
- (e) Chemical dependency treatment providers;
- (f) Licensed health care practitioners;
- (g) Social service providers;
- (h) Youth residential placement providers;
- (i) Other family members;
- (j) Church representatives; and
- (k) Members of the family's community.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0955, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0960 When may a multidisciplinary team be requested? (1) After a youth is admitted into a crisis residential center (CRC), the CRC director or designee must advise the parent or guardian and the youth of their rights to request a multidisciplinary team.

(2) The director or designee also may set up a multidisciplinary team when he or she:

(a) Believes that the:

(i) Youth is a "child in need of services" under RCW 13.32A.030; and

(ii) Parent is unavailable or unwilling to continue efforts to maintain the family structure.

(b) Needs help contacting the youth's parents. If the director or designee is unable to contact the parent or guardian within forty-eight hours, the director or designee must:

(i) Contact the department and request the case be reviewed for a dependency filing under chapter 13.34 RCW or a "child in need of services" filing under chapter 13.32A WAC; and

(ii) Document this information in the child's case file.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0960, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0965 How is a multidisciplinary team convened? (1) The crisis residential center (CRC) director or designee must notify the members of the multidisciplinary team of the need to convene.

(2) The director or designee must:

(a) Tell the youth's parents or guardians about the multidisciplinary team if the parents did not make the initial request to form a team;

(b) Advise the parents of their right to select additional members; and

(c) Assist in getting prompt involvement of additional persons that the parent or youth have requested to be added to the multidisciplinary team.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0965, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0970 May a parent disband the multidisciplinary team? (1) The crisis residential center (CRC) director or designee must advise the parents of their right to disband the multidisciplinary team within twenty-four hours after they receive notice of the team forming, excluding weekends and holidays.

(2) Parents may disband the multidisciplinary team:

(a) Unless a dependency petition has been filed (under RCW 13.32A.140); or

[Title 388 WAC—p. 712]

(b) After a dispositional hearing has taken place ordering out-of-home placement for the youth.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0970, filed 8/28/01, effective 9/28/01.]

CRISIS RESIDENTIAL CENTERS—STAFF QUALIFICATIONS AND STAFFING RATIOS

WAC 388-148-0975 What qualifications must a crisis residential center executive director have? A crisis residential center executive director must meet the same qualifications that are specified for group care executive directors (see WAC 388-148-0700).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0975, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0980 Do I need a program manager on-site at each facility? Each crisis residential center facility must have an on-site program manager or person meeting those qualifications to coordinate the day-to-day operations of the facility on the premises during business hours, when youth are present.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0980, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0985 What qualifications must the on-site program manager for a crisis residential program have? Each on-site program manager must meet the qualifications outlined under WAC 388-148-0710.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0985, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0990 What additional qualifications must the crisis residential center youth care staff have?

(1) At a crisis residential center (CRC), the primary duties of the youth care staff are the care, supervision, and behavioral management of youth. All youth care staff in a CRC must meet the qualifications for youth care staff in a group care program (see WAC 388-148-0715).

Additional CRC youth care staff qualifications

(2) Additional requirements for youth care staff that work in a CRC are as follows:

(a) At least fifty percent of the youth care staff must have completed:

(i) A bachelor's degree; or

(ii) At least two years of college and one year of work in a residential care program for adolescents.

Note: Youth care staff may substitute experience for education on a year-for-year basis. A Bachelor of Arts degree in behavioral or social science may substitute for experience.

(3) The remaining youth care staff must have at least a high school diploma or GED and one of the following:

(a) One year of successful experience working with youth in a group setting;

(b) One year of successful experience as a foster parent for three or more children;

(c) Have skills and abilities to work successfully with the challenging behaviors of children in care; and

(d) Have effective communication and problem solving skills.

Note: Two years of college may be substituted for the required experience.

(4) Each youth care staff person must be at least twenty-one years of age, unless they are between eighteen and twenty-one, enrolled and participating in an internship program with an accredited college or university.

Note: Staff under twenty-one years of age must be supervised by a staff twenty-one years old or older.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0990, filed 8/28/01, effective 9/28/01.]

WAC 388-148-0995 What are the ratio requirements of youth care staff to youth in crisis residential centers?

(1) You must ensure the safety of the youth that are residing in crisis residential centers (CRCs) by maintaining staffing ratios. This may require a staffing ratio higher than the minimum listed if necessary for the health and safety of youth and/or staff.

Regular CRCs

(2) At all times, regular crisis residential centers must have at least one youth care staff on duty for every four youth in care when youth are present.

(3) Regular crisis residential centers must have at least two awake youth care staff on duty during waking hours of the youth when youth are present.

(4) Regular crisis residential centers must have at least one awake youth care staff on duty during sleeping hours of the youth. One or more additional (back-up) staff must be on the premises during sleeping hours to maintain staffing ratios.

Under extraordinary circumstances, the DLR director may approve an alternative back-up plan.

Secure CRCs

(5) At all times, secure crisis residential centers must have at least two staff on duty when youth are present.

(6) At all times, secure crisis residential centers not collocated with a detention center must have at least one youth care staff on duty for every three youth in care.

(7) At all times, secure crisis residential centers that are located in the same facility as a detention center must have at least one awake youth care staff on duty for every four youth in care.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-0995, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-0995, filed 8/28/01, effective 9/28/01.]

CRISIS RESIDENTIAL CENTERS—STAFF TRAINING

WAC 388-148-1000 What training must staff at a crisis residential center have? (1) All staff working at a crisis residential center (CRC) must complete a minimum of sixteen hours of preservice job orientation prior to beginning unsupervised child care responsibilities. Training must include:

- (a) Presentation of the CRC agency's policies and procedures manual;
- (b) Behavior management techniques;
- (c) Crisis intervention techniques;
- (d) Family intervention techniques;
- (e) Child abuse and neglect reporting requirements;
- (f) Youth supervision requirements; and

(g) HIV/AIDS/Bloodborne pathogen training.

(2) Staff working at a CRC must complete a minimum of twenty-four hours of on-going education and in-service training annually. This training must include:

- (a) Crisis intervention techniques, including verbal de-escalation, positive behavior support, and physical response/restraint training as approved by the department;
- (b) Behavior management techniques;
- (c) Substance abuse;
- (d) Suicide assessment and intervention;
- (e) Family intervention techniques;
- (f) Cultural diversity;
- (g) Mental health issues and interventions;
- (h) Mediation skills;
- (i) Conflict management/problem-solving skills;
- (j) Physical and sexual abuse; and
- (k) Emergency procedures.

(3) All staff working at a CRC must have current first-aid and CPR training.

(4) The director or designee of the CRC must document completion of all training in each staff person's personnel file.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1000, filed 8/28/01, effective 9/28/01.]

CRISIS RESIDENTIAL CENTERS—RECORD-KEEPING

WAC 388-148-1005 What record keeping is required for crisis residential centers? (1) Crisis residential centers (CRC) must follow the general licensing requirements for record keeping (see WAC 388-148-0125).

(2) In addition, a CRC must record:

- (a) The time and date a placement is made;
- (b) The names of the person and organization making the placement; and
- (c) Reasons for the placement.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1005, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1010 What additional record-keeping requirements exist for secure crisis residential centers?

(1) If you operate secure crisis residential centers (CRC), you must maintain, at a minimum, hourly logs of where the youth are physically located.

(2) You must have a policy on the use and retention of these logs, including but not limited to staff briefings between shifts to verify:

- (a) Where youth are physically located at each shift change; and
- (b) That weekly inspections take place of any security devices.

(3) You must retain these logs for seven years.

(4) You must also maintain a log and written report that identifies all incidents requiring physical restraints for a youth. (see WAC 388-148-0490)

(5) Within seven days of a youth's discharge, you must send the child's social worker a written summary that includes, but is not limited to:

- (a) Community-based referrals;
- (b) Assessment information on the family and child;
- (c) Family reconciliation attempts;

- (d) Contacts with families and professionals involved;
- (e) Recommendations for all family members;
- (f) Medical and health related issues; and
- (g) Any other concerns, such as legal issues and school problems.

(6) You must retain a copy of any discharge summaries in the youth's case record at the secure crisis residential center.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1010, filed 8/28/01, effective 9/28/01.]

STAFFED RESIDENTIAL HOMES—PROGRAM AND SERVICES

WAC 388-148-1015 What is the purpose of a staffed residential home? A staffed residential home may employ staff to provide twenty-four-hour care to children who:

- (1) Are unable to successfully live in a foster home;
- (2) Have emotional disturbances or physical or mental disabilities;
- (3) Are medically fragile; or
- (4) Are in transition from residential care to a foster home.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1015, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1025 What must be included in a written program description for a staffed residential home?

(1) A written program description to provide services to children at a staffed residential home must be submitted for department approval.

(2) The program description must include but is not limited to:

- (a) The number of children served at one time;
- (b) The expectations of services to be provided;
- (c) The steps to be taken to include the child's family;
- (d) The plan on how coordination will occur with community partners;
- (e) The plan on how permanency planning for the children will take place;
- (f) A safety and supervision plan for each child; and
- (g) A behavior management plan for each child, as appropriate.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1025, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1025, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1030 What services must a staffed residential home provide? (1) A staffed residential home must be able to provide the specialized services required by the group that is served in the staffed residential home. These services may be provided through your own program or through using other community resources.

(2) You must provide a safety and supervision plan for each child you serve considering his or her age and physical condition.

(3) A list of services that you will provide to children and their families must include but is not limited to:

- (a) The steps to be taken to include the child's family in the services;
- (b) Who and how these services will be carried out; and

[Title 388 WAC—p. 714]

(c) A schedule of typical daily activities for the children under your care.

(4) Services for children must include:

- (a) Transportation;
- (b) Teaching social and living skills;
- (c) Opportunities for play and recreation; and
- (d) Opportunities to participate in community and cultural activities.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1030, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1030, filed 8/28/01, effective 9/28/01.]

STAFF RESIDENTIAL HOMES—STAFF QUALIFICATIONS, STAFFING RATIOS, AND CAPACITY

WAC 388-148-1035 Who must be on the premises when children are under care at a staffed residential home? The on-site program manager or a person meeting the same qualifications must be on the premises of the staffed residential home during business hours when children are under care if:

- (1) The major focus of the program is behavioral rather than the development of independent living skills such as a teen parent program or responsible living skills program; and
- (2) A youth's behavior poses a risk to self or others.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1035, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1035, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1040 What are the qualifications for staff at a staffed residential home? The executive director, on-site program manager, and child care staff at a staffed residential home must meet the qualifications outlined for group care program section (WAC 388-148-0700, 388-148-0715, and 388-148-0720).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1040, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1045 What is the ratio of child care staff to children in staffed residential homes? (1) You must meet the minimum ratios of child care staff to children under care at a staffed residential home.

(2) To keep the proper ratio of staff to children, the director, support staff and maintenance staff may serve as child care staff if they have adequate training.

(3) The ratio for staffed residential homes is, at least, one child care staff for every six children during waking hours of children.

(4) During sleeping hours of youth, at least, one staff person must be awake when:

- (a) There is a written supervision agreement or a contract with the department of social and health services specifying an awake staff is needed for either the program or a specific child;
- (b) A youth's behavior poses a safety risk to self and/or others; or
- (c) A child's medical condition requires constant monitoring.

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(5) The need for overnight supervision must be documented in each child's treatment plan, if awake supervision is necessary.

(6) You may only be licensed for maximum of three pregnant or parenting youth.

(7) When only one child care staff person is on duty, a second person must be on call and available to respond within one half-hour.

(8) You must have relief staff so that all staff can have the equivalent of two days off a week. This is not required for family members if the staffed residential home is a family residence.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1045, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1045, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1050 How many children may I serve in my staffed residential home? The department restricts the number of children that a licensed staffed residential home may serve.

(1) The department may license a staffed residential home for six or fewer children. The maximum number of children in your home or facility must not exceed six at any time.

(2) The department may restrict the number of children in a staffed residential home according to the age and needs of the children.

(3) If only one staff person is on duty at a staffed residential home providing maternity services, that home must not care for more than four persons under the age of eighteen. An additional staff person is required to care for more than four persons under the age of eighteen.

(4) Except for maternity program, you may have only two children under two years of age in your home at a time.

(5) The department may license a staffed residential home for up to three children with mental or physical disabilities that are severe enough to require nursing care if you meet the following conditions:

(a) You provide staff that are qualified by training and experience to provide proper care, including necessary medical procedures; and

(b) The children's treatment is under the supervision of physicians.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1050, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1050, filed 8/28/01, effective 9/28/01.]

STAFFED RESIDENTIAL HOMES—ROOM REQUIREMENTS

WAC 388-148-1055 Are there room requirements for staffed residential homes? The department has certain requirements for rooms that you must meet in order to operate a staffed residential home.

(1) You must provide rooms that are ample in size and properly furnished for the number of children you serve.

(2) You must provide each of the following rooms or areas:

(a) Bedrooms that meet general licensing requirements (WAC 388-148-0260 through 388-148-0270) and have addi-

tional space for any special medical equipment needed by children;

(b) At least one comfortably furnished living room;

(c) A dining room area that is ample in size and suitably furnished for your residents;

(d) At least one separate indoor recreation area with a size and location that is suitable for recreational and informal education activities;

(e) A room or area that may be used as an administrative office; and

(f) A visiting area where visitors can have privacy.

(3) The licensor and staffed residential home director may decide what rooms may have multiple uses (for example, dining room and recreation area or visiting area and living room).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1055, filed 8/28/01, effective 9/28/01.]

CHILD-PLACING AGENCIES—PROGRAM AND SERVICES

WAC 388-148-1060 What services may a child-placing agency provide? The department licenses child-placing agencies to provide:

(1) Certification of eligible foster homes meeting full licensing requirements, including respite care foster homes;

(2) Maternity services to expectant mothers;

(3) Specialized (treatment) foster care;

(4) Residential care programs, such as group homes, crisis residential centers, and independent living skills programs; and

(5) Adoption services.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1060, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1060, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1066 What written information is needed before a child is accepted for care by a child-placing agency? Before accepting a child for care from a parent or legal guardian, a child-placing agency must obtain the following written consent and information from the parent or legal guardian:

(1) Permission from the child's parent or legal guardian authorizing the placement of the child;

(2) Permission to seek emergency medical care or surgery on behalf of the child;

(3) Permission to transport the child;

(4) Basic family information, including address, telephone numbers, and emergency contacts; and

(5) Basic medical information, including current medication, immunization history (if available), known allergies, and at-risk behaviors of the child.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1066, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1070 What health histories need to be provided to foster or adoptive parents? A child-placing agency must provide adoptive parents with information that meets the federal and state statutes on full disclosure of health information.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1070, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1070, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1075 When may child-placing agencies from outside the state place children in this state? Child-placing agencies with offices in other states or another country may arrange to place children in Washington state under each of the following conditions:

(1) The out-of-state agency must be fully licensed, certified, or recognized for child-placing functions in its own home state or country.

(2) All public and private agencies must comply with the requirements of the "interstate compact on the placement of children (ICPC)" (see RCW 26.34.011).

Note: Contact the ICPC program manager with children's administration for more information.

(3) The in-state facility receiving children is responsible for:

(a) Conducting a study of the home where the child will be placed;

(b) Related case management; and

(c) Supervising the placement until the child is legally adopted, reaches eighteen years of age, or returns to the originating state.

(4) An out-of-state agency must give us copies of the following written documents:

(a) Written agreements with Washington state agencies;

(b) Evidence of the agency's legal authority to place the child; and

(c) Certification that the agency will assume financial responsibility for any child placed in Washington state until the child is adopted, financially independent, or reaches the age of eighteen.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1075, filed 8/28/01, effective 9/28/01.]

CHILD-PLACING AGENCY STAFF QUALIFICATIONS

WAC 388-148-1076 What are the qualifications for an executive director, a program manager/social service staff, and a consultant for a child-placing agency? The qualifications of child-placing agency staff are as follows:

(1) The executive director of a child-placing agency must meet the executive director qualifications outlined for programs and agencies in WAC 388-148-0700.

(2) A program manager/social service staff for a child-placing agency must meet the program manager qualifications outlined in WAC 388-148-0715.

(3) A consultant for a child-placing agency must meet the consultant qualifications outlined in WAC 388-148-0600.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1076, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1077 What are the qualifications for a case aide for a child-placing agency program? The qualifications for a case aide at a child-placing agency program must meet the qualifications for the child care staff at a group care program, outlined in WAC 388-148-0720.

[Title 388 WAC—p. 716]

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1077, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1078 What are the qualifications for health care staff hired or contracted by a child-placing agency to provide services to children in care? A child-placing agency health care staff, such as licensed practical nurses (LPN) and nursing assistants-certified must meet the health care staff qualifications outlined in WAC 388-148-0722.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1078, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1079 What are the qualifications or the foster home licensor for a child-placing agency? A child-placing agency licensor responsible for the certification of foster homes supervised by their child-placing agency must meet, at a minimum, the requirements that follow:

(1) Be at least twenty-one years old;

(2) Have a bachelor's degree in social services or related field; or

(3) Four years of relevant full-time experience serving children may be substituted for the bachelor's degree with DLR administrative approval.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1079, filed 4/5/04, effective 5/6/04.]

CHILD-PLACING AGENCIES—ROOM REQUIREMENTS

WAC 388-148-1080 Are child-placing agencies required to have office space? You must be housed in offices that are adequately equipped to carry out your child-placing agency's programs and that can offer privacy for interviews with parents and children and storage space.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1080, filed 8/28/01, effective 9/28/01.]

CHILD-PLACING AGENCIES—FOSTER CARE SERVICES

WAC 388-148-1085 How may my child-placing agency certify a foster home for licensing by the department? (1) To certify a foster home for licensing by the department, you must use applications, home study forms, and procedures that are approved by the department (see WAC 388-148-0050 through 388-148-0080).

(2) A foster home must be certified by your child-placing agency as meet the licensing requirements your child-placing agency in order to be licensed by the department.

(3) A social service staff person must review and sign approving the foster home licensing application packet before the application is submitted to DLR.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1085, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1085, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1090 What children may child-placing agency foster homes accept? As part of our requirements, foster homes that child-placing agencies certify as

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meeting our licensing requirements may accept children only from:

- (1) The licensed child-placing agency that certified the foster home; or
- (2) The department, as long as these conditions are met:
 - (a) The child is in the legal custody of, or is under the department's supervision; and
 - (b) The child placements are approved in advance in writing by the child-placing agency responsible for supervising the foster home or facility.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1090, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1095 May different child-placing agencies share eligible foster parents for placement? (1) Different child-placing agencies may share eligible foster parents for placement as long as safety and health requirements are met.

(2) The participating agencies must have written agreements between them specifying the criteria and conditions for sharing foster parents prior to the placement of the children. This includes child-placing agencies placing children in DCFS foster homes.

(3) The written agreements must specify roles and responsibilities of each agency.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1095, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1100 What do I need to consider in making foster care placements? (1) In planning a foster care placement for a child, you must consider:

- (a) The child's basic right to their own home and family;
- (b) The importance of providing skillful professional service to the child's birth parents to help them meet each child's needs in the home;
- (c) Each child's individual needs, cultural, and religious background and family situation;
- (d) The wishes and participation of each child's parent(s); and
- (e) The selection of a foster home that will enhance each child's capacities and meet each child's individual needs.

(2) You must use a written social summary for each child as the basis for acceptance for foster care and related social services.

(3) Every foster care placement that you facilitate must be based on well-planned, individual preparation of the child and the child's family. However, in an emergency situation, you may place a child in a foster home prior to preparing the child and the child's family.

(4) A child may be placed in foster care only with the written consent of the child's parents, a protective custody order, or under a court order. This consent or order must include approval for emergency medical care or surgery.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1100, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1105 May I share information about the child with the foster parents? (1) You must give foster parents any information that may be shared about the child and the child's family. Sharing information about behavioral

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and emotional problems is especially important. This helps foster parents make an informed decision about whether or not to accept a child in their home.

(2) You must inform the foster parents that this information is confidential and can not be shared with persons who are not involved with the care of the child.

(3) You must document in the child's file that you have shared this information at the time of placement.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1105, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1110 How often should the case manager contact the foster child and family? The case manager must contact a foster child and the foster child's foster family, according to a case plan that reflects the child's needs. Case managers must make in-home health and safety visits as required by children's administration policy. Each foster child and one or both foster parents must be seen at each visit.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1110, filed 8/28/01, effective 9/28/01.]

CHILD-PLACING AGENCIES—ADOPTION SERVICES

WAC 388-148-1115 What are the requirements for providing adoptive services? (1) As a child-placing agency providing adoption services, you must:

- (a) Comply with federal and state adoption and adoption support laws and policies;
- (b) Recruit potential adoptive families that reflect the diversity of children in your community; and
- (c) Provide adoptive applicants with the following services, at a minimum:
 - (i) Information about the adoption process;
 - (ii) Adoption support programs;
 - (iii) Your agency's policies, practices and legal procedures;
 - (iv) Types of children available for adoption and implications for parenting different types of children; and
 - (v) Information on adoption support programs.

(2) You must document that you provided this information to the adoptive applicant in the applicant's file.

(3) You must have contact with each adoptive home of all adoptive placements at least once every thirty days, until the adoption is finalized. Contact may include a home visit, telephone call, or office visit.

(4) Every ninety days you must complete a face-to-face visit in the adoptive home to observe the parent and child and complete a health and safety check.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1115, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1115, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1120 What is the process for adoptions? You must go through the following steps to place a child for adoption.

(1) The applicants must submit an application (including a completed background inquiry form) to the child-placing agency.

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(2) Once you have received an application, but before you sign a contract for services, you must give the applicants a written statement about:

(a) The adoption agency's fixed fees and fixed charges to be paid by the applicant;

(b) An estimate of additional itemized expenses to be paid by applicant; and

(c) Specific services covered by fees that you offer for child placement or adoption.

(3) Your staff must complete an adoptive home study as required in RCW 26.33.190 with the participation of the applicant(s). For the study, your staff and the applicants must decide the following:

(a) The suitability of the applicant(s) to be adoptive parent(s) including completion of background checks of the applicant(s) independent of the department; and

(b) The type of child(ren) for which the applicant or applicants are best suited.

(4) Your staff must accept or deny the application and give an explanation for your decision.

(5) You must file preplacement (home study) reports with the court (as required by RCW 26.33.180 through 26.33.190).

(6) Your staff must prepare the potential adoptive parent(s) for placement of a specific child by:

(a) Locating and providing information about the child and the birth family to the prospective adoptive family provided under federal and state statute;

(b) Discussing the likely implications of the child's background for adjusting in the adoptive family.

(7) Your staff must reevaluate the applicant(s) suitability for adopting a child each time an adoptive placement is considered.

(8) You must advise the family of the existence of the adoption support program and procedures for applying.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1120, filed 4/5/04, effective 5/6/04. Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1120, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1125 What requirements exist for specialized adoptive services? Specialized adoptive services are inter-country adoption, interstate adoption and adoptions for children with special needs (such as developmental disability or emotional disability).

(1) If your child-placing agency is providing specialized adoptive services, you must have:

(a) Supervisory staff who have specialized training in the particular area of adoption that you want to provide; and

(b) A written in-service training program for staff in these specialized adoptive services.

(2) If you are facilitating the adoptive placement of children who have special needs, you must:

(a) Have adoptive families who are able to meet the children's special needs, such as behavioral disturbance, medical problems or developmental disabilities; or

(b) Have a plan for active recruitment of suitable adoptive families.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1125, filed 8/28/01, effective 9/28/01.]

[Title 388 WAC—p. 718]

CHILD-PLACING AGENCIES—ADOPTION RECORDS

WAC 388-148-1130 Must my child-placing agency retain the records of adopted children? Your child-placing agency must retain a record of each child you place in permanent custody. This record must contain all available identifying legal, medical, and social information and must be kept confidential, as required by chapter 26.33 RCW.

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1130, filed 8/28/01, effective 9/28/01.]

WAC 388-148-1135 What happens to the adopted children's records if my agency closes? If your agency closes, you must make arrangements for the permanent retention of the adopted children's records. You must inform DSHS, children's administration state adoption program manager about the closure of the agency and where the files will be kept (for example, by another adoption agency or Washington state archival files).

[Statutory Authority: RCW 74.15.030. 01-18-037, § 388-148-1135, filed 8/28/01, effective 9/28/01.]

GROUP CARE FACILITIES—GROUP RECEIVING CENTERS PROGRAM REQUIREMENTS AND SERVICES

WAC 388-148-1205 What is a group receiving center? A group receiving center is a facility licensed by the division of licensed resources for the care of more than six children placed by the department, generally for thirty days or less.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1205, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1210 What age children may a center serve? Group receiving centers may provide care for children from age two through seventeen. There may be situations when a group receiving center would be licensed for children less than two years of age to accommodate sibling groups.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1210, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1215 What hours must a center be open? A group receiving center must be open twenty-four hours a day, seven days a week.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1215, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1220 What services are provided or arranged for by a group receiving center? (1) A group receiving center must provide direct receiving care and assessment or an appraisal of a child in terms of his or her physical, mental, social, and emotional condition.

(2) A group receiving center may provide transportation and/or family support services, such as the supervision of family visits.

(3) Arrange for or provide transportation for each school-age child in care to attend school.

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[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1220, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1225 Is a center required to provide an orientation for a child placed? (1) As part of admission to a center, the staff must provide an orientation to children, as age-appropriate that includes, but is not limited to:

- (a) A description of the program and services;
- (b) The physical facility;
- (c) The department-approved policy that states that youth may not have guns or other weapons, alcohol, tobacco, or illegal drugs within the facility; and
- (d) The department-approved policy on client visitation that includes access to the youth's attorney and social worker.

(2) Written documentation of this orientation must be in each child's file.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1225, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1230 Does each child need space for personal items at the center? You must provide separate space for the storage of personal items such as clothing, radios, and toys for each child at your group receiving center.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1230, filed 4/5/04, effective 5/6/04.]

GROUP RECEIVING CENTERS—STAFF TRAINING

WAC 388-148-1235 What staff training is required?

(1) All group receiving center staff must complete a minimum of sixteen hours of pre-service job orientation prior to beginning unsupervised child care responsibilities. Training must include:

- (a) Presentation of the group receiving centers policies and procedures as well as the standards contained in this chapter;
- (b) Behavior management techniques;
- (c) Crisis intervention techniques;
- (d) Family dynamics and family intervention techniques;
- (e) Child abuse and neglect reporting requirements;
- (f) Youth supervision requirements; and
- (g) HIV/AIDS/blood borne pathogen training.

(2) Staff must complete a minimum of twenty-four hours of on-going education and in-service training annually. This training must include:

- (a) Crisis intervention techniques, including verbal de-escalation, positive behavior support, and physical response/restraint training as approved by the department;
- (b) Behavior management techniques;
- (c) Substance abuse;
- (d) Suicide assessment and intervention;
- (e) Family intervention techniques;
- (f) Cultural diversity;
- (g) Mental health issues and interventions;
- (h) Mediation skills;
- (i) Conflict management/problem-solving skills;
- (j) Physical and sexual abuse identification;
- (k) Characteristics and management of sexually aggressive and physically assaultive behavior; and
- (l) Monthly fire drill proactive and disaster training for each staff.

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(3) You must record the amount of time and type of training provided to staff.

(4) This information must be kept in each employee's file or in a separate training file.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1235, filed 4/5/04, effective 5/6/04.]

GROUP CARE FACILITIES—GROUP RECEIVING CENTERS—STAFFING RATIOS AND SUPERVISION

WAC 388-148-1240 What is the ratio of child care staff to children at a center? The department has specific requirements for the ratio of child care staff to children at group receiving centers.

(1) At least two staff, including at least one child care staff person, must be on site whenever children are on the premises.

(2) The ratio for a group receiving center is at least one child care staff person on site for every four children who are under age six, during waking and sleeping hours.

(3) The ratio for a group receiving center is at least one child care staff person on site for every six children age six years and older, during waking and sleeping hours.

(4) If a DLR-approved safety plan addressing the age groups is in effect, the center may provide care for more than one of the following age groups:

- (a) Age two through five;
- (b) Six through twelve; and
- (c) Thirteen through seventeen.

(5) If the center provides care for children under age six and children six and older, you may allow common activities for the children of different age groups provided you maintain the staffing ratio designated for the youngest child in the group and have an approved safety plan in place.

(6) To keep the proper ratio of staff to children, the executive director, on-site program manager, support staff, and maintenance staff may serve temporarily as child care staff if they have adequate training and are performing child care staff duties.

(7) You must have relief staff so that all staff can have the equivalent of two days off a week.

(8) If you have more than one program in one building, such as a group receiving center and a crisis residential center, you must follow the most stringent staffing ratio requirements, if the same staff are supervising both programs.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1240, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1245 What are the requirements for supervision of children at a center? (1) A group receiving center must operate under a DLR-approved, written supervision and safety plan for the children in care.

(2) At a group receiving center, children under age six must be within visual range at all times during waking hours.

(3) You must ensure that the staff providing direct care and supervision of the children is free of other duties at the time of care.

(4) When a child has exhibited behavior that posed a safety risk to other children in a previous placement or the placing agency believes the child poses a risk to other chil-

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dren the placing agency must inform the provider and jointly develop a plan to address the risk.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1245, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1250 Who must be on the premises while children are in care at a center? (1) The director or on-site program manager at a group receiving center must normally be on the premises during business hours when children are in care.

(2) If temporarily absent (for two hours or less) from the center, the director and on-site program manager must leave a competent, designated staff person in charge. This person must meet the qualifications of a child care staff person.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1250, filed 4/5/04, effective 5/6/04.]

GROUP CARE FACILITY-GROUP RECEIVING CENTERS—RECREATIONAL ACTIVITIES, EQUIPMENT, AND SPACE

WAC 388-148-1255 What are the requirements for an activity program? (1) You must provide an activity program at a group receiving center that is designed to meet the developmental, cultural, and individual needs of the children served at your group receiving center.

(2) You must ensure that group receiving center's activity program allows time for children to have daily opportunities for small and large muscle activities and outdoor play, as appropriate to the weather conditions.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1255, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1260 What activities must I provide to children? (1) Activities must be designed for the developmental stages of the children you serve at a group receiving center, allowing a balance between:

- (a) Child-initiated and staff-initiated activities;
- (b) Free play and organized events;
- (c) Individual and group activities; and
- (d) Quiet and active experiences.

(2) You must ensure that children at a group receiving center are grouped to ensure the safety of the children.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1260, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1265 What are the requirements for indoor recreation areas? (1) Depending on the number and age range of children served, the group receiving center's indoor premises must contain:

- (a) Adequate area for the child play; and
- (b) Sufficient space to house a developmentally appropriate program.

(2) You must provide a minimum of thirty-five square feet of usable floor space per child, not counting bathrooms, hallways, and closets.

(3) You may use and consider the napping area as child care space, if there are not beds or cots on the floor space.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1265, filed 4/5/04, effective 5/6/04.]

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WAC 388-148-1270 What are the requirements for an outdoor recreation area? (1) You must provide a safe and securely-fenced or department-approved, enclosed outdoor recreation area at a group receiving center.

(2) The fenced or approved enclosed outdoor recreation must prevent child access to roadways and other dangers.

(3) The fence or enclosure must protect the play area from unauthorized exit or entry. Any fence or enclosure must be designed to discourage climbing.

(4) The outdoor recreation area must adjoin directly the indoor premises or be reachable by a safe route and method.

(5) The outdoor recreation area must promote the child's active play, physical development, and coordination.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1270, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1275 What are the size requirements for an outdoor recreation area? (1) You must ensure the recreation area at a group receiving center contains a minimum of seventy-five usable square feet per child.

(2) If not all of the children are using the outdoor recreation area at the same time, you may reduce the size to the number of children normally using the area at one time.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1275, filed 4/5/04, effective 5/6/04.]

WAC 388-148-1280 What are the requirements for playground equipment? (1) You must provide a variety of age-appropriate play equipment for climbing, pulling, pushing, riding, and balancing activities at a group receiving center.

(2) You must design, construct, arrange, and maintain equipment and ground cover to prevent child injury.

(3) The quantity of outdoor play equipment must offer a child a range of outdoor recreation options.

[Statutory Authority: RCW 74.15.030 and chapter 74.15 RCW. 04-08-073, § 388-148-1280, filed 4/5/04, effective 5/6/04.]

Chapter 388-160 WAC

MINIMUM LICENSING REQUIREMENTS FOR OVERNIGHT YOUTH SHELTERS

WAC

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388-160-0015	What is the purpose of overnight youth shelters?
388-160-0025	What definitions apply to this chapter?
388-160-0035	What services must be offered at a shelter?
388-160-0045	What must I include in the assessment when a youth first enters a shelter?
388-160-0055	How does the department decide how many youth I may serve in my overnight youth shelter?
388-160-0065	How old do I have to be to apply for a shelter license?
388-160-0075	What qualifications does a person need to care for youth at an overnight youth shelter?
388-160-0085	Who must be on the premises when youth are present at an overnight youth shelter?
388-160-0095	What qualifications must a program supervisor have in order to work in a shelter?
388-160-0105	What qualifications must a lead counselor have in order to work in a shelter?
388-160-0115	What minimum qualifications must child care staff, lead counselors, interns, and volunteers have in order to work in a shelter?
388-160-0125	What training is required for overnight youth shelter staff, lead counselors, interns and volunteers?
388-160-0135	What is the required ratio of staff to youth in a shelter?
388-160-0145	How do I apply or reapply for a license?

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		DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER
388-160-0155	May I receive more than one type of group care license at the same physical location?	
388-160-0165	Does the department put limitations or conditions on a person who is licensed?	
388-160-0175	Does the department allow exceptions to the licensing requirements?	388-160-010 Authority. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-010, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0185	Does the department issue probationary licenses?	
388-160-0195	When must the department deny, suspend or revoke a license?	388-160-020 Definitions. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-020, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0205	Are there other reasons the department must suspend my overnight youth shelter license?	
388-160-0215	When may the department suspend or revoke my overnight youth shelter license?	
388-160-0225	How does the department notify me if my license is modified, denied, suspended or revoked?	388-160-030 Exceptions to rules. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-030, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0235	What may I do if I disagree with the department's decision to modify, deny, suspend or revoke my license?	
388-160-0245	What incidents involving youth must I report?	388-160-040 Effect of local ordinances. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-040, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0255	Are there other reporting requirements?	
388-160-0265	Do I need to report runaway youth who stay at the shelter?	388-160-050 Fire standards. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-050, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-050, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0275	What changes to my overnight youth shelter must I report to my licensor?	
388-160-0285	What are the department's requirements for keeping client records?	
388-160-0295	Do I need a citizens' board for my overnight youth shelter?	388-160-060 Certification of exempt agency. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-060, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0305	What personnel policies must I have?	
388-160-0315	What personnel records must I keep?	
388-160-0325	Where must I post my license?	
388-160-0335	What other information must I keep readily available?	
388-160-0345	Are local ordinances part of our licensing requirements?	388-160-070 Application or reapplication for license or certification—Investigation. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-070, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0355	What fire safety requirements must I follow to qualify for a license?	
388-160-0365	Where may my shelter be located?	
388-160-0375	May I have firearms in my overnight youth shelter?	
388-160-0385	What substances are prohibited at overnight youth shelters?	
388-160-0395	What are your requirements for storing dangerous items?	388-160-080 Limitations on licenses and dual licensure. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-080, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-080, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0405	Do I need to have first-aid supplies?	
388-160-0415	What structural safety requirements must my facility meet?	
388-160-0425	What measures must I take for pest control?	
388-160-0435	What are your requirements for kitchens?	
388-160-0445	What are the requirements for bedrooms in shelters?	
388-160-0455	What are your requirements for bedding?	
388-160-0465	What telephone requirements must I follow?	388-160-090 General qualifications of licensee, applicant, and persons on the premises. [Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-160-090, filed 4/26/96, effective 5/27/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-090, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0475	What are the lighting requirements for my overnight youth shelter?	
388-160-0485	What are the requirements about drinking water?	
388-160-0495	What are your requirements for laundry facilities?	
388-160-0505	What are the requirements for washing clothes?	
388-160-0515	What are the requirements for toilets, sinks, and bathing facilities in shelters?	388-160-100 Age of licensee. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-100, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0525	Do overnight youth shelters require a housekeeping sink?	
388-160-0535	What are the requirements for sewage and liquid wastes?	
388-160-0545	What health and emergency policies and procedures must I have?	388-160-110 Posting of license. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-110, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0555	How must I manage medications for youth at my shelter?	
388-160-0565	What must I do to prevent the spread of infections and communicable diseases?	388-160-120 Licensure—Denial, suspension, or revocation. [Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-160-120, filed 4/26/96, effective 5/27/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-120, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0575	What nutritional guidelines must I follow?	
388-160-0585	What are your requirements for protecting a youth under my care from child abuse and neglect?	
388-160-0595	What are the requirements about nondiscrimination?	
388-160-0605	What religious activities are allowed in overnight youth shelters?	
388-160-0615	How much supervision is required for child care staff and volunteers?	388-160-130 Licensed capacity. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-130, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0625	What requirements must I follow when disciplining youth?	
388-160-0635	What types of disciplinary practices are forbidden?	
388-160-0645	What types of physical restraint are acceptable for youth in overnight youth shelters?	388-160-140 Discrimination prohibited. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-140, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-0655	What types of physical restraint are not acceptable in overnight youth shelters?	
388-160-0665	Do I need to document instances when physical restraint is used?	

388-160-150	Religious activities. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-150, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.		
388-160-160	Discipline. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-160, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-320	Water supply. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-320, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-170	Corporal punishment. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-170, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-340	Health and emergency policies and procedures. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-340, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-180	Abuse, neglect, or exploitation. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-180, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-350	First aid. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-350, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-190	Site and telephone. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-190, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-360	Medication management. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-360, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-200	Equipment, safety, and maintenance. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-200, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-370	Staff health. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-370, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-210	Firearms and other weapons. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-210, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-380	HIV/AIDS education and training. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-380, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-220	Prohibited substances. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-220, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-390	Nutrition. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-390, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-230	Storage. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-230, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-400	Bedding. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-400, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-240	Bedrooms and sleeping areas. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-240, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-410	Overnight youth shelters—Purpose and limitations. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-410, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-250	Kitchen facilities. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-250, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-420	Governing body/citizens board for overnight youth shelters. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-420, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-260	Housekeeping sink. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-260, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-430	Intake. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-430, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-430, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-270	Laundry. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-270, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-440	Groupings. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-440, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-280	Toilets, handwashing sinks, and bathing facilities. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-280, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-460	Staffing. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-460, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-460, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-290	Lighting. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-290, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-470	Supervision of youth. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-470, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
388-160-300	Pest control. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-300, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.	388-160-480	Child care workers—Qualifications. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-480, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-480, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-
388-160-310	Sewage and liquid wastes. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-310, filed 7/21/93, effective 8/21/93.] Repealed by 01-		

- 001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
- 388-160-490 Program supervision. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-490, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-490, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
- 388-160-500 Training. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-500, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-500, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
- 388-160-510 Services. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-510, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
- 388-160-520 Client records and information—Overnight youth shelters. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-520, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
- 388-160-530 Personnel policies and records—Overnight youth shelters. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-530, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-530, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
- 388-160-540 Reporting of death, injury, illness, epidemic, or child abuse. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-540, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
- 388-160-550 Reporting runaway youth. [Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-550, filed 10/4/96, effective 11/4/96.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.
- 388-160-560 Reporting circumstantial changes. [Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-560, filed 7/21/93, effective 8/21/93.] Repealed by 01-15-001, filed 7/5/01, effective 8/5/01. Statutory Authority: Chapter 75.15 [74.15] RCW.

WAC 388-160-0005 Authority. The following rules including minimum licensing requirements for overnight youth shelters are adopted under chapter 74.15 RCW.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0005, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0015 What is the purpose of overnight youth shelters? (1) The purpose of overnight youth shelters is to provide youth with an emergency sleeping arrangements.

(2) The overnight youth shelter may be licensed to provide care for one of the following categories of youth:

- (a) Youth from thirteen through seventeen years of age; or
- (b) Youth sixteen through twenty years of age.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0015, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0025 What definitions apply to this chapter? The following definitions apply to this chapter.

"Capacity" means the maximum number of children a facility is licensed to care for at a given time.

(2007 Ed.)

"Children's administration" means a management section of the department of social and health services responsible for many services to children including but not limited to: Child protective services, child welfare services, policy development, budget and fiscal operations.

"Compliance agreement" means a written plan of short duration with a specific ending date for completion of the plan. The agreement addresses the improvement or correction of specific issues to maintain or increase the safety and well-being of children in care.

"Department" means the department of social and health services (DSHS).

"DLR" means the division of licensed resources. A division of children's administration of the department of social and health services.

"Full licensure" means the facility licensed or approved by the department of social and health services meets all applicable licensing standards.

"I" or "you" refers to anyone who operates an overnight youth shelter.

"Overnight youth shelter" or "OYS" means a licensed facility operated by a nonprofit agency that provides overnight shelter to homeless or runaway youth. Overnight youth shelters do not provide residential care during daytime hours.

"We" refers to the department, including DLR licensors.

"Youth" means an individual who is under twenty-one years old. The term "child" or "children" may also be used in some sections.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0025, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0035 What services must be offered at a shelter? (1) At a minimum, all overnight youth shelters must offer the following services to all clients:

(a) A client identification and intake assessment including:

- (i) Emergency contacts (phone numbers);
- (ii) Areas of possible problems, such as school status, medical problems, family situation and suicide evaluation;
- (iii) History of assaultive or predatory behavior; and
- (iv) Drug and/or alcohol involvement.

(b) Individual crisis intervention;

(c) Assistance in accessing emergency resources, including child protective services (CPS) and emergency medical services; and

(d) Resource information.

(2) An overnight youth shelter must provide (as needed by the youth) information about:

- (a) Educational or vocational services;
- (b) Housing;
- (c) Medical care or services;
- (d) Substance abuse services;
- (e) Mental health services;
- (f) Other treatment agencies;
- (g) Food programs;
- (h) Disability services; and
- (i) Other DSHS services.

(3) If the overnight youth shelter cannot directly provide these services, staff must have information for referrals to

programs or organizations that would provide these services to clients.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0035, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0045 What must I include in the assessment when a youth first enters a shelter? (1) When a youth first enters an overnight youth shelter, you must:

- (a) Determine whether the parents are aware of the whereabouts of the youth;
- (b) Determine whether an adult contact exists; and
- (c) Notify the police or children's administration intake (either the local CPS number or toll-free 1-886-ENDHARM) of any youth twelve years of age or younger who is unaccompanied by an adult and is requesting service.

(2) As part of the initial assessment, you must also assess the youth's:

- (a) Recent history;
- (b) Outstanding warrants;
- (c) Physical and medical needs, including medication;
- (d) School status;
- (e) Immediate needs for counseling; and
- (f) Options for the near future.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0045, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0055 How does the department decide how many youth I may serve in my overnight youth shelter? (1) The number of youth that an overnight youth shelter may serve is based on an evaluation of the following factors:

- (a) Physical accommodations in your overnight youth shelter;
- (b) The number of staff and volunteers available for providing care;
- (c) The skills of your staff and volunteers; and
- (d) The ages and characteristics of the people you are serving.

(2) Based on our evaluation, we may license you for the care of fewer persons than you would normally serve in your category.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0055, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0065 How old do I have to be to apply for a shelter license? You must be at least twenty-one years old to apply for a license for an overnight youth shelter.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0065, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0075 What qualifications does a person need to care for youth at an overnight youth shelter? If a person is requesting a license or a position as an employee, intern, or a volunteer at an overnight youth shelter, he/she must not:

- (1) Have a history of child abuse or neglect.
- (2) Be disqualified by our background check (see chapter 388-06 WAC).
- (3) Have had a license denied or revoked from an agency that provides care to children or vulnerable adults, unless the department determines that the denial or revocation was not

based on a factor that may pose a risk to the health, safety or welfare of children.

(4) The department may require additional information from you, your staff, interns, or volunteers. We may request this information at any time and it may include, but is not limited to any of the following evaluations and/or documentation of completed treatment:

- (a) Substance and alcohol abuse evaluations;
- (b) Psychiatric evaluations;
- (c) Psycho-sexual evaluations; and
- (d) Medical evaluations or reports.

(5) Any evaluation or information requested by the department must be supplied at the expense of the applicant or licensee.

(6) The department must approve the evaluator providing the above services and you must give the licenser permission to speak with the evaluator before and after the evaluation.

[Statutory Authority: RCW 74.15.010, 74.15.030. 05-14-013, § 388-160-0075, filed 6/22/05, effective 7/23/05. Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0075, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0085 Who must be on the premises when youth are present at an overnight youth shelter? (1) In an open or dormitory type setting, a same gender staff person must be within visual and auditory range of same gender youth at all times. The staff must be awake while on-duty.

(2) At least one fully trained lead counselor must be on the premises at all times when youth are present.

(3) A qualified program supervisor must be on call at all times when the shelter is open or youth are present (see WAC 388-160-0095 for qualifications). The program supervisor may be on-staff, on contract or available by written agreement.

(4) Staff must represent both genders to reflect the population of youth in care.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0085, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0095 What qualifications must a program supervisor have in order to work in a shelter? Every overnight youth shelter must have a program supervisor. The program supervisor must have either a:

- (1) Master's degree in social work or a related field and one year of experience working with adolescents; or
- (2) Bachelor's degree and three years of experience working with adolescents.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0095, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0105 What qualifications must a lead counselor have in order to work in a shelter? To work in an overnight youth shelter, lead counselors must meet the following qualifications:

- (1) Be at least twenty-one years of age;
- (2) Have at least one year of experience working with adolescents;
- (3) Have completed HIV/AIDS/Bloodborne pathogen training;
- (4) Have completed first aid and CPR; and

(5) Have completed a tuberculin test (as required under WAC 388-160-0565).

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0105, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0115 What minimum qualifications must child care staff, lead counselors, interns, and volunteers have in order to work in a shelter?

(1) All child care staff, lead counselors, interns, and volunteers who work at an overnight youth shelter must be at least twenty-one years old. Note: Eighteen through twenty-year-old persons may work or volunteer at an overnight youth shelter if they are enrolled and participating in an internship program through an accredited college or university. They must be on-duty and supervised by a fully trained staff person twenty-one years old or older.

(2) Child care staff, interns, and volunteers also must have successfully completed:

- (a) A background check (see chapter 388-06 WAC);
- (b) A tuberculin test (as required under WAC 388-160-0565);
- (c) Current first-aid and cardiopulmonary resuscitation (CPR) training; and
- (d) HIV/AIDS/Bloodborne pathogen training consistent with the department of health approved curriculum prior to beginning work with youth. If the training is not readily available, it must be completed within sixty days of beginning work.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0115, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0125 What training is required for overnight youth shelter staff, lead counselors, interns and volunteers?

(1) All overnight youth shelter staff, lead counselors, interns, and volunteers must receive training before providing care for youth. The overnight youth shelter must ensure that this training includes, at a minimum, the following subjects:

- (a) Job responsibilities, including the mandatory reporting requirements for licensee and their staff;
- (b) Facility administration;
- (c) Supervision of youth;
- (d) Behavior management training in accordance with department behavior management guidelines;
- (e) Fire safety procedures;
- (f) Handling of emergency situations; and
- (g) Current first-aid and cardiopulmonary resuscitation (CPR) training.

(2) HIV/AIDS/Bloodborne pathogen training consistent with the department of health approved curriculum must be completed prior to beginning work with youth. If the training is not readily available, it must be completed within sixty days of beginning work.

(3) An overnight youth shelter must provide on-going training to all staff, interns, and volunteers.

(a) The training must cover qualifications for each position, including supervisory skills, adolescent development and problems, and the needs of youth.

(b) The shelter's training must also include, at a minimum, classes addressing:

- (i) Sexual abuse;

- (ii) Predatory behavior;
- (iii) Substance abuse;
- (iv) Depression;
- (v) Mental health;
- (vi) Teen suicide;
- (vii) Injurious behavior towards one's self or others; and
- (viii) Cultural sensitivity.

(3) New overnight youth shelter staff, interns, and volunteers must work shifts with fully trained staff until the new person has completed all required training.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0125, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0135 What is the required ratio of staff to youth in a shelter?

(1) A shelter licensed for youth who are thirteen through seventeen years old must have one staff person to every eight youth.

(2) A shelter licensed for youth who are sixteen through twenty years old must have one staff person to every six youth.

(3) A shelter must maintain the staffing ratio while youth are asleep.

(4) At least one staff person must remain awake while youth are asleep. Other staff persons may be asleep, but must be available in the shelter in case of emergency.

(5) Whenever only one staff person is required to be on duty, a second staff person must be on call.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0135, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0145 How do I apply or reapply for a license?

(1) To apply or reapply for a license, the person or legal entity responsible for your overnight youth shelter must send the following information to the department licensor:

- (a) The application form;

Note: If you are applying for a license renewal, you must send the application form to the department licensor ninety days prior to the expiration of your current license.

(b) A completed and signed criminal history and background inquiry form from each applicant, staff person, intern, board member and volunteer who:

- (i) Is at least sixteen years old;
- (ii) Is not a foster child or shelter youth; and
- (iii) Has unsupervised access to youth.

(c) Written verification of:

(i) A tuberculosis test unless you have religious beliefs which prohibit the test;

(ii) First-aid and cardiopulmonary resuscitation (CPR) training; and

(iii) HIV/AIDS/Bloodborne pathogens training.

(2) If a person required to have a background check has lived in Washington state less than three years immediately prior to their application, a completed FBI fingerprint form must be provided to us for that person.

(3) We may require additional information from you including, but not limited to:

- (a) Substance and alcohol abuse evaluations;
- (b) Psychiatric evaluations;
- (c) Psycho-sexual evaluations; and
- (d) Medical evaluations.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0145, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0155 May I receive more than one type of group care license at the same physical location?

(1) If you are licensed to operate an overnight youth shelter, you may not hold a license for any other type of residential care at the same physical location.

(2) If you make it clear to us that care for one kind of client does not interfere with the care for another kind of client an exception to WAC 388-160-0155(1) may be granted. (See WAC 388-160-0175 for exceptions.)

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0155, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0165 Does the department put limitations or conditions on a person who is licensed? Even if we approve you for an overnight youth shelter license, we may put limitations or conditions on the license to ensure youth's safety and health.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0165, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0175 Does the department allow exceptions to the licensing requirements? (1) At its discretion, the department may make a written exception, and license or continue to license an overnight youth shelter that does not meet the minimum licensing requirements.

(2) Exceptions are approved for nonsafety requirements only.

(3) The safety and well-being of the youth receiving care must not be compromised.

(4) You must request an exception to the licensing requirements in writing.

(5) You must keep a copy of the approved exception to the licensing requirements for your files.

(6) Along with an exception to the licensing requirements, the department may require you to enter into a compliance agreement to ensure the safety and well-being of the youth in your care.

(7) You do not have appeal rights if the department denies your request for an exception to our requirements.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0175, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0185 Does the department issue probationary licenses? (1) The department may issue a probationary license as part of a corrective action plan with a licensed provider.

(2) The department must base its decision as to whether a probationary license will be issued on the following:

(a) Intentional or negligent noncompliance with the licensing rules;

(b) A history of noncompliance with the rules;

(c) Current noncompliance with the rules;

(d) Evidence of a good faith effort to comply; and

(e) Any other factors relevant to the specific situation.

(3) A probationary license may be issued for up to six months. At its discretion, the department may extend the probationary license for an additional six months.

[Title 388 WAC—p. 726]

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0185, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0195 When must the department deny, suspend or revoke a license? (1) A license must be denied, suspended or revoked if the department decides that you cannot provide care for youth in a way that ensures their safety, health and well-being.

(2) The department must deny, suspend, or revoke your license for any of the reasons that follow.

(a) You have failed your background check (see chapter 388-06 WAC).

(b) You have been found to have committed child abuse or neglect or you treat, permit or assist in treating children in your care with cruelty, indifference, abuse, neglect, or exploitation.

(c) You or anyone on the premises had a license denied or revoked from an agency that provided care to children or vulnerable adults.

(d) You attempt to get a license by deceitful means, such as making false statements or leaving out important information on the application.

(e) You commit, permit or assist in an illegal act on the premises of a home or facility providing care to children.

(f) You are using illegal drugs, or excessively using alcohol and/or prescription drugs.

(g) You knowingly allowed employees or volunteers who made false statements on their applications to work at your agency.

(h) You repeatedly lack qualified or an adequate number of staff to care for the number and types of children under your care.

(i) You have refused to allow our authorized staff and inspectors to have requested information or access to your facility, child and program files, and/or your staff and clients.

(j) You are unable to manage the property, fiscal responsibilities, or staff in your agency.

[Statutory Authority: RCW 74.15.010, 74.15.030. 06-03-047, § 388-160-0195, filed 1/10/06, effective 2/10/06; 05-14-013, § 388-160-0195, filed 6/22/05, effective 7/23/05. Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0195, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0205 Are there other reasons the department must suspend my overnight youth shelter license? (1) The department must suspend your license to provide care to children, if we receive a notice from the division of child support that you are not in compliance with a support order.

Note: The governing authority is RCW 43.20A.205 and 74.20A.320.

(2) The suspension of your license for noncompliance of a support order would be effective the date you receive a notice that we received the certificate of noncompliance from the division of child support.

(3) Your license would remain suspended until you provide proof that you are in compliance with the child support order.

(4) You would not have a right to an administrative hearing based on a suspension of your license due to noncompliance of a child support order.

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[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0205, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0215 When may the department suspend or revoke my overnight youth shelter license? A license may be suspended or revoked if you exceed the conditions of your facility license by:

- (1) Having more youth than the license allows;
- (2) Having youth with ages different than the license allows;
- (3) Failing to provide a safe and healthy environment for youth in your care; or
- (4) Failing to comply with any other licensing requirements.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0215, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0225 How does the department notify me if my license is modified, denied, suspended or revoked? The department sends you a certified letter informing you of our decision to modify, deny, suspend or revoke your license. The letter will include any applicable laws or regulations and provide you with information on what to do if you disagree with the department's decision.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0225, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0235 What may I do if I disagree with the department's decision to modify, deny, suspend or revoke my license? You have the right to appeal any decision the department makes to modify, deny, suspend or revoke your license, except for circumstances identified in WAC 388-160-0205.

(1) You may request an administrative hearing if you disagree with our decision to modify, suspend, revoke or deny your license.

(2) You must request an administrative hearing within twenty-eight days of receiving a certified letter with our decision (chapter 34.05 RCW).

(3) You must send a letter to the Office of Administrative Hearings, P.O. Box 42489, Olympia, WA 98504-2489, 1-800-583-8271 requesting an administrative hearing. The letter must have the following attachments:

- (a) A specific statement of your reasons for disagreeing with the decision and any laws that relate to your reasons; and
- (b) A copy of the certified letter from the department containing the decision that you are disputing.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0235, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0245 What incidents involving youth must I report? (1) You or your staff must report any of the following incidents within forty-eight hours to your local children's administration child protective services intake staff:

- (a) Any alleged incidents of child abuse or neglect;
- (b) Any violations of the licensing requirements;
- (c) Death of a child;
- (d) Any youth's suicide attempt that results in injury requiring medical attention or hospitalization;
- (e) Any emergent medical care to any youth in care;

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(f) Any use of physical restraint that is alleged improper or excessive;

(g) Sexual contact between two or more youth;

(h) Physical assaults between two or more youth that result in injury requiring off-site medical attention or hospitalization;

(i) Unexpected health problems that require off-site medical attention;

(j) Any medication given incorrectly that required off-site medical attention;

(k) Serious property damage that is a safety hazard and is not immediately corrected.

(2) In addition to WAC 388-160-0245 (1)(a) through (k), you or your staff must report any of the following incidents to the youth's DSHS social worker, if the youth is a client of DSHS;

(a) Suicidal/homicidal ideas, gestures or attempts that do not require professional medical attention;

(b) Unexpected health problems that do not require professional medical attention;

(c) Any incident of medication incorrectly administered;

(d) Physical assaults between two or more children resulting in injury that does not require professional medical attention;

(e) Runaways; and

(f) Use of physical restraints for routine discipline.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0245, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0255 Are there other reporting requirements? Any occurrence of food poisoning or communicable disease must be reported to the local public health department, as required by the department of health.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0255, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0265 Do I need to report runaway youth who stay at the shelter? (1) Within eight hours of learning that a youth staying at a shelter does not have parental permission to be there, shelter staff must report the location of the youth to:

(a) The parent;

(b) The law enforcement agency having jurisdiction in the shelter's area; or

(c) The department.

(2) The shelter staff must:

(a) Make the report by telephone or other reasonable means; and

(b) Document the report in writing in the youth's file.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0265, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0275 What changes to my overnight youth shelter must I report to my licensor? (1) You must report to your licensor any changes in the information contained in your original licensing application that might cause the department to reclassify your overnight youth shelter. Changes include any of the following:

(a) Changes in your location;

(b) Change in the designated space, or phone number;

[Title 388 WAC—p. 727]

(c) Changes in the maximum number, age ranges, and gender of persons you wish to serve;

(d) Changes in the structure of your facility or premises due to events causing damage such as a fire, or caused by remodeling; or

(e) Additions of any new staff person, intern, employee or volunteer, who might have contact with the youth in care.

(2) A license is valid only for the person or organization named on the license.

(3) You must also report the following changes to your licensur:

(a) A change of your facility's chief executive;

(b) The death, retirement, or incapacity of the person who holds the license;

(c) A change in name of a licensed corporation, or name by which your facility is commonly known; or

(d) Changes in the agency's articles of incorporation and bylaws.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0275, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0285 What are the department's requirements for keeping client records? (1) Your records must be kept at your overnight youth shelter and contain, at a minimum, the following information:

(a) The child's name and birthdate;

(b) Daily attendance logs and referrals;

(c) Names, address and home and business telephone numbers of parents or persons to be contacted in case of emergency;

(d) Dates and kinds of illnesses, accidents, medications and treatments given at the shelter;

(e) An incident log documenting the use of physical restraint; and

(f) Other information determined relevant by the department.

(2) Identifying and personal information about the youth must be kept confidential.

(3) You must keep information about the youth and their families in a secure place.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0285, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0295 Do I need a citizens' board for my overnight youth shelter? (1) Every overnight youth shelter must have a citizens' board that complies with laws and rules for nonprofit boards of directors. If the overnight youth shelter is part of a larger agency that has a citizens' board, that board will suffice.

(2) The shelter director must keep the following on file:

(a) A list of all members of the current citizens' board; and

(b) A copy of the articles of incorporation filed with the secretary of state verifying nonprofit status.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0295, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0305 What personnel policies must I have? The following requirements apply to licensed overnight youth shelters.

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(1) Employees, interns, or volunteers with unsupervised access to youth are not allowed to have unsupervised access to youth until the department approves their background checks.

(2) If you have five or more staff, you must have written policies describing duties and qualifications of staff, and staff benefits.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0305, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0315 What personnel records must I keep? You must keep personnel records on file for each staff person and volunteer for your overnight youth shelter. These must include:

(1) An employment application, including work and education history;

(2) Documentation of completed criminal history and background check form;

(3) A record of a negative Mantoux, tuberculin skin tests results, X ray, or an exemption to the skin test or X ray;

(4) A record of participation in HIV/AIDS education and training, including bloodborne pathogens training;

(5) A record of participation in staff development training;

(6) A record of participation in the program's orientation;

(7) Documentation of a valid food handler permit, when applicable; and

(8) A record of participation in the current first-aid/CPR/Bloodborne pathogens training.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0315, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0325 Where must I post my license? You must post your license where it can be easily viewed by the public.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0325, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0335 What other information must I keep readily available? If you operate an overnight youth shelter, you must have the telephone number of "on-call" master's or bachelor's degree-level persons with other emergency numbers readily available for staff.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0335, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0345 Are local ordinances part of our licensing requirements? (1) Local ordinances (laws), such as zoning regulations and local building codes, fall outside the scope of our licensing requirements.

(2) The department may require you to provide proof that you have met local ordinances.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0345, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0355 What fire safety requirements must I follow to qualify for a license? If you operate an overnight youth shelter, you must follow the regulations developed by the Washington state fire marshall's office. The regulations are minimum requirements for protecting life and

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property against fire. You can find these contained in the Uniform Fire Code as adopted with Washington state amendments.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0355, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0365 Where may my shelter be located? (1) Your overnight youth shelter must be located on a well-drained site free from hazardous conditions. The safety of the youth in care is paramount.

(2) You must discuss with the licenser any potential hazardous conditions, considering the youth's ages and behaviors. Some examples of hazards are natural or man-made water hazards such as lakes or streams, steep banks, ravines, and busy streets.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0365, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0375 May I have firearms in my overnight youth shelter? (1) You may not have firearms or other weapons on the premises.

(2) Firearms and weapons that are confiscated from youth must be locked up and given to law enforcement officers as soon as possible.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0375, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0385 What substances are prohibited at overnight youth shelters? (1) During operating hours when youth are in care, no staff, intern, or volunteer on the premises or caring for youth off-site may be under the influence of, consume, or possess alcoholic beverages or illegal drugs.

(2) You must prohibit smoking in:

- (a) Your facility while caring for youth; and
- (b) Any motor vehicles transporting youth.

(3) You may permit adults to smoke outdoors away from youth.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0385, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0395 What are your requirements for storing dangerous items? (1) You must lock the following items:

- (a) Cleaning supplies,
- (b) Toxic substances,
- (c) Poisons,
- (d) Aerosols,
- (e) Items with warning labels.

(2) You must label containers filled from a stock supply. The labels must identify all contents.

(3) Toxic substances must be stored separately from food items.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0395, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0405 Do I need to have first-aid supplies? (1) You must keep first-aid supplies on hand for immediate use, including unexpired syrup of ipecac that is to be (2007 Ed.)

used only when following the instructions of the poison control center.

(2) The following first-aid supplies must be kept on hand:

- (a) Barrier gloves and one-way resuscitation mask;
- (b) Ace bandage and band-aids;
- (c) Scissors and tweezers;
- (d) Gauze; and
- (e) Thermometer.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0405, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0415 What structural safety requirements must my facility meet? You must keep your equipment and the physical structures in your facility safe and clean for the youth you serve. At a minimum you must:

(1) Maintain your buildings, premises, and equipment in a clean and sanitary condition, free of hazards and in good repair;

(2) Provide handrails for steps if the department decides handrails are necessary for safety;

(3) Have emergency lighting devices available and in operating condition;

(4) Refinish all flaking or deteriorating lead-based paint with lead-free paint or other nontoxic material for exterior and interior wall surfaces and equipment;

(5) Have washable, water-resistant floors in the facility's toilet rooms, kitchen, and other rooms exposed to moisture;

Exception: We may approve washable, short-pile carpeting that is kept clean and sanitary for your facility's kitchen.

(6) Have easy access to rooms occupied by youth in case an emergency arises.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0415, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0425 What measures must I take for pest control? You must keep the premises free from pests, such as rodents, flies, cockroaches, fleas, and other insects using the least toxic methods.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0425, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0435 What are your requirements for kitchens? If your overnight youth shelter provides food service, you must ensure:

(1) The proper storage, preparation, and service of food to meet the needs of the youth; and

(2) Provide the facilities and implement practices as required by the rules and regulations of the department of health that govern food service sanitation (see chapter 246-215 WAC).

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0435, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0445 What are the requirements for bedrooms in shelters? You must comply with the following requirements for bedrooms:

(1) Provide sleeping areas at least fifty square feet per occupant of unobstructed floor area with a ceiling height of at least seven feet, six inches;

(2) Not use hallways and kitchens as sleeping rooms;

(3) Maintain a space that is at least thirty inches between sleeping youths;

(4) Provide sleeping areas separated by a visual barrier five feet high or more for gender; and

(5) Separate youth under eighteen years old from youth who are eighteen through twenty years old by having a staff or volunteer supervise open space or have a physical barrier to prevent contact.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0445, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0455 What are your requirements for bedding? (1) An overnight youth shelter providing youth with sleeping equipment and bedding must keep the equipment and bedding in good repair, clean, and sanitary.

(2) The shelter must accept the use of sleeping and bedding equipment that is personally provided by the youth if it is not a health or safety risk.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0445, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0465 What telephone requirements must I follow? The department has two requirements for the telephone that you must meet at your overnight youth shelter.

(1) You must have at least one telephone on the premises for incoming and outgoing calls. The telephone must be accessible for emergency use at all times.

(2) You must post emergency phone numbers next to the phone.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0465, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0475 What are the lighting requirements for my overnight youth shelter? You must locate light fixtures and provide lighting that promotes good visibility and comfort for the youth.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0475, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0485 What are the requirements about drinking water? You must provide:

(1) A public water supply or a private water supply approved by the local health authority prior to the time of licensing or relicensing; and

(2) Disposable paper cups, individual drinking cups or glasses, or inclined-jet type drinking fountains.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0485, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0495 What are your requirements for laundry facilities? The department has specific requirements for laundry facilities at your overnight youth shelter. You must:

(1) Have separate and adequate facilities for storing soiled and clean linen;

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(2) Provide adequate laundry and drying equipment or make other arrangements for getting laundry done on a regular basis; and

(3) Locate laundry equipment in an area separate from the kitchen.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0495, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0505 What are the requirements for washing clothes? You must sanitize laundry contaminated with urine, feces, lice, scabies, or other potentially infectious materials through temperature or chemical measures.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0505, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0515 What are the requirements for toilets, sinks, and bathing facilities in shelters? You must provide:

(1) Two or more indoor flush-type toilets close to handwashing sinks with hot and cold running water;

(2) One toilet and sink for the first eight youth, with a second toilet and sink when four more youth are on the premises;

(3) Privacy for persons of the opposite sex at toilets and any bathing facilities;

(4) Hot and cold running water not exceeding one hundred twenty degrees Fahrenheit at handwashing sinks, and bathing facilities;

(5) A conveniently located grab bar or nonslip floor surfaces in any bathing facilities;

(6) Urinals instead of toilets as long as only urinals do not replace more than one-third of the total required number of toilets; and

(7) Dispenser soap and individual towels, disposable towels, or other approved single-use hand drying devices, at handwashing sinks, and any bathing facilities.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0515, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0525 Do overnight youth shelters require a housekeeping sink? An overnight youth shelter must have and use a method of drawing clean mop water and disposing of wastewater.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0525, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0535 What are the requirements for sewage and liquid wastes? An overnight youth shelter must discharge sewage and liquid wastes into a public sewer system or into a functioning septic system.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0535, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0545 What health and emergency policies and procedures must I have? (1) An overnight youth shelter must have current written health policies and procedures including, but not limited to:

(a) First aid;

(b) Infection control;

(c) Care of minor illnesses; and

(d) General health practices and actions to be taken in event of medical and other emergencies.

(2) Health policies and procedures must be readily available for staff orientation and implementation.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0545, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0555 How must I manage medications for youth at my shelter? An overnight youth shelter must requirements for manage nonprescription and prescription medications by:

(1) Place any medication brought into the shelter by a youth in locked storage so it is unavailable to other youth in care;

(2) Supervise youth who take their own medication according to the prescription or manufacturer's instructions; and

(3) Properly dispose of medications that are no longer being taken.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0555, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0565 What must I do to prevent the spread of infections and communicable diseases? (1) You must take precautions to guard against infections and communicable diseases infecting the youth in care in your overnight youth shelter.

(2) Staff with a reportable communicable disease, as defined by the department of health, in an infectious stage must not be on duty until the staff has a physician's approval for returning to work.

(3) Those persons who have been approved for unsupervised access to children in an overnight youth shelter facility must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test prior to being employed, volunteering, or being licensed unless:

(a) The person has evidence of testing within the previous twelve months;

(b) The person has evidence that they have a negative chest X ray since a previously positive skin test;

(c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis; or

(d) A physician indicates that the test is medically unadvisable.

(4) Persons whose tuberculosis skin test is positive must have a chest X ray within thirty days following the skin test.

(5) The department does not require retesting unless a person believes they have been exposed to someone with tuberculosis or if testing is recommended by their health care provider.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0565, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0575 What nutritional guidelines must I follow? An overnight youth shelter providing meals must consider the age, cultural background, and nutritional requirements of youth served when preparing meals.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0575, filed 7/5/01, effective 8/5/01.]

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WAC 388-160-0585 What are your requirements for protecting a youth under my care from child abuse and neglect? As part of ensuring health, welfare and safety, you must protect youth in your care from all forms of child abuse and neglect (see RCW 26.44.020(12)).

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0585, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0595 What are the requirements about nondiscrimination? Overnight youth shelters must follow all state and federal laws regarding nondiscrimination while providing services to youth in care.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0595, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0605 What religious activities are allowed in overnight youth shelters? (1) You must respect the religious rights of the youth in care.

(2) Youth have the right to practice their own faith.

(3) Youth have the right not to practice another person's or any faith.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0605, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0615 How much supervision is required for child care staff and volunteers? The program supervisor must provide two hours of supervision for each forty hours that child care staff and volunteers work at overnight youth shelters.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0615, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0625 What requirements must I follow when disciplining youth? (1) You are responsible for disciplining youth in your care. This responsibility must not be delegated to any nonstaff, including youth in care.

(2) You must write down your disciplinary practices and include these with your application for a license.

(3) Discipline must be:

(a) Based on an understanding of the individual's needs and stage of development;

(b) Designed to help the youth under your care to develop inner control, acceptable behavior and respect for the rights of others; and

(c) Fair, reasonable, consistent, and related to the individual's behavior.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0625, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0635 What types of disciplinary practices are forbidden? (1) You must not use cruel, unusual, frightening, unsafe or humiliating discipline practices, including but not limited to:

(a) Spanking the youth with a hand or object;

(b) Biting, jerking, kicking, or shaking the youth;

(c) Pulling the youth's hair;

(d) Throwing the youth;

(e) Purposely inflicting pain as a punishment;

(f) Name calling, using derogatory comments, or abusing the youth verbally; and

(g) Threatening the youth with physical harm.

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(2) You must not use methods that interfere with a youth's basic needs, including but not limited to:

- (a) Depriving the youth of sleep;
- (b) Depriving the youth of adequate food, clothing or shelter; or

(c) Interfering with a youth's ability to take care of their own hygiene and toilet needs.

(3) You must not use methods that deprive a youth of necessary services, including:

- (a) Access to the youth's legal representative;
 - (b) DSHS social worker, if one is assigned; or
 - (c) Emergency medical or dental care.
- (4) You must not use medication in an amount or frequency other than that prescribed by a physician or psychiatrist.

(5) You must not use medications for a youth that have been prescribed for someone else.

(6) You must not physically lock doors or windows in a way that prohibits a youth from exiting.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0635, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0645 What types of physical restraint are acceptable for youth in overnight youth shelters? (1) If your overnight youth shelter is approved for the use of physical restraint, the licensee and staff must be trained in the appropriate use of restraining techniques in accordance with the department's behavior management policy before restraining a youth. Restraint training must be nationally recognized and DLR approved.

(2) You must use other efforts to redirect or de-escalate the situation before using a physical restraint.

(3) If a youth's behavior poses an immediate risk to physical safety you may use physical restraint that is reasonable and necessary to:

- (a) Protect youth on the premises from harming themselves or others; or
- (b) Protect property from serious damage.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0645, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0655 What types of physical restraint are not acceptable in overnight youth shelters? (1) You must not use physical restraint as a form of punishment.

(2) You must not use mechanical restraints, such as handcuffs and belt restraints.

(3) You must not use locked time-out rooms.

(4) You must not use physical restraint techniques that restrict breathing, inflict pain as a strategy for behavior control or might injure a youth. These include, but are not limited to:

- (a) An adult sitting on or straddling a youth;
- (b) Sleeper holds, which are holds used by law enforcement officers to subdue a person;
- (c) Arm twisting;
- (d) Hair holds;
- (e) Youth being thrown against walls, furniture, or other large immobile objects;
- (f) Choking or putting arms around a throat;
- (g) Restriction of body movement by placing pressure on joints, chest, heart, or vital organs; or

[Title 388 WAC—p. 732]

(h) Chemical restraints, except prescribed medication, including but not limited to pepper spray.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0655, filed 7/5/01, effective 8/5/01.]

WAC 388-160-0665 Do I need to document instances when physical restraint is used? (1) You must document all instances of the use of physical restraints and follow the behavior management policy of children's administration regarding the information to be reported. You must keep a copy of this document at your overnight youth shelter. At a minimum, you must record:

- (a) The youth's name and age;
 - (b) The date of the use of the restraint;
 - (c) The time in and out of the restraint;
 - (d) The events preceding the behavior that lead to using the restraint;
 - (e) The de-escalation methods that were used;
 - (f) Names of those involved in the restraint and any observers;
 - (g) A description of the type of restraint used;
 - (h) A description of injuries to the youth, or others, including caregivers;
 - (i) An analysis of how the restraint might have been avoided; and
 - (j) The signature of the person making the report.
- (2) Additional information on behavior management and the use of physical restraints can be obtained from the department.

[Statutory Authority: Chapter 75.15 [74.15] RCW. 01-15-001, § 388-160-0665, filed 7/5/01, effective 8/5/01.]

Chapter 388-165 WAC CHILDREN'S ADMINISTRATION CHILD CARE SUBSIDY PROGRAMS

WAC

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- 388-165-240 What are the parent/guardian payment responsibilities when they choose in-home/relative child care?
- 388-165-245 What is the responsibility of DSHS regarding child care subsidies for in-home/relative child care?
- 388-165-250 When can DSHS pay toward the cost of in-home/relative child care provided outside the child's home?

Reviser's note: Chapter 388-165 (Consolidated emergency assistance program—Social services (CEAP-SS)) was repealed by 98-01-125, filed 12/18/98. WSR 99-15-076, filed 7/20/99 reactivated and renamed this chapter.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 388-165-005 Purpose. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-005, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-010 General provisions. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-010, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-020 Application procedure. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-020, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-030 Application form. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-030, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-040 Assistance unit. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-040, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-050 Eligibility conditions—Emergent need. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-050, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-060 Eligibility conditions—Income and resource eligibility. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-060, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-070 Eligibility conditions—Living with a relative of a specified degree. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-070, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-080 Eligibility conditions—Job refusal. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-080, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
- 388-165-090 Eligibility conditions—Residency and alien status. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-090, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125,

filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-100 Payment limitations. [Statutory Authority: RCW 74.08.090, 74.04.660, 74.04.050 and 45 CFR 233.120 Title IV-A Section 406(e). 95-11-048 (Order 3850), § 388-165-100, filed 5/10/95, effective 6/10/95.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

388-165-130 Subsidized child care for seasonal workers. [99-19-087, recodified as § 388-165-130, filed 9/17/99, effective 9/17/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-174, filed 10/22/98, effective 11/22/98.] Repealed by 03-14-109, filed 6/30/03, effective 8/1/03. Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW.

WAC 388-165-108 What are the types of child care subsidies? This chapter relates to the following programs:

- (1) Seasonal child care;
- (2) Teen parent child care;
- (3) Child protective services child care;
- (4) Child welfare services child care; and
- (5) Employed foster parent child care.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-108, filed 10/22/99, effective 11/22/99.]

WAC 388-165-110 Definitions. The following definitions apply to WAC 388-15-171, 388-15-174, 388-15-175 and 388-15-176.

"Child" means a person twelve years of age or younger or a person under nineteen years of age who is physically, mentally, or emotionally incapable of self care as verified by a licensed medical practitioner or masters level or above mental health professional.

"Co-payment" means the amount of money the family is responsible to pay the child care provider toward the cost of child care each month.

"Income" means the gross earned income minus the average payroll and income tax paid at that income level, plus any unearned income.

"In-home/relative child care provider" see definition for **"in-home/relative provider"** under WAC 388-290-020.

"Parent" see definition for **"parent"** under WAC 388-290-020.

"Teen parent" means a parent twenty-one years of age or younger.

[99-15-076, recodified as § 388-165-110, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-170, filed 10/22/98, effective 11/22/98. Statutory Authority: RCW 74.12.340 and 45 CFR Part 98.41 Child Care and Development Block Grant. 93-10-021 (Order 3535), § 388-15-170, filed 4/28/93, effective 5/29/93. Statutory Authority: RCW 74.12.340 and 45 CFR 98.20, 98.30, 98.43 and 98.45; and 45 CFR 257.21, 257.30, 257.31 and 257.41. 92-11-062 (Order 3393), § 388-15-170, filed 5/19/92, effective 6/19/92. Statutory Authority: RCW 74.08.090. 88-24-023 (Order 2732), § 388-15-170, filed 12/2/88; 86-12-051 (Order 2387), § 388-15-170, filed 6/3/86; 86-03-078 (Order 2333), § 388-15-170, filed 1/22/86; 83-02-028 (Order 1931), § 388-15-170, filed 12/29/82. Statutory Authority: RCW 43.20A.550. 82-14-048 (Order 1839), § 388-15-170, filed 6/30/82. Statutory Authority: RCW 74.08.090. 82-01-051 (Order 1735), § 388-15-170, filed 12/16/81; 81-10-034 (Order 1650), § 388-15-170, filed 4/29/81; 80-15-010 (Order 1552), § 388-15-170, filed 10/6/80. Statutory Authority: RCW 43.20A.550. 78-04-004 (Order 1276), § 388-15-170, filed 3/2/78; Order 1238, § 388-15-170, filed 8/31/77; Order 1204, § 388-15-170, filed 4/1/77; Order 1147, § 388-15-170, filed 8/26/76; Order 1124, § 388-15-170, filed 6/9/76; Order 1120, § 388-15-170, filed 5/13/76; Order 1088, § 388-15-170, filed 1/19/76.]

WAC 388-165-120 Subsidized child care for teen parents. (1) The department may authorize teen parent child care within available funds for parents who:

- (a) Are twenty-one years of age or younger;
- (b) Are enrolled in an approved secondary education or general equivalency diploma (GED) program;
- (c) Are not receiving a temporary assistance for needy families (TANF) grant; and
- (d) Have an income at or below one hundred seventy-five percent of the federal poverty level (FPL).

(2) All teen parents contribute to the cost of child care by making a monthly co-payment to the child care provider which is:

- (a) Determined by the teen parent's income; and
 - (b) Calculated by using the rules under WAC 388-290-090 (2)(a), (b), and (c)(i) and (ii).
- (3) The department funds child care only during the portion of the day when the child's parent(s) is unable to provide necessary care and supervision due to the parents participation in DSHS approved activities.

[99-15-076, recodified as § 388-165-120, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-171, filed 10/22/98, effective 11/22/98.]

WAC 388-165-140 Child care for child protective services (CPS) and child welfare services (CWS). The department may purchase CPS/CWS child care within available funds for children of families in need of support as part of a CPS/CWS case plan. This service is short-term and time-limited. Social workers must determine if other resources are available to meet this need before authorizing payment by the department.

[99-15-076, recodified as § 388-165-140, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-175, filed 10/22/98, effective 11/22/98.]

WAC 388-165-179 When are DSHS child care subsidy rates in this chapter effective? (1) DSHS child care subsidy rates in this chapter are effective on or after November 1, 1999 when a family:

- (a) Has a change that requires their authorization to be updated;
 - (b) Is newly authorized to receive child care subsidies; or
 - (c) Is reauthorized to continue receiving child care subsidies.
- (2) DSHS child care subsidy rates are authorized at the provider's usual rate or the DSHS maximum child care subsidy rate, whichever is less.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-179, filed 10/22/99, effective 11/22/99.]

WAC 388-165-180 What are the maximum child care subsidy rates DSHS pays for child care in a licensed or certified child care center? DSHS pays directly to a licensed or certified child care center, whichever is less:

- (1) The provider's usual rate for that child; or
- (2) The DSHS maximum child care subsidy rate for that child as listed in the following table.

[Title 388 WAC—p. 734]

DSHS Maximum Child Care Subsidy Rate for Licensed Child Care Centers

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$22.73	\$19.85	\$18.00	\$16.70
	Half-Day	\$11.36	\$9.93	\$9.00	\$8.35
Region 2	Full-Day	\$23.18	\$20.45	\$17.75	\$16.82
	Half-Day	\$11.59	\$10.23	\$8.88	\$8.41
Region 3	Full-Day	\$30.18	\$26.00	\$22.00	\$19.77
	Half-Day	\$15.09	\$13.00	\$11.00	\$9.89
Region 4	Full-Day	\$37.80	\$29.55	\$26.14	\$23.40
	Half-Day	\$18.90	\$14.77	\$13.07	\$11.70
Region 5	Full-Day	\$25.82	\$22.18	\$19.45	\$17.50
	Half-Day	\$12.91	\$11.09	\$9.73	\$8.75
Region 6	Full-Day	\$25.59	\$22.73	\$20.00	\$20.00
	Half-Day	\$12.80	\$11.36	\$10.00	\$10.00

(3) The maximum rate paid for a five year old child is:

- (a) The preschool rate for a child who has not entered kindergarten; or
- (b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-180, filed 10/22/99, effective 11/22/99.]

WAC 388-165-185 What are the maximum child care subsidy rates DSHS pays for child care in a licensed or certified family child care home? DSHS pays directly to a licensed or certified family child care provider, whichever is less:

- (1) The provider's usual rate for that child; or
- (2) The DSHS maximum child care subsidy rate for that child as listed in the following table.

DSHS Maximum Child Care Subsidy Rate for Licensed Family Child Care Homes

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$19.00	\$17.60	\$17.00	\$15.00
	Half-Day	\$9.50	\$8.80	\$8.50	\$7.50
Region 2	Full-Day	\$18.00	\$18.00	\$16.00	\$15.00
	Half-Day	\$9.00	\$9.00	\$8.00	\$7.50
Region 3	Full-Day	\$28.00	\$24.00	\$22.00	\$20.00
	Half-Day	\$14.00	\$12.00	\$11.00	\$10.00
Region 4	Full-Day	\$30.00	\$27.27	\$25.00	\$22.50
	Half-Day	\$15.00	\$13.64	\$12.50	\$11.25
Region 5	Full-Day	\$21.00	\$20.00	\$19.00	\$17.00
	Half-Day	\$10.50	\$10.00	\$9.50	\$8.50
Region 6	Full-Day	\$20.50	\$20.00	\$18.00	\$17.00
	Half-Day	\$10.25	\$10.00	\$9.00	\$8.50

(3) The maximum rate paid for a five year old child is:

- (a) The preschool rate for a child who has not entered kindergarten; or
- (b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-185, filed 10/22/99, effective 11/22/99.]

WAC 388-165-190 When can DSHS pay in addition to the maximum DSHS child care subsidy rate? DSHS pays additional subsidies to a licensed or certified family child care home or center when:

- (1) Care is for nonstandard hours (see WAC 388-165-195 and 388-165-200);

(2007 Ed.)

(2) The infant bonus is authorized (see WAC 388-165-205);

(3) A child has a documented special need(s) (see WAC 388-165-210, 388-165-215, or 388-165-220); or

(4) Care is not available at the DSHS rate and the provider's usual rate is authorized.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-190, filed 10/22/99, effective 11/22/99.]

WAC 388-165-195 What is nonstandard hour child care? DSHS authorizes nonstandard hour child care when fifteen or more hours of care are needed per month, that are:

(1) Before 6:00 a.m. or after 6:00 p.m. Monday through Friday; and/or

(2) Anytime on Saturday or Sunday.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-195, filed 10/22/99, effective 11/22/99.]

WAC 388-165-200 How does DSHS pay for non-standard hour child care? DSHS authorizes the nonstandard hour bonus to licensed or certified child care providers, DSHS pays:

(1) The DSHS maximum child care subsidy rate as listed in WAC 388-165-180 or 388-165-185 or the provider's usual rate for that child, whichever is less; and

(2) The monthly nonstandard hour bonus as listed in the table below.

Monthly Nonstandard Hour Bonus

Region 1	\$74.00
Region 2	\$73.00
Region 3	\$91.00
Region 4	\$108.00
Region 5	\$80.00
Region 6	\$83.00

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-200, filed 10/22/99, effective 11/22/99.]

WAC 388-165-205 Does DSHS pay a bonus for infants who receive child care subsidies? DSHS child care subsidy programs pay a two hundred and fifty dollar infant bonus directly to the licensed or certified family child care home or center if:

(1) The child care facility has not already received a bonus for that infant;

(2) The infant was first enrolled in the child care facility after August 30, 1998;

(3) The infant is less than one year old; and

(4) The provider cares for the infant a total of five or more days before the child's first birthday.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-205, filed 10/22/99, effective 11/22/99.]

WAC 388-165-210 How does DSHS determine that a child qualifies for a special needs rate? To qualify for the DSHS child care programs special needs subsidy rate the child must:

(1) Be under nineteen years old;

(2) Have a verified physical, mental, emotional, or behavioral condition that requires a higher level of care; and

(2007 Ed.)

(3) Have their condition and need for higher level of care verified by a health, mental health, or education professional with at least a master's degree.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-210, filed 10/22/99, effective 11/22/99.]

WAC 388-165-215 What is the DSHS child care subsidy rate for children with special needs in a licensed or certified child care center? DSHS pays child care subsidies for a child with special needs to licensed or certified child care centers as described in WAC 388-165-180 and whichever of the following is greater:

(1) The provider's documented additional cost associated with the care of that child with special needs; or

(2) The rate listed in the table below.

Licensed Child Care Centers Special Needs Rate

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$6.82	\$5.96	\$5.40	\$5.01
	Half-Day	\$3.41	\$2.98	\$2.70	\$2.51
Region 2	Full-Day	\$6.95	\$6.14	\$5.33	\$5.05
	Half-Day	\$3.48	\$3.07	\$2.66	\$2.52
Region 3	Full-Day	\$9.05	\$7.80	\$6.60	\$5.93
	Half-Day	\$4.53	\$3.90	\$3.30	\$2.97
Region 4	Full-Day	\$11.34	\$8.86	\$7.84	\$7.02
	Half-Day	\$5.67	\$4.43	\$3.92	\$3.51
Region 5	Full-Day	\$7.75	\$6.65	\$5.84	\$5.25
	Half-Day	\$3.87	\$3.33	\$2.92	\$2.63
Region 6	Full-Day	\$7.68	\$6.82	\$6.00	\$6.00
	Half-Day	\$3.84	\$3.41	\$3.00	\$3.00

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-215, filed 10/22/99, effective 11/22/99.]

WAC 388-165-220 What is the DSHS child care subsidy rate for children with special needs in a licensed or certified family child care home? DSHS pays child care subsidies for a child with special needs to licensed or certified family child care homes as described in WAC 388-165-195 and whichever of the following is greater:

(1) The provider's documented additional cost associated with the care of that child with special needs; or

(2) The rate listed in the table below.

Licensed Family Child Care Homes Special Needs Bonus

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 years)	School-age (5 - 12 years)
Region 1	Full-Day	\$5.70	\$5.28	\$5.10	\$4.50
	Half-Day	\$2.85	\$2.64	\$2.55	\$2.25
Region 2	Full-Day	\$5.40	\$5.40	\$4.80	\$4.50
	Half-Day	\$2.70	\$2.70	\$2.40	\$2.25
Region 3	Full-Day	\$8.40	\$7.20	\$6.60	\$6.00
	Half-Day	\$4.20	\$3.60	\$3.30	\$3.00
Region 4	Full-Day	\$9.00	\$8.18	\$7.50	\$6.75
	Half-Day	\$4.50	\$4.09	\$3.75	\$3.38
Region 5	Full-Day	\$6.30	\$6.00	\$5.70	\$5.10
	Half-Day	\$3.15	\$3.00	\$2.85	\$2.55
Region 6	Full-Day	\$6.15	\$6.00	\$5.40	\$5.10
	Half-Day	\$3.08	\$3.00	\$2.70	\$2.55

[Title 388 WAC—p. 735]

(3) The maximum rate paid for a five year old child is:

(a) The preschool rate for a child who has not entered kindergarten; or

(b) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-220, filed 10/22/99, effective 11/22/99.]

WAC 388-165-225 What is the DSHS in-home/relative child care rate for children with special need? DSHS subsidy programs pay in-home/relative child care providers for care of a child with special needs (as described in WAC 388-15-185) two dollars per hour plus whichever is greater of the following:

(1) Sixty-two cents per hour; or

(2) The provider's documented additional cost associated with the care for that child with special needs.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-225, filed 10/22/99, effective 11/22/99.]

WAC 388-165-230 What is the maximum child care subsidy rate DSHS pays for in-home/relative child care?

(1) The DSHS child care subsidy programs pay toward the cost of child care directly to the parent, who is the employer. DSHS pays whichever of the following that is less:

(a) Two dollars and six cents per hours for the child who needs the greatest amount of care and one dollar and three cents per hour for the care of each additional child in the family; or

(b) The provider's usual rate for that care.

(2) DSHS may pay above the maximum rate for children who have special needs as stated in WAC 388-165-225.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-230, filed 10/22/99, effective 11/22/99.]

WAC 388-165-235 In-home/relative child care. (1)

When the parent(s) chooses in-home/relative child care, the parent(s) will give the in-home/relative child care provider's name and address to the department and make the following assurances at the time child care is authorized:

(a) The in-home/relative provider is:

(i) Eighteen years of age or older;

(ii) Of sufficient physical, emotional, and mental health to meet the needs of the child in care. If requested by the department, the parent(s) must provide written evidence that the in-home child care provider of the parent's choice is of sufficient physical, emotional, and mental health to be a safe child care provider;

(iii) Able to work with the child without using corporal punishment or psychological abuse;

(iv) Able to accept and follow instructions;

(v) Able to maintain personal cleanliness; and

(vi) Prompt and regular in job attendance.

(b) The child is current on the immunization schedule as described in the National Immunization Guidelines, developed by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices;

(c) The home where care is provided is safe for the care of the child; and

(d) The in-home/relative child care provider is informed about basic health practices, prevention and control of infectious disease, immunizations, and home and physical premises safety relevant to the care of the child.

(2) The in-home/relative child care provider's primary function while on duty is to provide child care. The in-home/relative child care provider will have the following responsibilities:

(a) Provide constant care and supervision of the child for whom the provider is responsible throughout the arranged time of care in accordance with the needs of the child; and

(b) Provide developmentally appropriate activities for the child who is under the in-home/relative child care provider's care.

(3) The department provides the parent(s) with information about basic health practices, prevention and control of infectious diseases, immunizations, and building and physical premises safety relevant to the care of the child.

[99-15-076, recodified as § 388-165-235, filed 7/20/99, effective 7/20/99. Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055, 74.08.090 and 74.13.0903. 98-22-008, § 388-15-176, filed 10/22/98, effective 11/22/98.]

WAC 388-165-240 What are the parent/guardian payment responsibilities when they choose in-home/relative child care? The parent is the employer of the in-home/relative provider. The parent:

(1) Pays the provider the entire amount that DSHS gives them toward the cost of care;

(2) Pays the provider the amount that was authorized for a co-payment;

(3) Requires the in-home/relative provider to sign a receipt when they receive payment;

(4) Keeps the receipts for DSHS to review at the next eligibility determination; and

(5) Keeps accurate attendance records.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-240, filed 10/22/99, effective 11/22/99.]

WAC 388-165-245 What is the responsibility of DSHS regarding child care subsidies for in-home/relative child care? (1) On all payments DSHS makes toward the cost of in-home/relative child care, DSHS pays the employer's share of:

(a) Social Security taxes;

(b) Medicare taxes;

(c) Federal Unemployment Taxes (FUTA); and

(d) State unemployment taxes (SUTA) when applicable.

(2) On all payments DSHS makes toward the cost of in-home/relative child care DSHS withholds the following taxes:

(a) Social security taxes up to the wage base limit; and

(b) Medicare taxes.

(3) If an in-home/relative child care provider receives less than one thousand one hundred dollars per family in a calendar year, DSHS refunds all withheld taxes to the provider.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-245, filed 10/22/99, effective 11/22/99.]

WAC 388-165-250 When can DSHS pay toward the cost of in-home/relative child care provided outside the child's home? DSHS will pay toward the cost of child care provided in the relative's home by the following adult relative of the child:

- (1) Siblings and stepsiblings living outside the child's home;
- (2) Grandparents;
- (3) Aunts;
- (4) Uncles;
- (5) First cousins;
- (6) Great grandparents;
- (7) Great aunts;
- (8) Great uncles; and
- (9) Extended family members as determined by law or custom of the Indian child's tribe.

[Statutory Authority: RCW 74.12.340, 74.04.050, 74.04.055 and 74.08.090. 99-22-011, § 388-165-250, filed 10/22/99, effective 11/22/99.]

Chapter 388-180 WAC

STANDARDS FOR HEALTH AND SAFETY REVIEWS OF THE WASHINGTON STATE SCHOOL FOR THE DEAF

WAC

PURPOSE

388-180-0100 What is the purpose of this chapter?

DEFINITIONS

388-180-0110 What are the definitions for this chapter?

CHILD PROTECTIVE SERVICES (CPS) INVESTIGATIONS

388-180-0120 Is CPS required to investigate allegations of CA/N of students at the school?

388-180-0130 What is included in the CPS investigation?

HEALTH AND SAFETY REVIEWS

388-180-0140 What health and safety reviews are required?

388-180-0150 Who receives a copy of the completed health and safety reports?

388-180-0160 What health and safety standards and written policies will the monitors be looking for when conducting their health and safety reviews of the school?

388-180-0170 What specific areas must be included in the comprehensive health and safety review?

388-180-0180 What health and safety areas must be included in the monitoring review?

388-180-0190 Must WSD allow the department access to the records of the school?

388-180-0200 Must WSD allow the department access to all students and staff for the reviews?

388-180-0210 What must be included in the incident documentation?

388-180-0220 What are the staffing requirements for the residential portion of the school?

388-180-0230 What are the physical environment safety requirements for the residential facilities?

PURPOSE

WAC 388-180-0100 What is the purpose of this chapter? The purpose of this chapter is to outline the process of investigating child abuse or neglect at Washington state school for the deaf and establish rules for completing health and safety monitoring reviews of the school.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0100, filed 1/24/03, effective 3/1/03.]

(2007 Ed.)

DEFINITIONS

WAC 388-180-0110 What are the definitions for this chapter? The following definitions apply to this chapter:

"CA/N" means child abuse or neglect as defined in chapter 26.44 WAC.

"Department" means the department of social and health services (DSHS).

"DLR" means the division of licensed resources, a division of children's administration, department of social and health services.

"Residential staff" means individuals in charge of supervising the day-to-day living situation of the children in the residential portion of the school.

"School" means the Washington State School for the Deaf.

"Superintendent" means the superintendent of the Washington state school for the deaf.

"WSD" means the Washington state school for the deaf.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0110, filed 1/24/03, effective 3/1/03.]

CHILD PROTECTIVE SERVICES (CPS) INVESTIGATIONS

WAC 388-180-0120 Is CPS required to investigate allegations of CA/N of students at the school? The department's child protective services (CPS) must investigate referrals of alleged child abuse or neglect occurring at the Washington state school for the deaf. This includes alleged incidents of students abusing other students.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0120, filed 1/24/03, effective 3/1/03.]

WAC 388-180-0130 What is included in the CPS investigation? (1) A CPS investigation at the school must determine if:

- (a) Abuse or neglect is substantiated or "founded"; and
- (b) A referral to law enforcement is appropriate.

(2) CPS must send a copy of the investigative report for incidents of alleged abuse or neglect to the school's superintendent.

(3) CPS may include recommendations for increasing student safety to the superintendent and the board of trustees or its successor board.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0130, filed 1/24/03, effective 3/1/03.]

HEALTH AND SAFETY REVIEWS

WAC 388-180-0140 What health and safety reviews are required? The department must complete health and safety reviews of the school as follows.

(1) A comprehensive health and safety review of WSD must be completed every three years; and

(2) Monitoring health and safety reviews must be completed at least quarterly until December 1, 2006.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0140, filed 1/24/03, effective 3/1/03.]

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WAC 388-180-0150 Who receives a copy of the completed health and safety reports? (1) The department must provide a copy of the comprehensive health and safety review report of the school to:

- (a) The governor;
- (b) The legislature;
- (c) The superintendent; and
- (d) The school's board of trustees or its successor board.

(2) The department provides a copy of the periodic monitoring health and safety review reports of the school to the superintendent and to the governor.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0150, filed 1/24/03, effective 3/1/03.]

WAC 388-180-0160 What health and safety standards and written policies will the monitors be looking for when conducting their health and safety reviews of the school? Reporting requirements

The health and safety standards that apply to WSD are as follows:

(1) All residential program personnel and volunteer staff at the school must comply with the mandatory reporting requirements of child abuse or neglect, RCW 26.44.020.

(2) The school must comply with all applicable fire marshal and department of health requirements.

Written policies and procedures

(3) The department will be reviewing the written policies and procedures of the school that:

(a) Promote a program aimed at providing personal safety and protection of all students residing at the school;

(b) Provide sufficient staffing levels on all shifts to meet the physical, emotional, and safety needs of all students, as required under RCW 72.40.240;

(c) Implement and maintain effective admission and retention policies that protect all students from sexual victimization, as required under RCW 72.40.270;

(d) Implement and maintain an effective communication system between educational staff and residential staff and parents and/or legal guardians;

(e) Ensure that the residential facility meets all applicable fire and health requirements and promote environmental safety against physical risk or harm to students;

(f) Minimize student-to-student conflict or harm when transporting students;

(g) Conduct and document background and CA/N checks on all staff to determine each employee's suitability for employment at the school (see chapter 388-06 WAC);

(h) Provide all students with training on self-protection from abuse or neglect, as required under RCW 72.40.230 and 72.40.260;

(i) Implement and maintain effective child protection policies that include proper reporting of incidents, notification, documentation, and cooperation with the department and law enforcement;

(j) Describe what procedures staff must follow when they have reason to believe a student may have been abused or neglected, as defined under RCW 26.44.020; and

(k) Maintain adequate documentation of all abuse or neglect incidents.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0160, filed 1/24/03, effective 3/1/03.]

[Title 388 WAC—p. 738]

WAC 388-180-0170 What specific areas must be included in the comprehensive health and safety review?

(1) In conducting a comprehensive health and safety review of the school, the department must review the children's administration's case and management information system (CAMIS) records for any child abuse or neglect referrals and the disposition of the investigations.

(2) The reviewers must:

(a) Examine the residential facilities for health and safety (a specific list of elements for review are outlined in WAC 388-180-0230);

(b) Develop appropriate questionnaires or survey tools for interviews;

(c) Conduct interviews of staff, students, parent, teacher, and community stakeholders for concerns of student health and safety at the school.

(d) Review facility logs, including incident reports and daily shift logs;

(e) Review medication policies, including documentation of medicine disbursement when and by whom;

(f) Review admissions and expulsion policies for compliance with RCW 72.40.040;

(g) Review staff coverage policies for compliance with RCW 72.40.240 and 72.40.270;

(h) Review behavior management policy for compliance with RCW 72.40.220, including a description of the de-escalation techniques used with different ages or developmental levels of students;

(i) Review employee/volunteer supervision policies for compliance with RCW 72.40.250;

(j) Review policies for protecting students from abuse or neglect policies for compliance with RCW 72.40.250;

(k) Review any corrective action plans including implementing the written plan of action to assure health and safety and prevention of abuse or neglect incidents as directed in RCW 72.40.250;

(l) Review the documentation of awareness and prevention training of staff for compliance with RCW 72.40.230 and 72.40.260; and

(m) Sample criminal history and CA/N checks of school employees for compliance with the school's criminal history inquiry and FBI fingerprinting process.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0170, filed 1/24/03, effective 3/1/03.]

WAC 388-180-0180 What health and safety areas must be included in the monitoring review? (1) The health and safety areas covered in the monitoring review must include, but are not limited to, the following:

(a) Inspection and evaluation of the school's incident log;

(b) Child protective services investigation documentation;

(c) Residential program policies and procedures;

(d) Residential facilities, cafeteria, nurse's station, and all other venues where residential students frequent;

(e) Staff, student, and parent interviews; and

(f) Review any corrective action plans including implementing the written plan of action to assure health and safety and prevention of abuse or neglect incidents.

(2) The monitoring review may include, but is not limited to, the following:

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- (a) Written personnel policies and procedures;
- (b) Personnel records including background check results; and
- (c) Job descriptions and history of personnel training.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0180, filed 1/24/03, effective 3/1/03.]

WAC 388-180-0190 Must WSD allow the department access to the records of the school? Consistent with federal law, the school must give the department complete access to all records and documents requested by the reviewers in monitoring and conducting the reviews of the school.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0190, filed 1/24/03, effective 3/1/03.]

WAC 388-180-0200 Must WSD allow the department access to all students and staff for the reviews? Consistent with federal law, the school must give the department complete access to students and staff requested by the reviewers in monitoring and conducting the reviews of the school.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0200, filed 1/24/03, effective 3/1/03.]

WAC 388-180-0210 What must be included in the incident documentation? The incident log documentation must include:

- (1) The students involved (not identified to the reviewers);
- (2) The date and time of the incident;
- (3) A description of what occurred, any injury and severity of injury;
- (4) Any other persons present at the time of the incident; and
- (5) Any action taken by WSD staff, including notification of the child's parents.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0210, filed 1/24/03, effective 3/1/03.]

WAC 388-180-0220 What are the staffing requirements for the residential portion of the school? (1) A staffing ratio of 1:7 must be maintained for residential students while students are in dorms or cottages and when they are participating in elective activities.

(2) A staffing ratio of 1:9 must be maintained for visiting and day students while they are in the residential settings.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0220, filed 1/24/03, effective 3/1/03.]

WAC 388-180-0230 What are the physical environment safety requirements for the residential facilities? The school must ensure that the residential facilities comply with the applicable state fire marshal and department of health regulations, including the following:

- (1) The grounds, office, living areas, kitchen, bedrooms, bathrooms, shops, recreational areas, and laundry areas are clean and free of hazardous conditions.
- (2) Furnishings are clean, comfortable, durable, and safe.
- (3) Cleaning products and toxic chemicals are securely stored.

(2007 Ed.)

- (4) Medications are securely stored.
- (5) First-aid supplies are readily available.
- (6) Emergency lighting devices are available.
- (7) Kitchen and bathrooms are ventilated.
- (8) The facilities regularly conduct and document fire drills.
- (9) Smoke detectors are regularly inspected and the results of the inspections are documented.
- (10) Procedures for evacuation and other emergencies are posted, reviewed, and tested at regular intervals.

[Statutory Authority: RCW 74.15.030 and 74.20.280. 03-04-013, § 388-180-0230, filed 1/24/03, effective 3/1/03.]

Chapter 388-200 WAC

FINANCIAL AND MEDICAL ASSISTANCE— GENERAL PROVISIONS

WAC

388-200-1250 Gifts, bequests by will, and contributions.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

- 388-200-1050 Department and client responsibilities. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1050, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.04.050 and 1993 National Voter Registration Act, SSA Sect. 402 (a)(9) and 403 (a)(3). 94-23-128 (Order 3807), § 388-200-1050, filed 11/23/94, effective 1/1/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1050, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-38-030, 388-38-250, 388-38-255 and 388-38-260.] Repealed by 01-10-104, filed 5/1/01, effective 6/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.
- 388-200-1100 Grievance procedure. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1100, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1100, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-389.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
- 388-200-1150 Exception to rule. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1150, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-20-010.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
- 388-200-1160 Notification of exception to rule request and decision. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1160, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-23-387.] Repealed by 00-03-035, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035.
- 388-200-1200 Translation of written communications with a limited English proficient client. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1200, filed 5/3/94, effective 6/3/94. Formerly WAC 388-38-045.] Repealed by 03-01-115, filed 12/18/02, effective 1/18/03. Statutory Authority: RCW 74.04.025 and 74.08.090. Later promulgation, see chapter 388-271 WAC.
- 388-200-1300 Necessary supplemental accommodation services (NSA). [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1300, filed 12/30/96, effective 1/30/97.] Repealed by 01-10-104, filed 5/1/01, effective 6/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.

- 388-200-1350 Dispute resolution for clients needing supplemental accommodations. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1350, filed 12/30/96, effective 1/30/97.] Repealed by 01-10-104, filed 5/1/01, effective 6/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.
- 388-200-1400 Application of rules—Temporary assistance to needy families. [Statutory Authority: RCW 74.08.090, 74.04.050, 70.04.055 and Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, § 103). 97-07-008, § 388-200-1400, filed 3/10/97, effective 4/10/97.] Repealed by 00-22-063, filed 10/27/00, effective 11/27/00. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.04.055.

WAC 388-200-1250 Gifts, bequests by will, and contributions. (1) The department may accept a gift, bequest, or contributions in cash, or otherwise, from an association or corporation.

(2) The department shall not accept a gift or contribution from a person applying for, or receiving, public assistance.

(3) The department shall not advise any person desiring information or assistance regarding the preparation of a will. The department shall advise the person to contact an attorney, or the local legal aid society.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1250, filed 5/3/94, effective 6/3/94.]

Chapter 388-271 WAC

LIMITED ENGLISH PROFICIENT SERVICES

WAC

- 388-271-0010 What are limited English proficient (LEP) services?
- 388-271-0020 What are the department's responsibilities in providing me with an interpreter?
- 388-271-0030 What are the department's responsibilities in providing me with written communication in my primary language?

WAC 388-271-0010 What are limited English proficient (LEP) services? (1) The department provides limited English proficient (LEP) services to you if you are limited in your ability to read, write and/or speak English. These services provide a way for us to communicate with you even though you are limited in your ability to communicate in English. LEP services are provided in your primary language by authorized bilingual workers or by contracted interpreters and translators. Your primary language is the language you have indicated on your application or your eligibility review as the language you wish to communicate in with the department.

(2) LEP services include:

(a) Interpreter (verbal) services in person and/or over the telephone; and

(b) Translation of department forms, letters and other printed materials.

[Statutory Authority: RCW 74.04.025 and 74.08.090. 03-01-115, § 388-271-0010, filed 12/18/02, effective 1/18/03.]

WAC 388-271-0020 What are the department's responsibilities in providing me with an interpreter? (1) If you have trouble speaking and/or understanding English, and a bilingual worker is not available to assist you, we get a qualified interpreter in your primary language to help you communicate verbally with us. A qualified interpreter is

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someone who is fluent in English and your primary language and is trained on the Interpreter Code of Professional Conduct.

(2) Interpreter services are provided in-person or over the telephone.

(3) We pay for the interpreter. You do not have to pay anything.

(4) If a worker from our department feels that they are not able to communicate with you well enough to provide adequate services, they may request the services of an interpreter even if you did not ask for help.

(5) We will provide interpreter services to you in a timely manner so that we can process your case within the processing time frames defined in chapters 388-406, 388-418, and 388-434 WAC.

[Statutory Authority: RCW 74.04.025 and 74.08.090. 03-01-115, § 388-271-0020, filed 12/18/02, effective 1/18/03.]

WAC 388-271-0030 What are the department's responsibilities in providing me with written communication in my primary language? (1) We provide fully translated written communication in your primary language. This includes, but is not limited to:

(a) Department pamphlets, brochures and other informational material that describe department services and client rights and responsibilities;

(b) Department forms, including applications and individual responsibility plans, that we ask you to complete and/or sign; and

(c) Department letters as described in chapter 388-458 WAC.

(2) We pay for the written translation. You do not have to pay anything.

(3) We will provide translated documents to you in a timely manner so that we can process your case within the processing time frames defined in chapters 388-406, 388-418, and 388-434 WAC.

[Statutory Authority: RCW 74.04.025 and 74.08.090. 03-01-115, § 388-271-0030, filed 12/18/02, effective 1/18/03.]

Chapter 388-273 WAC

WASHINGTON TELEPHONE ASSISTANCE PROGRAM

(Formerly chapter 388-31 WAC)

WAC

- 388-273-0010 Purpose of the Washington telephone assistance program.
- 388-273-0020 Who may receive WTAP?
- 388-273-0025 Benefits you receive as a WTAP participant.
- 388-273-0030 How you can apply for WTAP.
- 388-273-0035 What we reimburse the local telephone company.

WAC 388-273-0010 Purpose of the Washington telephone assistance program. The Washington telephone assistance program (WTAP) is designed to help low-income households afford access to local telephone service. For the purposes of this chapter, "we" and "us" mean the department of social and health services (DSHS). "You" means the person who is applying and eligible for WTAP.

[Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0010, filed 4/9/01, effective 6/1/01.]

WAC 388-273-0020 Who may receive WTAP? (1) To receive WTAP benefits, you must:

- (a) Be age eighteen or older or, if under eighteen, be the responsible head of household, and either;
- (b) Be receiving one of the following programs from us:
 - (i) Temporary assistance for needy families (TANF);
 - (ii) State family assistance (SFA);
 - (iii) General assistance;
 - (iv) Refugee assistance;
 - (v) Food assistance;
 - (vi) State Supplemental Security Income (SSI);
 - (vii) Medical assistance, including Medicare cost sharing programs;
 - (viii) Community options program entry system (COPES);
 - (ix) Chore services; or

(c) Have completed using community service voice mail services, and been identified to the department as eligible for WTAP by the community agency that provided your community service voice mail program; and

(2) Apply to a local exchange company for WTAP and request the lowest available flat rate telephone service at the WTAP rate. In exchange areas where wireline service is not available without service extension, you may apply to a wire-less carrier:

(a) **"Local exchange company"** means a telephone company that is required by the Washington utilities and transportation commission to offer WTAP benefits and offers local calling, i.e., calling without long distance charges.

(b) **"Flat rate service"** is telephone service with a single monthly payment that allows unlimited local calling for a specified length of time. The local exchange flat rate includes any federal end user access charges and other charges necessary to obtain the service; and

(3) You must have the local telephone service billed in your name.

[Statutory Authority: RCW 74.08.090, 80.36.440, 2002 c 104. 02-18-106, § 388-273-0020, filed 9/3/02, effective 10/4/02. Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0020, filed 4/9/01, effective 6/1/01.]

WAC 388-273-0025 Benefits you receive as a WTAP participant. (1) WTAP participants receive a:

(a) Discount on local telephone flat rate services, when the flat rate is more than the WTAP assistance rate;

(b) Waiver of deposit requirements on local telephone service;

(c) Fifty percent discount on service connection fees through June 30, 2003. Effective July 1, 2003, fifty percent discount for the first connection; and for a second or subsequent connection when you ask for service at a new address. Any connection fee discounts available from other programs are added to the WTAP discount, to pay part or all of the remaining fifty percent; or

(d) Effective July 1, 2003, a community service voice mail box offered by a community agency that has been contracted with the department of community, trade and economic development to provide the service.

(2) WTAP benefits are limited to one residential line per household.

(2007 Ed.)

(3) Your benefits begin the date you are approved for WTAP assistance and continue through the next June 30, except if you qualified for telephone assistance through using the community services voice mail programs, you will receive one additional service year of benefits. "Service year" means the period beginning July 1 and ending June 30 of the following calendar year.

(4) WTAP benefits do not include charges for line extension, optional extended area service, optional mileage, customer premises equipment, applicable taxes or delinquent balances owed to the telephone company.

[Statutory Authority: RCW 74.08.090, 80.36.440, 2003 c 134. 04-13-136, § 388-273-0025, filed 6/22/04, effective 7/23/04. Statutory Authority: RCW 74.08.090, 80.36.440, 2002 c 104. 02-18-106, § 388-273-0025, filed 9/3/02, effective 10/4/02. Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0025, filed 4/9/01, effective 6/1/01.]

WAC 388-273-0030 How you can apply for WTAP.

(1) You can apply for telephone benefits by contacting the local telephone company.

(2) The telephone company contacts us to verify that you are eligible for benefits under WAC 388-273-0020 before they add WTAP to your telephone account.

(3) You will know you are receiving WTAP benefits when you have a WTAP credit on your telephone bill.

(4) Effective July 1, 2003, you can apply for community service voice mail by contacting your local community service voice mail provider.

[Statutory Authority: RCW 74.08.090, 80.36.440, 2003 c 134. 04-13-136, § 388-273-0030, filed 6/22/04, effective 7/23/04. Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0030, filed 4/9/01, effective 6/1/01.]

WAC 388-273-0035 What we reimburse the local telephone company. (1) Within available funding limits, we reimburse local telephone companies for fully documented administrative and program expenses associated with WTAP.

The reimbursable expenses are limited to:

(a) Program services provided to eligible households June 1, 2003 and beyond, and after eligibility for WTAP is verified;

(i) Monthly flat rate service.

We reimburse the local telephone company an amount equal to the monthly flat rate of the incumbent local exchange carrier providing service in the customer's exchange area, minus the WTAP assistance rate set by the commission, and minus the amount of federal lifeline program reimbursement available to an eligible telecommunications carrier. An "incumbent local exchange carrier" is a telephone company in the U.S. that was providing local service when the Telecommunications Act of 1996 was enacted, and is required to file tariffs with the commission. For all exchange areas, the WTAP reimbursement shall be limited to not more than nine-teen dollars for each eligible household.

(ii) Connection fee.

We reimburse the local telephone company an amount equal to one-half the connection fee rate or twenty-two dollars, whichever is less, for your first connection at a given address. If you move, we will reimburse the local telephone company for your first connection at the new address.

(iii) Waiver of local deposit.

We reimburse the local telephone company an amount up to two times the WTAP assistance rate.

(b) Correct, verifiable billing items;

(c) One monthly invoice and supporting documentation submitted and received by WTAP by the fifteenth day following the month the expense occurred;

(d) Items charged in error that have been corrected within thirty days from the date we return the report of invoicing error to the local phone company;

(e) Salaries and benefits for time required to implement and maintain WTAP, with the exception that time required for the correction of billing, case number and client identification errors is not an allowable expense;

(f) Travel expenses for attending hearings, meetings, or training pertaining to WTAP;

(g) Expenses for supplies and materials for implementing and maintaining WTAP;

(h) Postage and handling for delivery of WTAP material;

(i) Administrative charge for change of service orders specified by tariffs; and

(j) Preapproved documented indirect costs associated with implementing and maintaining WTAP.

[Statutory Authority: RCW 74.08.090, 80.36.440, 80.36.410 through 80.36.470. 05-15-152, § 388-273-0035, filed 7/19/05, effective 8/19/05. Statutory Authority: RCW 74.08.090, 80.36.440, 2003 c 134. 04-13-136, § 388-273-0035, filed 6/22/04, effective 7/23/04. Statutory Authority: RCW 74.08.090, 80.36.440. 01-09-023, § 388-273-0035, filed 4/9/01, effective 6/1/01.]

Chapter 388-280 WAC

UNITED STATES REPATRIATION PROGRAM

WAC

388-280-0010	What is the United States Repatriation Program?
388-280-0020	How do I apply for repatriation assistance?
388-280-0030	Do I have to repay the repatriation assistance?
388-280-0040	Are there limits to my income and resources?
388-280-0050	How long can I receive repatriation assistance?
388-280-0060	What services are available to me under the repatriation program?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-280-1010	Purpose. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1010, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1020	Definition. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1020, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1030	Application. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1030, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1040	Repaying repatriation assistance. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1040, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1050	Safeguarding information. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1050, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.
388-280-1060	Referral to other agencies. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1060, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-

077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1070 Income and resources. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1070, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1080 Eligibility. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1080, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1090 Client responsibilities. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1090, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1100 Department responsibilities as the port of entry state. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1100, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1110 Department responsibilities as the final destination state. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1110, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1120 Unattended minors. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1120, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1130 Scope of services. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1130, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1140 Time limits on benefits. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1140, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1150 Payment limits. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1150, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

388-280-1160 Assistance payment—Types of payments. [Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1160, filed 5/26/93, effective 6/26/93.] Repealed by 00-19-077, filed 9/19/00, effective 11/1/00. Statutory Authority: RCW 74.08.090.

WAC 388-280-0010 What is the United States Repatriation Program? The United States Repatriation Program assists a U.S. citizen or dependent who is:

- (1) Without financial resources; and
- (2) Returned or brought back to the U.S. from a foreign country because of:

- (a) Mental illness; or
- (b) Destitution, physical illness, or a crisis such as war.

For the purposes of this chapter, "we" and "us" means the department of social and health services.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0010, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0020 How do I apply for repatriation assistance? You apply for repatriation assistance by contacting the U.S. State Department or us.

(1) If you contact the U.S. State Department, we consider a referral from them as an approved application.

(2) If you contact us directly, we apply for you to the U.S. Department of Health and Human Services (HHS).

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0020, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0030 Do I have to repay the repatriation assistance? Repatriation assistance is a loan. You, or your representative if you are mentally ill, must:

- (1) Sign a statement recognizing repatriation assistance as a loan; and
- (2) Agree to repay the funds.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0030, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0040 Are there limits to my income and resources? (1) You are ineligible to receive repatriation assistance if you have nonexempt:

- (a) Income, as defined by temporary assistance for needy families (TANF) equal to or greater than the TANF need standards as described in WAC 388-450-0005; or
 - (b) Resources, as defined by TANF under WAC 388-470-0005 that are available to meet your resettlement needs.
- (2) We consider a resource available to you when:
- (a) The value can be determined;
 - (b) It is controlled by you; and
 - (c) You can use the resource to meet your needs.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0040, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0050 How long can I receive repatriation assistance? (1) If you are mentally ill, you receive temporary care until you:

- (a) Can be released to the care of a relative or state agency; or
- (b) Are discharged or granted release from hospitalization.

(2) If you are not mentally ill, you may receive repatriation assistance up to twelve months as follows:

(a) "Temporary assistance" meaning repatriation assistance provided during the first ninety days after you return to the United States.

(b) "Extended assistance" meaning repatriation assistance provided for up to nine months after the end of your temporary assistance. We must have approval in advance from HHS, so you must ask us to apply for extended assistance while receiving temporary assistance and be:

- (i) Ineligible for any other assistance program; and
- (ii) Unable to support or care for yourself due to age, illness, or lack of job skills.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0050, filed 9/19/00, effective 11/1/00.]

WAC 388-280-0060 What services are available to me under the repatriation program? (1) The HHS sets limits on how much we pay for repatriation assistance. The limits are:

(a) The temporary assistance for needy families (TANF) payment standards under WAC 388-478-0015 for goods and services to meet basic needs;

(b) Up to five hundred sixty dollars per person to meet resettlement costs, if necessary, and for only one month while you receive temporary assistance.

(2) Within payment limits, repatriation assistance includes:

- (a) Travel to your place of residence, limited to:

(i) One domestic trip at the lowest fare and using the most direct means;

(ii) Meals and lodging while you are traveling;

(iii) Money for incidentals; and

(iv) If you are ill or disabled, travel expenses for an escort.

(b) Goods and services necessary for your health and welfare, including:

(i) Transportation for medical treatment, hospitalization or social services;

(ii) Temporary shelter;

(iii) Meals;

(iv) Clothing;

(v) Hospitalization to treat mental or acute illness or other medical care; and

(vi) Guidance, counseling and other social services.

(c) Resettlement costs, including:

(i) Utility or housing deposits; and

(ii) Basic household goods, such as cookware or blankets.

[Statutory Authority: RCW 74.08.090. 00-19-077, § 388-280-0060, filed 9/19/00, effective 11/1/00.]

Chapter 388-290 WAC

WORKING CONNECTIONS CHILD CARE

WAC

388-290-0001	What is the purpose of the working connections child care program?
388-290-0005	Who is considered a consumer for the WCCC program?
388-290-0010	What makes me eligible for WCCC benefits?
388-290-0012	When do I need to verify information?
388-290-0015	How does the WCCC program determine my family size for eligibility?
388-290-0020	Are there special circumstances that might affect my WCCC eligibility?
388-290-0025	What rights do I have when I apply for or receive WCCC benefits?
388-290-0030	What must I do when I apply for or receive WCCC benefits?
388-290-0031	What changes do I need to report when I apply for or receive WCCC?
388-290-0032	What are the consequences if I do not report changes within the specified time frames?
388-290-0035	What responsibilities does the WCCC program staff have?
388-290-0040	If I receive a temporary assistance for needy families (TANF) grant, what activities must I be involved in to be eligible for WCCC benefits?
388-290-0045	If I don't get a temporary assistance for needy families (TANF) grant, what activities must I be involved in to be eligible for WCCC benefits?
388-290-0050	If I am self-employed, can I get WCCC benefits?
388-290-0055	If I am not working or in an approved activity right now, can I get WCCC benefits?
388-290-0060	What income does the WCCC program count when determining eligibility and copayments?
388-290-0065	How does the WCCC program define and use my income?
388-290-0070	What income types and deductions does the WCCC program disregard when figuring my income eligibility and for WCCC benefits?
388-290-0075	What steps does the WCCC program take to determine my family's WCCC eligibility and copayment amount?
388-290-0082	When I am approved, how long is my eligibility period?
388-290-0085	When might my WCCC copayment change?
388-290-0090	When do I pay the minimum copayment?
388-290-0095	If I receive temporary assistance for needy families (TANF) and I am determined eligible for WCCC, when do my benefits begin?

		DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER	
388-290-0100	If I do not receive temporary assistance for needy families (TANF) and I am determined eligible for WCCC, when do my benefits begin?		
388-290-0105	How do I reapply for WCCC when my eligibility period is ending?	388-290-0080	When does the WCCC program determine and review my eligibility and copayments? [Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0080, filed 12/19/01, effective 1/19/02.] Repealed by 04-08-021 and 04-08-134, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25.
388-290-0107	When do I receive a denial letter?		
388-290-0108	What happens if I meet eligibility requirements after I receive a denial letter?		
388-290-0110	What circumstances might affect my eligibility for WCCC benefits and when might I be eligible again?	388-290-010	What is the purpose of the working connections child care program? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-010, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050. 98-21-005, § 388-290-010, filed 10/9/98, effective 11/9/98. Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-010, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-010, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-010, filed 11/8/95, effective 12/9/95.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-0115	When does the WCCC program provide me with advance and adequate notice of payment changes?		
388-290-0120	When doesn't advance and adequate notice of payment changes apply to me?		
388-290-0125	What child care providers can I choose under the WCCC program?		
388-290-0130	What in-home/relative providers can I choose under the WCCC program?		
388-290-0135	When I choose an in-home/relative provider, what information must I give the department?		
388-290-0138	What responsibilities does my eligible in-home/relative provider have?		
388-290-0140	When is my in-home/relative provider not eligible for WCCC payment?		
388-290-0143	Who must have a background check for the WCCC program and how often is the check done?		
388-290-0145	Why is a background check required and will I be notified of the results?	388-290-015	What basic steps does the department take to decide if I'm eligible for WCCC? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-015, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-015, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-0150	What information does the background check contain and where does it come from?		
388-290-0155	What happens after the WCCC program receives the background information?		
388-290-0160	What convictions would cause the WCCC program to permanently disqualify my in-home/relative provider?		
388-290-0165	Is there other background information or convictions that will disqualify my in-home/relative provider?	388-290-020	Subsidized child care—Definitions. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-020, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-020, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-020, filed 11/8/95, effective 12/9/95.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-0167	What happens if my in-home/relative provider, who provides care in their home, is disqualified based solely on the disqualifying background of an individual living with that provider?		
388-290-0180	When are the WCCC program subsidy rates in this chapter effective?		
388-290-0185	How does the WCCC program set rates when my child is five years old?		
388-290-0190	What does the WCCC program pay for and when can the program pay more?		
388-290-0200	What daily rates does DSHS pay for child care in a licensed or certified child care center or DSHS contracted seasonal day camps?	388-290-0210	When can the WCCC program authorize the nonstandard hour child care bonus? [Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0210, filed 12/19/01, effective 1/19/02.] Repealed by 04-08-021 and 04-08-134, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25.
388-290-0205	What daily rates does DSHS pay for child care in a licensed or certified family home child care?		
388-290-0220	How does DSHS determine that my child qualifies for a special needs daily rate?		
388-290-0225	What is the additional subsidy daily rate for children with special needs in a licensed or certified child care center or DSHS contracted seasonal day camp?	388-290-025	Subsidy units and copayments. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-025, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-025, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-0230	What is the additional subsidy daily rate for children with special needs in a licensed or certified family home child care?		
388-290-0235	What is the DSHS in-home/relative child care daily rate for children with special needs?		
388-290-0240	What is the DSHS child care subsidy rate for in-home/relative child care and how is it paid?		
388-290-0245	When can the WCCC program authorize payment of fees for registration?	388-290-0250	When can WCCC pay a bonus for enrolling an infant? [Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0250, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0250, filed 12/19/01, effective 1/19/02.] Repealed by 05-20-051, filed 9/30/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2005 c 518 § 207(3).
388-290-0247	When can the WCCC program authorize payment for field trip fees?		
388-290-0260	Who has a right to ask for a hearing and how do they ask for one?		
388-290-0265	When can I get WCCC benefits pending the outcome of a hearing?		
388-290-0270	What is a WCCC overpayment and what can be included?		
388-290-0271	When might I get an overpayment?		
388-290-0273	When would my licensed or certified provider or DSHS contracted seasonal day camp get an overpayment?	388-290-0255	When can the WCCC program establish a protective payee to pay my in-home/relative provider? [Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-
388-290-0274	When would my in-home/relative provider get an overpayment?		

	290-0255, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-290-0255, filed 6/28/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0255, filed 12/19/01, effective 1/19/02.] Repealed by 05-22-078, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085.		
388-290-030	Responsibilities for the department, the consumer, and the provider under the subsidized child care program. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-030, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.	388-290-090	Subsidized child care—Income eligibility, copayments rates, and when to calculate copayments. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-090, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-090, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-035	Providers eligible for payment under the subsidized child care program. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-035, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-035, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.	388-290-105	Subsidized child care—Overpayments. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-105, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.
388-290-040	Assurances and responsibilities under JOBS, income assistance, and transitional child care. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-040, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.	388-290-110	JOBS, income assistance, and transitional child care programs. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-110, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
388-290-050	Eligible children and consumers under the subsidized child care program. [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-050, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-050, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.	388-290-115	JOBS, income assistance, and transitional child care programs—Eligible children and recipients. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-115, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
388-290-055	Payment for subsidized child care. [Statutory Authority: RCW 74.04.050. 98-21-005, § 388-290-055, filed 10/9/98, effective 11/9/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-055, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.	388-290-120	JOBS, income assistance, and transitional child care program—Payment. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-120, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
388-290-060	Adequate notice requirements and effective dates. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-060, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.	388-290-123	JOBS, income assistance, and transitional child care programs—Effective dates. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-123, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
388-290-070	Self-employment and subsidized child care. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-070, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.	388-290-125	What activities can the department pay WCCC for if I get a temporary aid for needy families (TANF) grant? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-125, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-075	Who is a consumer in WCCC? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-075, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-130	Income assistance and transitional child care programs—Effect on eligibility and payments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-130, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
388-290-080	Subsidized child care—Fair hearings. [Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-080, filed 10/1/97, effective 11/1/97.] Repealed by 99-14-023, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99.	388-290-135	JOBS, income assistance, and transitional child care—Hearings. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 96-09-058 (Order 3965), § 388-290-135, filed 4/12/96, effective 5/13/96; 95-23-028 (Order 3916), § 388-290-135, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
		388-290-140	Income assistance child care program—Conversion. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-140, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
		388-290-150	What activities can the department pay WCCC for if I don't get a TANF grant? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-150, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

388-290-155	Transitional child care—Purpose and initial eligibility. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-155, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.		6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-160	Transitional child care—Co-payment. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-160, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.	388-290-375	How is the income that my family receives used in WCCC? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-375, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-170	Transitional child care—Ongoing eligibility. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-170, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.	388-290-400	What makes up a family in the WCCC program? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-400, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-180	Child care overpayments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-180, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.	388-290-450	What income does the department count in WCCC? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-450, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-450, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-200	Can the department pay WCCC if I'm self-employed? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-200, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-475	What income does the department exempt in WCCC? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-475, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-475, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-210	Other supportive services. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-210, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.		
388-290-250	Transitional supportive services. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-250, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.	388-290-500	What are the different kinds of income in WCCC the department uses to get my expected average monthly income? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-500, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-260	Supportive services overpayments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-260, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.		
388-290-270	Can the department authorize WCCC if I'm not working or in an approved activity right now? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-270, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-525	How does the department figure my expected average monthly income? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-525, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-280	Can the department pay WCCC for activity fees or bonuses? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-280, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-280, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-550	How does the department figure my adjusted earned income? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-550, filed 6/28/99, effective 7/1/99.] Repealed by 00-17-005, filed 8/2/00, effective 9/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule).
388-290-300	Which children and consumers can and cannot get WCCC? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-300, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-600	How does the department figure my countable income, and what is countable income used for? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-600, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-600, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-350	If I'm in an approved activity, what are the steps the department takes to figure my WCCC copayment? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-350, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-350, filed	388-290-650	How does the department figure my copayment, once my countable income is known? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-650, filed 8/2/00, effective 9/2/00; 99-14-023,

	§ 388-290-650, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-878	74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-700	Does the department set the minimum copayment if I'm a minor parent? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-700, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-882	Can I still use my chosen in-home/relative provider to care for my child(ren) if the provider has been convicted of a disqualifying crime? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-878, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-750	Are there other times when the department sets the minimum copayment? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-750, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-886	What convictions permanently disqualify my in-home/relative provider from being authorized by WCCC? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-882, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-800	When does the department calculate copayments? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-800, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-888	Are there some crimes that require a set amount of time to pass before my in-home/relative provider may be authorized for WCCC? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-886, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-850	What child care providers can the department pay under the WCCC program? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-850, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-850, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-900	When can I ask the department to review the decision to deny authorization of my in-home/relative provider? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-888, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-854	When will the department not pay toward the cost of in-home/relative child care? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-854, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-905	When can the department establish a protective payee to pay my in-home/relative provider? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-900, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-858	Why do we review your in-home/relative provider's criminal background information? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-858, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-910	What responsibilities does the department have under the WCCC program? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-905, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-905, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-862	When is a criminal background check required? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-862, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-915	What responsibilities do I have under the WCCC program? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-910, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-910, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-866	Where does the department get the criminal background information on the in-home/relative provider? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-866, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).	388-290-920	When do WCCC payments start? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-915, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-870	What does the department do with the criminal background information on the in-home/relative provider? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-870, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).		When does the department provide me with advance and adequate notice of WCCC payment changes? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund rule). 00-17-005, § 388-290-920, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-920, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
388-290-874	Will I be notified of the results of the criminal background information on my in-home/relative provider? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-874, filed 8/1/00, effective 8/2/00.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW		

- 388-290-925 When don't advance and adequate notice rules apply? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-925, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-925, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
- 388-290-930 Under what circumstances does my eligibility for WCCC end? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-930, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
- 388-290-935 When might I be eligible for WCCC again? [Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-935, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
- 388-290-940 Do I have the right to request a hearing? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-940, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-940, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
- 388-290-945 Can I receive WCCC pending the outcome of a hearing? [Statutory Authority: RCW 43.43.830, 43.43.832, and 74.15.020. 00-16-100, § 388-290-945, filed 8/1/00, effective 8/2/00. Statutory Authority: RCW 74.04.050, 74.13.0903, Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99. 99-14-023, § 388-290-945, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).
- 388-290-950 When does the department collect overpayments? [Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605 and 45 C.F.R. Parts 98 and 99 (Child Care and Development Fund Rules). 00-17-005, § 388-290-950, filed 8/2/00, effective 9/2/00; 99-14-023, § 388-290-950, filed 6/28/99, effective 7/1/99.] Repealed by 02-01-135, filed 12/19/01, effective 1/19/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules).

WAC 388-290-0001 What is the purpose of the working connections child care program? The purpose of working connections child care (WCCC) is to:

- (1) Help families with children pay child care costs for approvable activities to find jobs, keep their jobs, and get better jobs; and
- (2) Consider the health and safety of children while they are in care and receiving child care subsidies.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0001, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0001, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0005 Who is considered a consumer for the WCCC program? For the purposes of this chapter, "you" and "your" refer to the consumer. If you apply for or receive WCCC, we consider you to be the consumer.

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(1) In WCCC, an eligible consumer is one of the following individuals who has parental control of one or more children, lives in the state of Washington, and is the child's:

- (a) Parent, either biological or adopted;
- (b) Stepparent;
- (c) Legal guardian verified by a legal or court document;
- (d) Adult sibling or step-sibling;
- (e) Nephew or niece;
- (f) Aunt;
- (g) Uncle;
- (h) Grandparent; or
- (i) Any of the relatives in (f) through (h) of this subsection with the prefix great, such as great-aunt.

(2) You are not an eligible consumer when you:

- (a) Are the only parent in the household; and
- (b) Will be away from the home for more than thirty days in a row.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0005, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0005, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0010 What makes me eligible for WCCC benefits? For the purposes of this chapter "we" and "us" refer to the department of social and health services. You may be eligible for WCCC benefits if:

- (1) Your family is described under WAC 388-290-0015;
- (2) You are participating in an approved activity under WAC 388-290-0040, 388-290-0045, 388-290-0050, or have been approved per WAC 388-290-0055;
- (3) You and your children are eligible under WAC 388-290-0020;
- (4) Your countable income, is at or below two hundred percent of the federal poverty level (FPL) (under WAC 388-290-0065); and
- (5) Your share of the child care cost, called a copayment (under WAC 388-290-0075), is lower than the total DSHS maximum monthly payment for all children in the family who are eligible for subsidized care. We do not prorate your copayment when care is provided for part of a month.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0010, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-14-067, § 388-290-0010, filed 6/27/02, effective 8/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0010, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0012 When do I need to verify information? (1) When you apply for benefits, we require you to provide information that helps us decide your eligibility. We call this "verification."

(2) After you apply, we ask you to give us new verification when:

- (a) You report a change;
- (b) We find out that your circumstances have changed; or
- (c) The information we have is questionable, confusing or outdated.

(3) Whenever we ask for verification, we give you a notice as described in WAC 388-458-0020.

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(4) We accept any verification that you can easily get when it reasonably supports your statement or circumstances. The verification you give to us must:

- (a) Clearly relate to what you are trying to verify;
- (b) Be from a reliable source; and
- (c) Be accurate, complete, and consistent.

(5) We cannot make you give us a specific type or form of verification.

(6) If the only type of verification that you can get costs money, we pay for it.

(7) If the verification that you give to us is questionable or confusing, we may:

(a) Ask you to give us more verification or provide a collateral contact (a "collateral contact" is a statement from someone outside of your residence that knows your situation); or

(b) Send an investigator from the division of fraud investigations (DFI) to make an unannounced visit to your home to verify your circumstances. See WAC 388-290-0025(10).

(8) If you do not give us all of the verification that we have asked for, we determine if you are eligible based on the information that we already have. If we cannot determine that you are eligible based on this information, we deny or stop your benefits per WAC 388-290-0107 or 388-290-0115.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0012, filed 3/29/04 and 4/7/04, effective 5/28/04.]

WAC 388-290-0015 How does the WCCC program determine my family size for eligibility? We determine your family size by reviewing those individuals who live together in the same household as follows:

(1) If you are:	We count the following individuals as part of the family for WCCC eligibility:
(a) A single parent, including a minor parent living independently;	You and your children.
(b) Unmarried parents who have at least one mutual child;	Both parents and all their children living in the household.
(c) Unmarried parents with no mutual children;	Unmarried parents and their respective children living in the household as separate WCCC families.
(d) Married parents;	Both parents and all their children living in the household.
(e) Undocumented parents;	Parents and children, documented and undocumented, as long as the child needing care is a U.S. citizen or legally residing in the United States. All other family rules in this section apply.
(f) A consumer as defined in WAC 388-290-0005 (1)(c) through (i);	The children only. (The children and their income are counted.)

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(g) A minor parent with children and live with a parent/guardian;	Only the minor parent and their children.
(h) A family member who is out of the household because of employer requirements, such as the military or training, and is expected to return to the household.	You, the absent individual, and the children. Subsection (1)(b) and (d) of this section apply.
(i) A family member who is voluntarily out of the household for reasons other than requirements of the employer, such as unapproved schooling and visiting family members, and is expected to return to the household.	You, the absent individual and the children. Subsection (1)(b) and (d) of this section apply as well as WAC 388-290-0020.
(j) An incarcerated family member.	The absent individual is removed from the household. We count all remaining household members. All other family rules in this section apply.
(2) If your household includes:	We count the following individuals as part of the family for WCCC eligibility:
(a) Eighteen year old siblings of the children who require care and are enrolled in high school or general equivalency diploma (GED) program.	The eighteen year olds (unless they are a parent themselves), until they turn nineteen or complete high school/GED, whichever comes first. All other family rules in this section apply.
(b) Siblings of the children requiring care who are up to twenty-one years of age and who are participating in an approved program through the school district's special education department under RCW 28A.155.020.	The individual participating in an approved program through RCW 28A.155.020 up to twenty-one years of age (unless they are a parent themselves). All other family rules in this section apply.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0015, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0015, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0015, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0020 Are there special circumstances that might affect my WCCC eligibility? (1) You might be eligible for WCCC if you are:

(a) An employee of the same child care center where your children receive care and you do not provide direct care to your own children during the time WCCC is requested;

(b) A sanctioned WorkFirst participant or an applicant who was terminated by a sanction review panel and in an activity needed to remove a sanction penalty or to reopen your case;

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(c) A parent in a two-parent family and one parent is not able or available to provide care for your children while the other is working, looking for work, or preparing for work;

(i) "Able" means physically and mentally capable of caring for a child in a responsible manner. If you claim one parent is unable to care for the children, you must provide written documentation from a licensed professional (see WAC 388-448-0020) that states the:

(A) Reason the parent is unable to care for the children;

(B) Expected duration and severity of the condition that keeps them from caring for the children; and

(C) Treatment plan if the parent is expected to improve enough to be able to care for the children. The parent must provide evidence from a medical professional showing they are cooperating with treatment and are still unable to care for the children.

(ii) "Available" means free to provide care when not participating in an approved work activity under WAC 388-290-0040, 388-290-0045, 388-290-0050, or 388-290-0055 during the time child care is needed.

(d) A married consumer described under WAC 388-290-0005 (1)(d) through (i). Only you or your spouse must be participating in activities under WAC 388-290-0040, 388-290-0045, 388-290-0050, or 388-290-0055.

(2) You might be eligible for WCCC if your children are legally residing in the country, are living in Washington state, and are:

(a) Less than age thirteen; or

(b) Less than age nineteen, and:

(i) Have a verified special need, according to WAC 388-290-0220; or

(ii) Are under court supervision.

(3) Any of your children who receive care at the same place where you work (other than (1)(a) of this subsection) are not eligible for WCCC payments but can be included in your household if they meet WAC 388-290-0015. This includes if you work:

(a) In a family home child care in any capacity and your children are receiving care at the same home during your hours of employment; or

(b) In your home or another location and your children receive care at the same location during your hours of employment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.260, chapter 74.08A RCW. 06-10-035, § 388-290-0020, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0020, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0020, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0020, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0020, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0025 What rights do I have when I apply for or receive WCCC benefits? When you apply for or receive WCCC benefits you have the right to:

(1) Be treated politely and fairly without regard to race, color, creed, religion, sex, presence of any sensory, mental or physical disability, sexual orientation, political affiliation, national origin, religion, age, gender, disability, or birthplace;

(2) Have WCCC eligibility determined within thirty days from your application date per WAC 388-290-0100(2);

(3) Be informed, in writing, of your legal rights and responsibilities related to WCCC benefits;

(4) Only have your information shared with other agencies when required by federal or state regulations;

(5) Get a written notice at least ten days before we make changes to lower or stop benefits except as stated in WAC 388-290-0120;

(6) Ask for a fair hearing if you do not agree with us about a decision per WAC 388-290-0260.

(7) Ask a supervisor or administrator to review a decision or action affecting your benefits without affecting the right to a fair hearing;

(8) Have interpreter or translator service within a reasonable amount of time and at no cost to you;

(9) Choose your provider as long as the provider meets the requirements in WAC 388-290-0125; and

(10) Ask the fraud early detection (FRED) investigator from the division of fraud investigations (DFI) to come back at another time. You do not have to let an investigator into your home. You may ask the investigator to come back at another time. This request will not affect your eligibility for benefits. If you refuse to cooperate (provide the information requested) with the investigator, it could affect your benefits.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0025, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0025, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0030 What must I do when I apply for or receive WCCC benefits? When you apply for or receive WCCC benefits you must:

(1) Give us correct and current information so we can determine your eligibility and authorize child care payments correctly;

(2) Choose a provider who meets requirements of WAC 388-290-0125;

(3) Pay, or make a plan to have someone pay, your WCCC copayment directly to your child care provider;

(4) Leave your children with your provider while you are in WCCC approved activities. If you are not in an approved activity and you want to use the provider, you must make a plan to pay the provider yourself if the provider wants payment.

(5) If you use an in-home/relative provider, make sure care is being provided in the right home per WAC 388-290-0130.

(6) Cooperate (provide the information requested) with the quality assurance review process to remain eligible for WCCC. You become ineligible for WCCC benefits upon a determination of noncooperation by quality assurance and remain ineligible until you meet quality assurance requirements or thirty days from the determination of noncooperation.

(7) Cooperate with the fraud early detection (FRED) investigator. If you refuse to cooperate (provide the information requested) with the investigator, it could affect your benefits.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0030, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0030, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0030, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0031 What changes do I need to report when I apply for or receive WCCC? (1) Notify WCCC staff, within five days, of any change in providers;

(2) Notify your provider within ten days when we change your child care authorization;

(3) Provide notice to WCCC staff within ten days of any change in:

(a) The number of child care hours you need (more or less hours);

(b) Your household income, including any TANF grant or child support increases or decreases;

(c) Your household size such as any family member moving in or out of your home;

(d) Employment, school or approved TANF activity (starting, stopping or changing);

(e) The address and telephone number of your in-home/relative provider;

(f) Your home address and telephone number; and

(g) Your legal obligation to pay child support.

(4) Report to your child care authorizing worker, within twenty-four hours, any pending charges or conviction information you learn about your in-home/relative provider.

(5) Report to the child care authorizing worker, within twenty-four hours, any pending charges or conviction information you learn about anyone sixteen years of age and older who lives with the provider when care occurs outside of the child's home.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0031, filed 3/29/04 and 4/7/04, effective 5/28/04.]

WAC 388-290-0032 What are the consequences if I do not report changes within the specified time frames? If you fail to report any changes as required in WAC 388-290-0031 within the stated time frames, we may establish an overpayment per WAC 388-290-0271 or you might have to pay more than your normal share of child care costs, such as:

(1) Paying a higher copayment;

(2) Paying for extra hours of care when your activity requires more than ten hours a day of care;

(3) Receiving an overpayment for the number of days your child was absent including the absences the licensed/certified or DSHS seasonal contracted day care provider is allowed to bill (see publication *Child Care Subsidies, A Booklet for Licensed and Certified Child Care Providers*, DSHS 22-877). An overpayment for absent days can occur when care is used when you are not eligible for WCCC and can be up to five days a month;

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0032, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0032, filed 3/29/04 and 4/7/04, effective 5/28/04.]

(2007 Ed.)

WAC 388-290-0035 What responsibilities does the WCCC program staff have? The WCCC program staff are responsible to:

(1) Determine your eligibility within thirty days from the date you applied (application date as described in WAC 388-290-0100(2)).

(2) Allow you to choose your provider as long as they meet the requirements in WAC 388-290-0125;

(3) Review your chosen in-home/relative provider's background information.

(4) Authorize payments only to child care providers who allow you to see your children whenever they are in care;

(5) Only authorize payment when no adult in your WCCC family is "able or available" to care for your children (under WAC 388-290-0020).

(6) Inform you of:

(a) Your rights and responsibilities under the WCCC program at the time of application and reapplication;

(b) The types of child care providers we can pay;

(c) The community resources that can help you select child care when needed; and

(d) Any change in your copayment during the authorization period except under WAC 388-290-0120(5).

(7) Respond to you within ten days if you report a change of circumstance that affects your:

(a) WCCC eligibility;

(b) Copayment; or

(c) Providers.

(8) Provide prompt child care payments to your child care provider.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0035, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0035, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0035, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0035, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0040 If I receive a temporary assistance for needy families (TANF) grant, what activities must I be involved in to be eligible for WCCC benefits? If you receive a temporary assistance for needy families (TANF) grant, you may be eligible for WCCC benefits, for activities in your individual responsibility plan (IRP), for up to sixteen hours maximum per day for your hours of participation in the following:

(1) An approved WorkFirst activity under WAC 388-310-0200;

(2) Employment or self-employment. We consider "employment" or "work" to mean:

(a) Engaging in any legal, income generating activity that is taxable under the United States Tax Code or that would be taxable with or without a treaty between an Indian Nation and the United States; or

(b) Working in a federal or state paid work study program. You may receive WCCC for paid work study and transportation hours (not for the time you are in an unapproved activity).

(3) Transportation time between the location of child care and your place of employment or approved activity;

(4) Up to ten hours per week of study time before or after regularly scheduled classes or up to three hours of study time per day when needed to cover time between approved classes; and

(5) Up to eight hours per day of sleep time when it is needed, such as if you work nights and sleep days.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0040, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0040, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0040, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0045 If I don't get a temporary assistance for needy families (TANF) grant, what activities must I be involved in to be eligible for WCCC benefits?

(1) If you do not receive TANF, you may be eligible for WCCC benefits for up to sixteen hours maximum per day, including travel, study, and sleep time, for the hours of your participation in the following:

(a) Employment or self-employment under WAC 388-290-0050. We consider "employment" or "work" to mean:

(i) Legal, income generating activity taxable under the United States Tax Code or that would be taxable with or without a treaty between an Indian Nation and the United States.

(ii) Federal or state paid work study.

(b) VISTA volunteers, AmeriCorps, JobCorps, and Washington Service Corps (WSC) if the income is taxed.

(c) High school (HS) or general equivalency diploma (GED) program until you reach your twenty-second birthday (You can be enrolled in a HS or GED program without a minimum number of employment hours).

(d) Approved WorkFirst activities according to WAC 388-310-0200 if you are a TANF applicant.

(e) Food stamp employment and training program under chapter 388-444 WAC.

(2) If you are participating in an activity listed in subsections (3) through (8) of this section, you may be eligible for WCCC benefits as described in subsection (1) of this section if you are actually working either:

(a) Twenty or more hours per week; or

(b) Sixteen or more hours per week in a paid federal or state work study program.

(3) Adult basic education (ABE).

(4) English as a second language (ESL).

(5) High school or GED completion if you are twenty-two years of age or older.

(6) Vocational education (Voc Ed). The voc ed program:

(a) Must lead to a degree or certificate in a specific occupation.

(b) Cannot include prerequisite classes or programs.

(c) Is offered by the following accredited entities only:

(i) Public and private technical college or school.

(ii) Community college.

(iii) Tribal college.

(7) Job skills training for no more than fourteen consecutive days. Job skills training is not tied to a specific occupation but is training in specific skills directly related to employment, such as CPR/First Aid, keyboarding, computer programs, project management, and oral and written commu-

nication skills. Training offered or required by a current employer, at or off your job site, may extend past the fourteen consecutive day limit.

(8) Post-employment services under WAC 388-310-1800.

(9) Child care for participation in voc ed is limited to thirty-six months regardless of the length of the educational program. The thirty-six months includes the months in which the following occurred at the same time:

(a) WCCC benefits were paid to support your participation in a voc ed program.

(b) You or someone in your household received TANF benefits.

(10) WCCC may be approved for activities listed in WAC 388-290-0040 (3) through (5), when needed.

[Statutory Authority: RCW 74.12.340, 06-12-094, § 388-290-0045, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0045, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0045, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0045, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0050 If I am self-employed, can I get WCCC benefits? You may be eligible for WCCC benefits for up to sixteen hours maximum per day when you are self-employed.

(1) We consider "employment" or "work" to mean engaging in any legal, income generating activity that is taxable under the United States Tax Code or that would be taxable with or without a treaty between an Indian Nation and the United States;

(2) You are eligible for the calculation discussed in subsection (4)(a) of this section one time only, for one self-employment venture. If you change self-employment, any months left up to the first six months are covered by child care according to subsection (4)(a)(i) of this section.

(3) If you get TANF and are self-employed:

(a) You must have an approved self-employment plan under WAC 388-310-1700;

(b) The amount of WCCC you get for self-employment is equal to the number of hours in your approved plan; and

(c) Income from self-employment while you are receiving TANF is determined by WAC 388-450-0085.

(4) If you don't get TANF at the time of application for WCCC and it is a:

(a) New self-employment business (established less than six months):

(i) The hours of care you are eligible to receive for the first six months is based on your report of how many hours are needed, up to sixteen hours per day; and

(ii) Your self-employment income is based on WAC 388-290-0060.

(b) For a self-employment business (established for six months or more) the number of hours of care you are eligible to receive is based on whichever is more:

(i) Your work hours reported in your business records; or

(ii) The average number of monthly hours equal to dividing your monthly self-employment income by the federal or state minimum wage (whichever minimum wage is lower).

(c) After the first six months, the number of hours of WCCC you can get each month is based on the lesser of subsections (4)(b)(i) or (ii) of this section.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0050, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0050, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0050, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0055 If I am not working or in an approved activity right now, can I get WCCC benefits? When care is approved in the situations described in subsections (1) and (2) of this section, the child needs to attend for the provider to bill.

(1) We can authorize WCCC payments for a child's attendance in child care for up to fourteen consecutive days when you're waiting to enter an approved activity under WAC 388-290-0040 or 388-290-0045.

(2) We can authorize WCCC payments for a child's attendance in child care for up to twenty-eight consecutive days if you or the other parent in the household experience a gap in your approved activity.

(3) Your household may be eligible for payment described in subsection (2) of this section:

(a) Twice in a calendar year;

(b) For the same number of units open while you were in the approved activity, not to exceed two hundred thirty hours a month;

(c) If you report the loss of activity or employment timely following WAC 388-290-0031; and

(d) If you receive WCCC immediately before the loss of employment or approved activity, and:

(i) Your employment, or the approved activity, will resume within that period; or

(ii) You are looking for another job.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0055, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0055, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0055, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0060 What income does the WCCC program count when determining eligibility and copayments? The WCCC program counts income as money you get from:

(1) A TANF grant, except when exempt under WAC 388-290-0070 (1)(h);

(2) Child support payments;

(3) Supplemental Security Income (SSI);

(4) Other Social Security payments, such as SSA and SSDI;

(5) Refugee assistance payments;

(6) Payments from the Veterans' Administration, disability payments, or payments from labor and industries (L&I);

(7) Unemployment compensation;

(8) Other types of income not listed in WAC 388-290-0070;

(9) VISTA volunteers, Americorps, and Washington Service Corps (WSC) if the income is taxed;

(2007 Ed.)

(10) Gross wages from employment or self-employment. Gross wages includes any wages that are taxable. "Self-employment income" means your gross income from self-employment minus allowable business expenses in WAC 388-450-0085;

(11) Lump sums as money you get from a one-time payment such as back child support, an inheritance, or gambling winnings; and

(12) Income for the sale of property as follows:

(a) If you sold the property before application, we consider the proceeds an asset and do not count as income;

(b) If you sold the property in the month you apply or during your eligibility period, we count it as a lump sum payment as described in WAC 388-290-0065(3).

(c) Property does not include small personal items such as furniture, clothes, and jewelry.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0060, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0060, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0065 How does the WCCC program define and use my income? We use your countable income when determining your eligibility and copayment. Your countable income is the sum of all income listed in WAC 388-290-0060 minus any child support paid out (through a court order, division of child support administrative order, or tribal government order).

(1) To determine your income we:

(a) Determine the number of months, weeks or pay periods it took your family to earn the income and divide the income by the number of months, weeks or pay periods to get an average monthly amount; or

(b) Use the best available estimate of your family's current income when you begin new employment or if you don't have an income history to make an accurate estimate of your future income, we may ask your employer to verify your income.

(2) If you receive a lump sum payment (such as money from the sale of property or back child support payment) in the month of application or during your WCCC eligibility we:

(a) Divide the lump sum payment by twelve to come up with a monthly amount; and

(b) Add the monthly amount to your expected average monthly income for the month it was received and the remaining months of the current authorization period;

(c) You must meet income guidelines for WCCC after the lump sum payment is applied to remain eligible for WCCC.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0065, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0065, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0070 What income types and deductions does the WCCC program disregard when figuring my income eligibility and for WCCC benefits? (1) The WCCC program does not count the following income types when figuring your income eligibility and copayment:

[Title 388 WAC—p. 753]

(a) Income types as defined in WAC 388-450-0035, 388-450-0040, and 388-450-0055;

(b) Compensatory awards, such as an insurance settlement or court-ordered payment for personal injury, damage, or loss of property;

(c) Adoption support assistance and foster care payments;

(d) Reimbursements, such as an income tax refund;

(e) Diversion cash assistance;

(f) Income in-kind that is untaxed, such as working for rent;

(g) Military housing and food allowance;

(h) The TANF grant for the first three consecutive calendar months after you start a new job. The first calendar month is the month in which you start working;

(i) Payments to you from your employer for benefits such as medical plans;

(j) Earned income of a WCCC family member defined under WAC 388-290-0015(2);

(k) Income of consumers described in WAC 388-290-0005 (1)(c) through (i);

(l) Earned income from a minor child who we count as part of your WCCC household; and

(m) Benefits received by children of Vietnam War veterans who are diagnosed with all forms or manifestations of spina bifida (except spina bifida occulta).

(2) WCCC deducts the amount you pay for child support under court order, division of child support administrative order, or tribal government order, from your other countable income when figuring your eligibility and copay for the WCCC program.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0070, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0070, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0075 What steps does the WCCC program take to determine my family's WCCC eligibility and copayment amount? (1) The WCCC program takes the following steps to determine your WCCC income eligibility and copayment:

(a) Determine your family size (under WAC 388-290-0015); and

(b) Determine your countable income (under WAC 388-290-0065).

(2) If your family's countable monthly income falls within the range below, then your copayment is:

YOUR INCOME	YOUR COPAYMENT is:
At or below 82% of the FPL	\$15
Above 82% of the FPL up to 137.5% of the FPL	\$50
Above 137.5% of the FPL -200% of the FPL	The dollar amount equal to subtracting 137.5% of FPL from countable income, multiplying by 44%, then adding \$50
Income above 200% of the FPL, you are not eligible for WCCC benefits.	

(3) We do not prorate the copayment when you use care for part of a month.

[Title 388 WAC—p. 754]

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0075, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-067, § 388-290-0075, filed 6/27/02, effective 8/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0075, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0082 When I am approved, how long is my eligibility period? We can approve you for a period up to six months. Your eligibility can end prior to your end date as stated in WAC 388-290-0110.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0082, filed 3/29/04 and 4/7/04, effective 5/28/04.]

WAC 388-290-0085 When might my WCCC copayment change? (1) Once we determine that you are eligible for WCCC benefits, your copayment could change when:

(a) Your monthly income decreases;

(b) Your family size increases;

(c) We make an error in your copayment computation;

(d) You did not report all income, activity and household information;

(e) You are no longer eligible for the minimum copayment under WAC 388-290-0090;

(f) We make a mass change in benefits due to a change in law or program funding; or

(g) You are approved for a new eligibility period.

(2) If your copayment changes during your eligibility period, the change is effective the first of the month following our becoming aware of the change.

(3) We do not increase your copayment during your current eligibility period when your countable income remains at or below two hundred percent of the FPL, and:

(a) Your monthly countable income increases; or

(b) Your family size decreases.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0085, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-067, § 388-290-0085, filed 6/27/02, effective 8/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0085, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0090 When do I pay the minimum copayment? You pay the minimum copayment:

(1) If your countable monthly income is at or below eighty-two percent of the FPL;

(2) If you are a minor parent, and are:

(a) Receiving TANF; or

(b) Part of your parent's or relative's TANF assistance unit.

(3) For the first full month following the month you get a job or apply for WCCC and we pay benefits;

(4) If there is a break of at least thirty days in your WCCC benefits due to your activity ending; or

(5) If you received child care benefits within the last thirty days immediately prior to the eligibility period and you do not meet the qualifications in subsections (1) through (4) of this section, your copayment will be computed according to WAC 388-290-0075.

(2007 Ed.)

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0090, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0090, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0095 If I receive temporary assistance for needy families (TANF) and I am determined eligible for WCCC, when do my benefits begin? When you receive TANF, and are eligible for WCCC, your benefits begin when your eligible provider (under WAC 388-290-0125) is caring for your children and you are participating in an approved activity under WAC 388-290-0040 or 388-290-0055.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0095, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0095, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0095, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0100 If I do not receive temporary assistance for needy families (TANF) and I am determined eligible for WCCC, when do my benefits begin? (1) If you do not receive TANF and are eligible for WCCC your benefits begin as described in WAC 388-290-0055(1) or the date you apply for WCCC and the following requirements are met:

- (a) You have turned in all your information within thirty days of your application date;
- (b) You meet all eligibility requirements; and
- (c) Your eligible provider (under WAC 388-290-0125) is caring for your children.
- (2) Your application date is whichever is earlier:
 - (a) The date your application is entered into our automated system; or
 - (b) The date your application is date stamped as received.
- (3) If you fail to turn in all your information within thirty days from your application date you must restart your application process. Your begin date for benefits is described in subsection (2) of this section.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0100, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0100, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0105 How do I reapply for WCCC when my eligibility period is ending? (1) If you want to receive child care benefits for another eligibility period you must reapply for WCCC benefits before your current eligibility period ends. We determine if you are eligible by:

- (a) Requesting application information prior to the end date of your current WCCC eligibility period; and
- (b) Verifying the requested information for completeness and accuracy.
- (2) You may be eligible for WCCC benefits for a new eligibility period if:
 - (a) Your application information is received no later than the last day of your current eligibility period;
 - (b) Your provider is eligible for payment under WAC 388-290-0125; and

(2007 Ed.)

(c) You meet all WCCC eligibility requirements.

(3) If you are determined eligible for WCCC benefits based on your application information, we notify you of your new eligibility period and copayment.

(4) If you provide the requested application information to us anytime after your eligibility period ends, you are determined eligible for WCCC and you:

(a) Receive TANF, your benefit begins when:

- (i) You are participating in your approved activity, and
- (ii) Your eligible provider (under WAC 388-290-0125) is caring for your child.

(b) Do not receive TANF, your benefit begin date is the date your:

(i) Application is date stamped as received or entered into our automated system;

(ii) Eligible provider (under WAC 388-290-0125) is caring for your child; and

(iii) Participation in an approved activity has started.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0105, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0105, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0105, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0107 When do I receive a denial letter? We send you a denial letter when you have applied for child care and you:

(1) Withdraw your request;

(2) Are not eligible due to your:

(a) Family composition;

(b) Income; or

(c) Activity.

(3) Did not provide information necessary to determine your eligibility according to WAC 388-290-0012.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0107, filed 3/29/04 and 4/7/04, effective 5/28/04.]

WAC 388-290-0108 What happens if I meet eligibility requirements after I receive a denial letter? If you turn in information or otherwise meet eligibility requirements after we send you a denial letter, we determine your benefit begin date by:

(1) WAC 388-290-0095 if you are TANF; or

(2) WAC 388-290-0100 if you are non-TANF.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0108, filed 3/29/04 and 4/7/04, effective 5/28/04.]

WAC 388-290-0110 What circumstances might affect my eligibility for WCCC benefits and when might I be eligible again? (1) We stop your eligibility for WCCC benefits when you do not:

(a) Pay copayment fees assessed by us and you do not make mutually acceptable arrangements with your child care provider to pay the copayment;

(b) Complete the requested reapplication before the deadline noted in WAC 388-290-0105 (2)(a);

(c) Meet other WCCC eligibility requirements related to family size, income and approved activities; or

[Title 388 WAC—p. 755]

(d) Cooperate with the quality assurance review process or with the division of fraud investigations.

(2) You might be eligible for WCCC again when you meet all WCCC eligibility requirements, and:

- (a) Back copayment fees are paid;
- (b) You make mutually acceptable payment arrangements with your child care provider; or
- (c) You cooperate with the quality assurance review process or with the division of fraud investigations.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0110, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0110, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0115 When does the WCCC program provide me with advance and adequate notice of payment changes? (1) The WCCC program provides you with advance and adequate notice for changes in payment when the change results in a suspension, reduction, termination, or forces a change in child care arrangements, except as noted in WAC 388-290-0120.

(2) "Advance and adequate notice," means a written notice of a WCCC reduction, suspension, or termination that is mailed at least ten days before the date of the intended action which includes the Washington Administrative Code (WAC) supporting the action, and your right to request a fair hearing.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0115, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0120 When doesn't advance and adequate notice of payment changes apply to me? We do not give you advance and adequate notice in the following circumstances:

- (1) You tell us you no longer want WCCC;
- (2) Your whereabouts are unknown to us;
- (3) You are receiving duplicate child care benefits;
- (4) Your current eligibility period is scheduled to end;
- (5) Your new eligibility period results in a change in child care benefits;
- (6) The location where child care occurs does not meet requirements under WAC 388-290-0130(2); or
- (7) We determine your in-home/relative provider:
 - (a) Is not of suitable character and competence;
 - (b) May cause a risk of harm to your children based on the provider's physical or mental health; or
 - (c) Has been convicted of, or has charges pending for crimes posted on the DSHS secretary's list of permanently disqualifying convictions for ESA. You can find the complete list at <http://www1.dshs.wa.gov/esa/dccel/>.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0120, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0120, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0120, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0125 What child care providers can I choose under the WCCC program? To receive payment under the WCCC program, your child care provider must be:

- (1) Licensed as required by chapter 74.15 RCW and chapters 388-155, 388-295, or 388-151 WAC;
- (2) Meeting their states licensing regulations, for providers who care for children in states bordering Washington. We pay the lesser of the following to qualified child care facilities in bordering states:
 - (a) The provider's usual daily rate for that child; or
 - (b) The DSHS maximum child care subsidy daily rate for the DSHS region where the child resides.
- (3) Exempt from licensing but certified by us, such as:
 - (a) Tribal child care facilities that meet the requirements of tribal law;
 - (b) Child care facilities on a military installation; and
 - (c) Child care facilities operated on public school property by a school district.
- (4) Seasonal day camps that have a contract with us to provide subsidized child care and are:
 - (a) Of a duration of three months or less;
 - (b) Engaged primarily in recreational or educational activities; and
 - (c) Accredited by the American Camping Association (ACA).
- (5) An in-home/relative provider meeting the requirements in WAC 388-290-0130.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0125, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0125, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0125, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0130 What in-home/relative providers can I choose under the WCCC program? (1) To be eligible as an in-home/relative provider the person must:

- (a) Be an adult who is a U.S. citizen or legally residing in the United States;
- (b) Meet the requirements in WAC 388-290-0135; and
- (c) Be one of the following adults providing care in the home of either the child or the adult:
 - (i) A sibling living outside the child's home;
 - (ii) An extended tribal family member according to chapter 74.15 RCW; or
 - (iii) A grandparent, aunt, uncle, or great-grandparent, great-aunt or great-uncle.
- (2) An adult not listed in (1)(c)(i), (ii), or (iii) of this section must:
 - (a) Meet the requirements in subsection (1)(a) and (b) of this section; and
 - (b) Provide care in the child's home.
- (3) If you use an in-home/relative provider you can:
 - (a) Have no more than two in-home/relative providers authorized for payment during your eligibility period at the same time (not including back-up providers);
 - (b) Have one back up provider (licensed or an in-home/relative provider).

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0130, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021

and 04-08-134, § 388-290-0130, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0130, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0130, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0135 When I choose an in-home/relative provider, what information must I give the department? When you choose in-home/relative child care, you must complete certain forms and give us the following:

- (1) The in-home/relative child care provider's legal name, address and telephone number;
- (2) A copy of the provider's valid Social Security card;
- (3) A copy of the provider's photo identification;
- (4) A completed background check authorization; and
- (5) A form supplied by us, completed and signed by you and the provider in which both of you attest to the following:
 - (a) The provider is:
 - (i) Of suitable character and competence;
 - (ii) Of sufficient physical and mental health to meet the needs of the children in care. If we request it, you must provide written evidence that the in-home child care provider of your choice is of sufficient physical and mental health to be a safe child care provider;
 - (iii) Able to work with the children without using corporal punishment or psychological abuse;
 - (iv) Able to accept and follow instructions;
 - (v) Able to maintain personal cleanliness;
 - (vi) Prompt and regular in job attendance;
 - (vii) Informed about basic health practices, prevention and control of infectious disease, immunizations; and
 - (viii) Able to provide constant care, supervision and activities based on the child's developmental needs.
 - (b) The children are current on the immunization schedule as described in the National Immunization Guidelines, developed by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices;
 - (c) The home where care is provided is safe for the care of the children.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085, 05-22-078, § 388-290-0135, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25, 04-08-021 and 04-08-134, § 388-290-0135, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0135, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0135, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0138 What responsibilities does my eligible in-home/relative provider have? Your in-home/relative provider must:

- (1) Report within ten days changes in their legal name, address or telephone number;
- (2) Report within twenty-four hours pending charges or convictions they have;
- (3) Report within twenty-four hours pending charges or convictions for anyone sixteen years of age and older who lives with the provider when care occurs outside of the child's home;
- (4) Bill WCCC only for care he/she provided;
- (5) Not bill WCCC for more than six children at one time for the same hours of care; and
- (6) Keep correct attendance records. Records must:

- (a) Show both days and times the care was provided;
- (b) Be kept for five years; and
- (c) Be given to us, within fourteen consecutive calendar days, if we ask for them.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085, 05-22-078, § 388-290-0138, filed 10/31/05, effective 12/1/05.]

WAC 388-290-0140 When is my in-home/relative provider not eligible for WCCC payment? We do not pay for the cost of in-home/relative care if:

- (1) Your provider does not meet the requirements in WAC 388-290-0130, 388-290-0135, and 388-290-0138;
- (2) Your in-home/relative provider has been convicted of, or has charges pending for crimes posted on the DSHS secretary's crime and action list for background checks for ESA. You can find the complete list at <http://www1.dshs.wa.gov/esa/dccel/policy.shtml>;
- (3) We do not have background check results according to WAC 388-290-0143;
- (4) The provider is:
 - (a) The child's biological, adoptive or step-parent;
 - (b) The child's nonneedy or needy relative or relative's spouse or live-in partner;
 - (c) The child's legal guardian or the guardian's spouse or live-in partner; or
 - (d) Another adult acting in loco parentis or that adult's spouse or live-in partner.
- (5) We do not have the results of all applicable criminal background checks under WAC 388-290-0143(1) and 388-290-0150. An in-home/relative provider is not an eligible provider (per WAC 388-290-0095 and 388-290-0100) prior to receiving these background results. Providers other than in-home/relative providers you can use are described in WAC 388-290-0125; or
- (6) We determine your provider is not of suitable character and competence or of sufficient physical or mental health to meet the needs of the child in care, or the household may be at risk of harm by this provider, as indicated by information other than conviction information. We will use criteria, such as the following, when reviewing information about incidents/issues/reports/findings:

- (a) Recency;
- (b) Seriousness;
- (c) Type;
- (d) Frequency; and
- (e) Relationship to the direct care of a child including health, mental health, learning, and safety.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085, 05-22-078, § 388-290-0140, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25, 04-08-021 and 04-08-134, § 388-290-0140, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0140, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0143 Who must have a background check for the WCCC program and how often is the check done? (1) A background check must be completed for:

- (a) All in-home/relative providers who apply to care for a WCCC consumer's child; and

(b) Any individual sixteen years of age or older who is residing with a provider when care occurs outside of the child's home.

(2) A background check must be completed for individuals listed in subsection (1)(a) and (b) of this section at least every two years.

(3) Additional background checks must be completed for individuals listed in subsection (1)(a) and (b) of this section when:

(a) Any individual sixteen years of age or older is newly residing with a provider when care occurs outside of the child's home;

(b) We have a valid reason to do a check more frequently;

(c) An in-home/relative provider applies to provide care for a family, such as when:

(i) A break in service occurs to the current consumer;

(ii) There is a break in consumer eligibility; or

(iii) A provider is currently providing care and there are no prior background results for this provider.

(4) We do not need to request a new background check for an individual in subsection (1)(a) or (b) if:

(a) We have results that were received no more than ninety days prior to the current requested start date of care; and

(b) The results indicate that there is no record.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0143, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-14-066, § 388-290-0143, filed 6/27/02, effective 7/1/02.]

WAC 388-290-0145 Why is a background check required and will I be notified of the results? (1) We require the background check to:

(a) Help safeguard the health, safety, and well-being of children;

(b) Reduce the possible risk of harm from persons who have been convicted or have charges pending of certain crimes having access to WCCC children; and

(c) Help you make informed decisions about individuals who have access to your children.

(2) We notify you, the WCCC consumer:

(a) Whether we can approve the provider for the WCCC program; and

(b) Of the following results from the background check:

(i) No background information is found given current sources of information;

(ii) Background information is found, but the information will not disqualify the individual being checked; or

(iii) Background information is found that disqualifies the individual being checked.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0145, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-14-066, § 388-290-0145, filed 6/27/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0145, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0150 What information does the background check contain and where does it come from?

(1) The background information includes, at a minimum, criminal convictions and pending charges.

(2) Additional sources may include:

(a) Child/adult protective service case information; and

(b) Civil judgments, determinations, or disciplinary board final decisions of abuse or neglect.

(3) We obtain background information, at a minimum, from the Washington state patrol under chapter 10.97 RCW via the background check central unit (BCCU).

(4) Additional sources of the background information may be obtained from:

(a) Child/adult protective service case files;

(b) Other states and federally recognized Indian tribes;

(c) The department of corrections and the courts;

(d) Law enforcement records of convictions and pending charges in other states or locations if:

(i) The individual being checked has lived in another state; and

(ii) Reports from credible community sources indicate a need to investigate another state's records.

(e) The individual being checked self-discloses information.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0150, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-14-066, § 388-290-0150, filed 6/27/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0150, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0155 What happens after the WCCC program receives the background information? After we receive the background information we:

(1) Compare the background information with convictions posted on the DSHS secretary's crime and action list for background checks for economic services administration (ESA). You can find the complete list at <http://www1.dshs.wa.gov/esa/dccel/policy.shtml>.

(2) Review the background information using the following rules:

(a) We give the same weight to a pending charge for a crime as a conviction;

(b) If the conviction has been renamed, we give the same weight as the previous named conviction. For example, larceny is now called theft;

(c) We give convictions whose titles are preceded with the word "attempted" the same weight as those titles without the word "attempted"; and

(d) We do not consider the crime a conviction for the purposes of WCCC when:

(i) It has been pardoned; or

(ii) A court of law acts to expunge, dismiss, or vacate the conviction record.

(3) Notify you whether or not we are able to approve the provider for WCCC.

(4) Allow you, the consumer, to decide character and suitability of the provider when an individual is not automatically disqualified due to the background information from the record of arrests and prosecutions (RAP) sheet.

(5) Deny or stop payment when the background information disqualifies the individual being checked.

(6) Assist you in finding other child care arrangements.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0155, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0155, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-066, § 388-290-0155, filed 6/27/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0155, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0160 What convictions would cause the WCCC program to permanently disqualify my in-home/relative provider? (1) If your provider or an individual listed in WAC 388-290-0143(1) has a background containing a permanently disqualifying conviction posted on the DSHS secretary's list of disqualifying convictions for ESA, we permanently disqualify the person as an in-home/relative child care provider for WCCC. You can find the complete list at <http://www1.dshs.wa.gov/esa/dccel/>.

(2) If the conditions in WAC 388-290-0167 (1)(a) and (b) are met, the disqualifying background of an individual sixteen years of age or over living with the provider may not permanently disqualify the provider.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0160, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-066, § 388-290-0160, filed 6/27/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0160, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0165 Is there other background information or convictions that will disqualify my in-home/relative provider? (1) We can disqualify your in-home/relative provider if the individual being checked has a background containing information other than conviction information that we determine:

(a) Makes the individual not of suitable character and competence or of sufficient physical or mental health to meet the needs of the child in care; or

(b) Puts the household at risk for harm.

(2) If an individual being checked has a background containing a five-year disqualifying conviction posted on the DSHS secretary's list of disqualifying convictions for ESA, your provider is disqualified as an in-home/relative child care provider for WCCC for five years after the conviction date. You can find the complete list at <http://www1.dshs.wa.gov/esa/dccel/>.

(3) If an individual being checked has:

(a) A conviction listed in subsection (2) of this section, and it has been more than five years; or

(b) Any conviction other than those posted on the DSHS secretary's list of disqualifying convictions for ESA we will allow you to determine the provider's character, suitability, and competence by reviewing important information such as the:

- (i) Amount of time that has passed since the conviction;
- (ii) Seriousness of the crime that led to the conviction;
- (iii) Individual's age at the time of conviction;
- (iv) Individual's behavior since the conviction;

(v) Number and types of convictions in the individual's background; and

(vi) Individual's verification, if any, of successful completion of all court-ordered programs and restitution.

(4) If conditions in WAC 388-290-0167 (1)(a) and (b) are met, the disqualifying background of an individual sixteen years of age or over living with the provider may not disqualify the provider.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0165, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-066, § 388-290-0165, filed 6/27/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0165, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0167 What happens if my in-home/relative provider, who provides care in their home, is disqualified based solely on the disqualifying background of an individual living with that provider? (1) If we disqualify your provider based solely on the disqualifying background of an individual living with that provider, we require that:

(a) Child care occurs in the child's home away from the disqualified individual, if you wish to continue using that provider; and

(b) The parent and provider sign an agreement with us indicating that:

(i) Care occurs in the child's home; and

(ii) There is no contact between the child and disqualified individual during child care hours.

(2) The parent may choose a licensed provider or submit an application for a different in-home/relative provider.

(3) If we become aware that the parent and provider are not meeting the conditions in subsection (1)(a) and (b) of this section:

(a) We terminate care without advance and adequate notice;

(b) You need to find a different provider; and

(c) You may be subject to an overpayment under WAC 388-290-0270.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0167, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-14-066, § 388-290-0167, filed 6/27/02, effective 7/1/02.]

WAC 388-290-0180 When are the WCCC program subsidy rates in this chapter effective? DSHS child care subsidy rates in this chapter are effective on or after November 1, 2005.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2005 c 518 § 207(3). 05-20-051, § 388-290-0180, filed 9/30/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0180, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0180, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0185 How does the WCCC program set rates when my child is five years old? The rate paid for a five year old child is:

(1) The preschool rate for a child who has not entered kindergarten; or

(2) The school-age rate for a child who has entered kindergarten.

[Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0185, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0190 What does the WCCC program pay for and when can the program pay more? (1) We may pay for:

(a) Basic child care hours, either full-day, half-day or hourly. We authorize:

(i) Full-day child care to licensed or certified facilities and DSHS contracted seasonal day camps when your children need care for five or more hours per day;

(ii) Half-day child care to licensed or certified facilities and DSHS contracted seasonal day camps when your children need care for less than five hours per day; and

(iii) Hourly child care for in-home/relative child care.

(b) A registration fee (under WAC 388-290-0245);

(c) A field trip fee (under WAC 388-290-0245); and

(d) Special needs care when the child has a documented need for higher level of care (under WAC 388-290-0220, 388-290-0225, 388-290-0230, and 388-290-0235).

(2) We may authorize up to the provider's usual daily rate if:

(a) The parent is a mandatory WorkFirst participant; and

(b) Appropriate child care, at the DSHS rate, is not available within a reasonable distance from the home or work (activity) site. "Appropriate" means child care approvable under WAC 388-290-0125. "Reasonable distance" is determined by comparing what other local families must travel to access appropriate child care.

(3) We authorize an additional amount of care if:

(a) More than ten hours of care is provided per day; and

(b) The provider's policy is to charge all families for these extra hours.

[Statutory Authority: RCW 74.12.340. 06-12-094, § 388-290-0190, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2005 c 518 § 207(3). 05-20-051, § 388-290-0190, filed 9/30/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0190, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0190, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0190, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0200 What daily rates does DSHS pay for child care in a licensed or certified child care center or DSHS contracted seasonal day camps? (1) We pay the lesser of the following to a licensed or certified child care center or DSHS contracted seasonal day camp:

(a) The provider's usual daily rate for that child; or

(b) The DSHS maximum child care subsidy daily rate for that child as listed in the following table:

		Infants (One month - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 12 yrs)
Region 1	Full-Day	\$25.89	\$21.77	\$20.57	\$19.36
	Half-Day	\$12.95	\$10.89	\$10.29	\$9.68
Spokane	Full-Day	\$26.48	\$22.27	\$21.04	\$19.80
County	Half-Day	\$13.25	\$11.14	\$10.53	\$9.90
Region 2	Full-Day	\$26.14	\$21.83	\$20.23	\$17.91
	Half-Day	\$13.07	\$10.92	\$10.12	\$8.96

		Infants (One month - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 12 yrs)
Region 3	Full-Day	\$34.60	\$28.84	\$24.92	\$24.20
	Half-Day	\$17.30	\$14.42	\$12.46	\$12.10
Region 4	Full-Day	\$40.27	\$33.63	\$28.21	\$25.40
	Half-Day	\$20.14	\$16.82	\$14.11	\$12.70
Region 5	Full-Day	\$29.52	\$25.40	\$22.36	\$19.85
	Half-Day	\$14.76	\$12.70	\$11.18	\$9.93
Region 6	Full-Day	\$29.03	\$24.92	\$21.77	\$21.29
	Half-Day	\$14.52	\$12.46	\$10.89	\$10.65

(2) The child care center WAC 388-295-0010 allows providers to care for children from one month up to and including the day before their thirteenth birthday. The provider must obtain a child-specific and time-limited waiver from their child care licensor to provide care for a child outside the age listed on their license.

(3) If the center provider cares for a child who is thirteen or older, the provider must have a child-specific and time-limited waiver and the child must meet the special needs requirement according to WAC 388-290-0220.

(4) Rates for Spokane County are subject to special funding allocated by the Legislature in the state operating budget. If the special funds are not allocated Region 1 rates apply to Spokane County.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2005 c 518 § 207(3). 05-20-051, § 388-290-0200, filed 9/30/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0200, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0200, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0200, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0205 What daily rates does DSHS pay for child care in a licensed or certified family home child care? (1) We pay the lesser of the following to a licensed or certified family home child care:

(a) The provider's usual daily rate for that child; or

(b) The DSHS maximum child care subsidy daily rate for that child as listed in the following table.

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 11 yrs)
Region 1	Full-Day	\$21.29	\$19.16	\$19.16	\$17.04
	Half-Day	\$10.65	\$9.58	\$9.58	\$8.52
Spokane	Full-Day	\$21.78	\$19.60	\$19.60	\$17.43
County	Half-Day	\$10.89	\$9.80	\$9.80	\$8.71
Region 2	Full-Day	\$21.29	\$20.23	\$18.10	\$18.10
	Half-Day	\$10.65	\$10.12	\$9.05	\$9.05
Region 3	Full-Day	\$30.88	\$26.62	\$23.42	\$21.29
	Half-Day	\$15.44	\$13.31	\$11.71	\$10.65
Region 4	Full-Day	\$31.94	\$31.59	\$26.62	\$25.55
	Half-Day	\$15.97	\$15.80	\$13.31	\$12.78
Region 5	Full-Day	\$23.42	\$21.29	\$20.23	\$18.10
	Half-Day	\$11.71	\$10.65	\$10.12	\$9.05
Region 6	Full-Day	\$23.42	\$21.29	\$21.29	\$20.23
	Half-Day	\$11.71	\$10.65	\$10.65	\$10.12

(2) The family home child care WAC 388-296-0020 and 388-296-1350 allows providers to care for children from birth up to and including the day before their twelfth birthday. The provider must obtain a child-specific and time-limited waiver from their child care licensor to provide care for a child outside the age listed on their license. If the provider has a waiver to care for a child who has reached their twelfth

birthday, the payment rate is the same as subsection (1) and the five to eleven year age range column is used for comparison.

(3) If the family home provider cares for a child who is thirteen or older, the provider must have a child-specific and time-limited waiver and the child must meet the special needs requirement according to WAC 388-290-0220.

(4) We pay family home child care providers at the licensed home rate regardless of their relation to the children (with the exception listed in subsection (5) of this section). Refer to subsection (1) and the five to eleven year age range column for comparisons.

(5) We cannot pay family home child care providers to provide care for children in their care if the provider is:

- (a) The child's biological, adoptive or step-parent;
- (b) The child's nonneedy or needy relative or that relative's spouse or live-in partner;
- (c) The child's legal guardian or the guardian's spouse or live-in partner; or
- (d) Another adult acting in loco parentis or that adult's spouse or live-in partner.

(6) Rates for Spokane County are subject to special funding allocated by the Legislature in the state operating budget. If the special funds are not allocated Region 1 rates apply to Spokane County.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2005 c 518 § 207(3), 05-20-051, § 388-290-0205, filed 9/30/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25, 04-08-021 and 04-08-134, § 388-290-0205, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0205, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0205, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0220 How does DSHS determine that my child qualifies for a special needs daily rate? To qualify for the DSHS child care programs special needs subsidy daily rate your child must either:

- (1) Be thirteen to nineteen years old and be under court supervision; or
- (2) Be under nineteen years old, and;
- (a) Have a verified physical, mental, emotional, or behavioral condition that requires a higher level of care while in the care of the licensed or certified facility, a DSHS contracted seasonal day camp or in-home/relative provider; and
- (b) Have their condition and need for higher level of care verified by an individual who is not employed by the child care facility and is either a:
 - (i) Health, mental health, education or social service professional with at least a master's degree; or
 - (ii) Registered nurse.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25, 04-08-021 and 04-08-134, § 388-290-0220, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0220, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0225 What is the additional subsidy daily rate for children with special needs in a licensed or certified child care center or DSHS contracted seasonal day camp? (1) In addition to the rate listed in WAC 388-290-0200, we authorize special needs daily rates to licensed or

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certified child care centers or DSHS contracted seasonal day camps according to whichever of the following is greater:

- (a) The provider's reasonable documented additional cost associated with the care of the child; or
- (b) The daily rate listed in the table below after you have verified that your child has a special need and requires a higher level of care according to WAC 388-290-0220:

		Infants (One month - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 12 yrs)
Region 1	Full-Day	\$7.30	\$6.14	\$5.80	\$5.45
	Half-Day	\$3.65	\$3.07	\$2.90	\$2.73
Region 2	Full-Day	\$7.36	\$6.15	\$5.70	\$5.05
	Half-Day	\$3.68	\$3.08	\$2.85	\$2.52
Region 3	Full-Day	\$9.75	\$8.13	\$7.02	\$6.82
	Half-Day	\$4.88	\$4.06	\$3.51	\$3.41
Region 4	Full-Day	\$11.35	\$9.48	\$7.95	\$7.16
	Half-Day	\$5.67	\$4.74	\$3.98	\$3.58
Region 5	Full-Day	\$8.32	\$7.16	\$6.30	\$5.59
	Half-Day	\$4.16	\$3.58	\$3.15	\$2.80
Region 6	Full-Day	\$8.18	\$7.02	\$6.14	\$6.00
	Half-Day	\$4.09	\$3.51	\$3.07	\$3.00

(2) The child care provider must verify the child's additional care needs when they request a rate above that listed in subsection (1)(b) of this section. The verification should include details about all of the child's additional needs in relevant areas such as environmental accommodations, ambulation, eating, personal hygiene, communication, and behavior.

(3) If a provider is requesting one-on-one supervision or direct care for the child with special needs the person providing the one-on-one care must be:

- (a) At least eighteen years of age; and
- (b) Meet the requirements for being an assistant under chapter 388-295 WAC.

- (4) If the provider has a waiver to care for a child who:
 - (a) Is thirteen years or older; and
 - (b) Has special needs according to WAC 388-290-0220, we authorize the special needs payment rate as described in subsection (1) of this section using the five to twelve year age range for comparison.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25, 04-08-021 and 04-08-134, § 388-290-0225, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085, 02-12-069, § 388-290-0225, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0225, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0230 What is the additional subsidy daily rate for children with special needs in a licensed or certified family home child care? (1) In addition to the rate listed in WAC 388-290-0205, we authorize special needs daily rates to licensed or certified family home child care providers according to whichever of the following is greater:

- (a) The provider's reasonable documented additional cost associated with the care of the child; or
- (b) The daily rate listed in the table below after you have verified that your child has a special need and requires a higher level of care according to WAC 388-290-0220:

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 11 yrs)
Region 1	Full-Day	\$6.00	\$5.40	\$5.40	\$4.80
	Half-Day	\$3.00	\$2.70	\$2.70	\$2.40

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		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 5 yrs)	School-age (5 - 11 yrs)
Region 2	Full-Day	\$6.00	\$5.70	\$5.10	\$5.10
	Half-Day	\$3.00	\$2.85	\$2.55	\$2.55
Region 3	Full-Day	\$8.70	\$7.50	\$6.60	\$6.00
	Half-Day	\$4.35	\$3.75	\$3.30	\$3.00
Region 4	Full-Day	\$9.00	\$8.90	\$7.50	\$7.20
	Half-Day	\$4.50	\$4.45	\$3.75	\$3.60
Region 5	Full-Day	\$6.60	\$6.00	\$5.70	\$5.10
	Half-Day	\$3.30	\$3.00	\$2.85	\$2.55
Region 6	Full-Day	\$6.60	\$6.00	\$6.00	\$5.70
	Half-Day	\$3.30	\$3.00	\$3.00	\$2.85

(2) A family home child care provider must verify the child's additional care needs when they request a rate above that listed in subsection (1)(b) of this section. The verification should include details about all of the child's additional needs in relevant areas such as environmental accommodations, ambulation, eating, personal hygiene, communication, and behavior.

(3) If the provider has a waiver to care for a child who:

(a) Is twelve years or older; and

(b) Has special needs according to WAC 388-290-0220, we authorize the special needs payment rate as described in subsection (1) of this section using the five to eleven year age range for comparison.

(4) If a provider is requesting one-on-one supervision/direct care for the child with special needs. The person providing the one-on-one care must be:

(a) At least eighteen years old; and

(b) Meet the requirements for being an assistant under chapter 388-155 WAC.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0230, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0230, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0230, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0235 What is the DSHS in-home/relative child care daily rate for children with special needs?

(1) We authorize a base rate of two dollars and six cents an hour for in-home/relative child care when a child has verified special needs and requires a higher level of care according to WAC 388-290-0220.

(2) In addition to the base rate, we authorize whichever of the following is greater:

(a) Sixty-two cents per hour; or

(b) The provider's reasonable documented additional cost associated with the care for that child.

(3) The in-home/relative provider must verify the child's additional care needs when they request a rate above that listed in subsection (1)(a) of this section. The verification must include details about all the child's additional needs in relevant areas such as environmental accommodations, ambulation, eating, personal hygiene, communication, and behavior.

(4) If other children in the home are also authorized for in-home/relative care with the same provider, we authorize:

(a) Two dollars and six cents an hour for the child needing the most care; and

(b) One dollar and three cents an hour for any additional children.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0235, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0235, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0240 What is the DSHS child care subsidy rate for in-home/relative child care and how is it paid? (1) When you employ an in-home/relative provider, the maximum we pay for child care is the lesser of the following:

(a) Two dollars and six cents per hour for the child who needs the greatest number of hours of care and one dollar and three cents per hour for the care of each additional child in the family; or

(b) The provider's usual hourly rate for that care.

(2) We may pay above the maximum hourly rate for children who have special needs under WAC 388-290-0235.

(3) We make the WCCC payment directly to your eligible provider.

(4) When appropriate, we pay your (the employer's) share of the following:

(a) Social Security and Medicare taxes (FICA) up to the wage limit;

(b) Federal Unemployment Taxes (FUTA); and

(c) State unemployment taxes (SUTA) when applicable.

(5) If an in-home/relative child care provider receives less than the wage base limit per family in a calendar year, we refund all withheld taxes to the provider.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0240, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0240, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0240, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0245 When can the WCCC program authorize payment of fees for registration? (1) We pay licensed or certified child care providers and DSHS contracted seasonal day camps a registration fee once per calendar year of fifty dollars per child or the provider's usual fee, whichever is less only if the fees are:

(a) Required of all parents whose children are in care with that provider; and

(b) Needed to maintain the child care arrangement.

(2) The registration fee may be authorized more than once per calendar year when:

(a) There is a break in your child care services for more than sixty days and the provider's policy is to charge an additional registration fee when there is a break in care; or

(b) The children change child care providers and the new provider meets subsection (1)(a) and (b) of this section.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0245, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0245, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0245, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0247 When can the WCCC program authorize payment for field trip fees? (1) We pay licensed or certified child care providers and DSHS contracted sea-

sonal day camps a monthly field trip fee up to twenty dollars per child or the provider's actual cost for the field trip, whichever is less, only if the fees meet the conditions in subsection (1)(a) and (b) of WAC 388-290-0245. The field trip fee is to cover the provider's actual expenses for:

- (a) Admission;
 - (b) Transportation (not to include the provider's gas and insurance); and
 - (c) The cost of hiring a nonemployee to provide an in-home field trip activity.
- (2) The field trip fee can only be reimbursed for children three years of age and older.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0247, filed 3/29/04 and 4/7/04, effective 5/28/04.]

WAC 388-290-0260 Who has a right to ask for a hearing and how do they ask for one? (1) WCCC consumers have a right to request a hearing under chapter 388-02 WAC on any action affecting WCCC benefits except for mass changes resulting from a change in policy or law.

(2) Licensed or certified child care providers or in-home/relative providers can request hearings under chapter 388-02 WAC and RCW 43.20B.675 only for WCCC overpayments.

(3) To request a hearing you, the licensed/certified provider, or in-home/relative provider:

- (a) Contacts the office which sent them the notice; or
- (b) Writes to the Office of Administrative Hearings, P.O. Box 42489, Olympia WA 98504-2489; and
- (c) Makes the request for a hearing within:
 - (i) Ninety days of the date a decision is received for consumers; or
 - (ii) Twenty-eight days of the date a decision is received for providers (per RCW 43.20B.675).

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0260, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0260, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0260, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0265 When can I get WCCC benefits pending the outcome of a hearing? (1) If you are a WCCC consumer, you can receive WCCC pending the outcome of a hearing if you request the hearing:

- (a) On or before the effective date of an action; or
- (b) No more than ten days after we send you a notice of adverse action.

"Adverse action" means an action to reduce or terminate your WCCC, or to set up a protective payee to receive your WCCC warrant for you.

(2) If you lose a hearing, any WCCC you use between the date of the adverse action and the date of the hearing or decision is an overpayment to you, the consumer.

(3) If you are a WCCC consumer, you may not receive WCCC benefits pending the outcome of a hearing if you request payment to a provider who is not eligible under WAC 388-290-0125.

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(4) If you are eligible for WCCC, you may receive child care benefits for another eligible provider, pending the outcome of the hearing.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0265, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0265, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0270 What is a WCCC overpayment and what can be included? (1) A WCCC overpayment:

(a) Occurs when you or a provider receives benefits or payment from WCCC that you or they are not eligible to receive;

(b) Is expected to be paid back by you or the provider; and

(c) Is written for the month care is billed for, not the month it is paid or the month the overpayment is written.

(2) When setting up an overpayment, we reduce the WCCC overpayment by the amount of the WCCC underpayment when applicable.

(3) In areas not covered by this section, you are subject to chapter 388-410 WAC (Benefit errors).

(4) Payments made through departmental error fall under subsection (1) of this section.

(5) Absent days can be added to an overpayment, either yours or the provider's, when care is used or billed when you were not eligible for WCCC per WAC 388-290-0032 or care is billed incorrectly.

[Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0270, filed 3/29/04 and 4/7/04, effective 5/28/04. Statutory Authority: RCW 74.04.050, 74.13.085. 02-12-069, § 388-290-0270, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.04.050 and C.F.R. Parts 98 and 99 (Child Care Development Fund Rules). 02-01-135, § 388-290-0270, filed 12/19/01, effective 1/19/02.]

WAC 388-290-0271 When might I get an overpayment? You get WCCC overpayments whether you are a current or past WCCC consumer, when we make payment for WCCC benefits and:

(1) You are no longer eligible or you are eligible for a smaller amount of care, such as using care for an unapproved activity or for children not in your WCCC household;

(2) You fail to report information to us that results in an error in our determination of:

- (a) Your eligibility;
 - (b) The amount of care authorized; or
 - (c) The amount of your copayment.
- (3) Your provider is not an eligible provider per WAC 388-290-0140;

(4) Your child is not eligible per WAC 388-290-0015 or 388-290-0020.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0271, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0271, filed 3/29/04 and 4/7/04, effective 5/28/04.]

WAC 388-290-0273 When would my licensed or certified provider or DSHS contracted seasonal day camp get an overpayment? (1) We establish WCCC overpay-

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ments for your licensed or certified child care provider and DSHS contracted seasonal day camps, when your provider:

(a) Billed and received payment for WCCC services not provided;

(b) Does not have attendance records that comply with licensing requirements (refer to WAC 388-295-7030, 388-296-0520, and 388-151-460 for attendance record requirements). Only attendance records meeting WAC requirements will be accepted for attendance verification;

(c) Billed and received payment for more than they are eligible to bill;

(d) Billed and received payment and the provider is not eligible based on WAC 388-290-0125; or

(e) Is caring for a child outside their licensed allowable age range without a waiver.

(2) The WCCC program staff may request documentation from your provider when preparing to establish an overpayment. Your provider has fourteen consecutive calendar days to supply any requested documentation.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0273, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.12.340, 74.13.085, and 2003 1st sp.s. c 25. 04-08-021 and 04-08-134, § 388-290-0273, filed 3/29/04 and 4/7/04, effective 5/28/04.]

WAC 388-290-0274 When would my in-home/relative provider get an overpayment? (1) We establish WCCC overpayments for your in-home/relative provider when your provider:

(a) Billed and received payment for WCCC services not provided;

(b) Does not have attendance records that comply with attendance records based on WAC 388-290-0138. Only attendance records meeting WAC requirements will be accepted for attendance verification;

(c) Billed and received payment for more than they are eligible to bill;

(2) The WCCC program staff may request documentation from your provider when preparing to establish an overpayment. Your provider has fourteen consecutive calendar days to supply any requested documentation.

[Statutory Authority: RCW 74.04.050, 74.12.340, and 74.13.085. 05-22-078, § 388-290-0274, filed 10/31/05, effective 12/1/05.]

Chapter 388-310 WAC

WORKFIRST

WAC

388-310-0100	WorkFirst—Purpose.
388-310-0200	WorkFirst—Activities.
388-310-0300	WorkFirst—Infant care exemptions for mandatory participants.
388-310-0350	WorkFirst—Other exemptions from mandatory participation.
388-310-0400	WorkFirst—Entering the WorkFirst program as a mandatory participant.
388-310-0500	WorkFirst—Individual responsibility plan.
388-310-0600	WorkFirst—Job search.
388-310-0700	WorkFirst—Comprehensive evaluation.
388-310-0800	WorkFirst—Support services.
388-310-0900	WorkFirst—Basic education.
388-310-1000	WorkFirst—Vocational education.
388-310-1050	WorkFirst—Job skills training.
388-310-1100	WorkFirst—Work experience.
388-310-1200	WorkFirst—On-the-job training.
388-310-1300	Community jobs.
388-310-1400	WorkFirst—Community service.

388-310-1450	Pregnancy to employment.
388-310-1500	WorkFirst—Employment conditions.
388-310-1600	WorkFirst—Sanctions.
388-310-1700	WorkFirst—Self-employment.
388-310-1800	WorkFirst—Post employment services.
388-310-1900	WorkFirst—Services for American Indian tribal members and other American Indians.
388-310-2000	Individual development accounts (IDA).

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-310-1650	WorkFirst—Child SafetyNet Payments. [Statutory Authority: RCW 74.08.090, 74.04.050, and 74.08A.340. 04-07-025, § 388-310-1650, filed 3/8/04, effective 5/1/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-084, § 388-310-1650, filed 6/28/02, effective 7/29/02.] Repealed by 06-10-035, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.260, chapter 74.08A RCW.
388-310-1850	Re-employ Washington Workers (RWW). [Statutory Authority: RCW 74.08.090 and 74.04.050. 00-08-021, § 388-310-1850, filed 3/24/00, effective 4/24/00; 99-14-044, § 388-310-1850, filed 6/30/99, effective 7/31/99.] Repealed by 00-24-040, filed 11/29/00, effective 12/30/00. Statutory Authority: RCW 74.08.090 and 74.04.050.

WAC 388-310-0100 WorkFirst—Purpose. (1) What is the WorkFirst program?

The WorkFirst program offers services and activities to help people in low-income families find jobs, keep their jobs, find better jobs and become self-sufficient. The program links families to a variety of state, federal and community resources to meet this goal. When you enter the WorkFirst program, you will be asked to work, look for work and/or prepare for work.

(2) Who does the WorkFirst program serve?

The WorkFirst program serves three groups:

(a) Parents and children age sixteen or older who receive cash assistance under the temporary assistance for needy families (TANF), general assistance for pregnant women (GA-S) or state family assistance (SFA) programs; and

(b) Parents who no longer receive cash assistance and need some continuing support to remain self-sufficient; and

(c) Low income parents who support their family without applying for or relying on cash assistance.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-08-051, § 388-310-0100, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0200 WorkFirst—Activities. (1) Who is required to participate in WorkFirst activities?

(a) You are required to participate in WorkFirst activities, and become what is called a "mandatory participant," if you:

(i) Receive TANF or SFA cash assistance; and

(ii) Are a custodial parent or age sixteen or older; and

(iii) Are not exempt. For exemptions see WAC 388-310-0300 and 388-310-0350.

(b) Participation is voluntary for all other WorkFirst participants (those who no longer receive or have never received TANF or SFA cash assistance).

(2) What activities do I participate in when I enter the WorkFirst program?

When you enter the WorkFirst program, you will participate in one or more of the following activities (which are described in more detail in other sections of this chapter):

- (a) Paid employment (see WAC 388-310-0400 (2)(a) and 388-310-1500);
- (b) Self employment (see WAC 388-310-1700);
- (c) Job search (see WAC 388-310-0600);
- (d) Community jobs (see WAC 388-310-1300)
- (e) Work experience (see WAC 388-310-1100);
- (f) On-the-job training (see WAC 388-310-1200);
- (g) Vocational educational training (see WAC 388-310-1000);
- (h) Basic education activities (see WAC 388-310-0900);
- (i) Job skills training (see WAC 388-310-1050);
- (j) Community service (see WAC 388-310-1400);
- (k) Activities provided by tribal governments for tribal members and other American Indians (see WAC 388-310-1400(1) and 388-310-1900);
- (l) Other activities identified by your case manager on your individual responsibility plan that will help you with situations such as drug and/or alcohol abuse, homelessness, or mental health issues; and/or
- (m) Activities identified by your case manager on your individual responsibility plan to help you cope with family violence as defined in WAC 388-61-001; and/or
- (n) Up to ten hours of financial literacy activities to help you become self-sufficient and financially stable.

(3) If I am a mandatory participant, how much time must I spend doing WorkFirst activities?

If you are a mandatory participant, you will be required to participate full time, working, looking for work or preparing for work. You might be required to participate in more than one part-time activity at the same time that add up to full time participation. You will have an individual responsibility plan (described in WAC 388-310-0500) that includes the specific activities and requirements of your participation.

(4) What activities do I participate in after I get a job?

You will participate in other activities, such as job search or training once you are working twenty hours or more a week in a paid unsubsidized job, to bring your participation up to full time.

You may also engage in activities if you are working full time and want to get a better job.

Post employment services (described in WAC 388-310-1800) include:

- (a) Activities that help you keep a job (called an "employment retention" service); and/or
- (b) Activities that help you get a better job or better wages (called a "wage and skill progression" service).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.08A.340, and 2006 c 107. 06-24-023, § 388-310-0200, filed 11/29/06, effective 12/30/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0200, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-0200, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0200, filed 3/1/00, effective 3/1/00; 99-08-051, § 388-310-0200, filed 4/1/99, effective 5/2/99; 97-20-129, § 388-310-0200, filed 10/1/97, effective 11/1/97.]

(2007 Ed.)

WAC 388-310-0300 WorkFirst—Infant care exemptions for mandatory participants. (1) If I am a mandatory participant, when can I be exempted from participating in WorkFirst activities?

(a) You can claim an exemption from participating in WorkFirst activities during months that you are needed in the home to personally provide care for your child under four months of age.

(b) You or the other parent of your child, living in your household can claim a one-time exemption from full-time participation, for one child only, if that child is between the age of four months and up to twelve months old. This means the parent who claims this exemption will only be required to participate part-time, up to twenty hours in certain activities described in WAC 388-310-1450.

(2) Can I participate in WorkFirst while I am exempt?

(a) You may choose to participate in WorkFirst while you are exempt with a child under four months old. If you decide later to stop participating, and you still qualify for an exemption, you will be put back into exempt status with no financial penalty. For a description of participation activities see WAC 388-310-1450.

(b) You may choose to participate full time while you are taking your one-time/part-time exemption. If you decide later to stop participating full-time, and you still qualify for the part-time exemption, you will be put back into part-time exempt status with no financial penalty. For a description of participation activities see WAC 388-310-1450.

(3) Does an exemption from participation affect my sixty-month time limit for receiving TANF or SFA benefits?

An exemption from participation does not affect your sixty-month time limit for receiving TANF or SFA benefits (described in WAC 388-484-0005). Even if exempt from participation, each month you receive a TANF/SFA grant counts toward your sixty-month limit.

[Statutory Authority: RCW 74.08.090, 74.04.050. 02-14-087, § 388-310-0300, filed 6/28/02, effective 7/29/02; 00-06-062, § 388-310-0300, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0300, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0300, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0350 WorkFirst—Other exemptions from mandatory participation. (1) When am I exempt from mandatory participation?

You are exempt from mandatory participation if you are:

- (a) An older needy caretaker relative:
 - (i) You are fifty-five years of age or older and caring for a child and you are not the child's parent; and
 - (ii) Your age is verified by any reliable documentation (such as a birth certificate or a driver's license).
- (b) An adult with a severe and chronic disability:
 - (i) The disability must be a severe and chronic mental, physical, emotional, or cognitive impairment that prevents you from participating in work activities and is expected to last at least twelve months; or
 - (ii) You have been assessed by a DSHS SSI facilitator as likely to be approved for SSI or other benefits and are applying for SSI or another type of federal disability benefit (such as railroad retirement or social security disability); and

[Title 388 WAC—p. 765]

(iii) Your disability is verified by documentation from the division of developmental disabilities (DDD), division of vocational rehabilitation (DVR), home and community services division (HCS), division of mental health (MHD), and/or regional support network (RSN), or evidence from another medical or mental health professional; and

(iv) Your SSI application status may be verified through the SSI facilitator and/or state data exchange.

(c) Required in the home to care for a child with special needs when:

(i) The child has a special medical, developmental, mental, or behavioral condition; and

(ii) The child is determined by a public health nurse, physician, mental health provider, school professional, other medical professional, HCS, MHD, and/or a RSN to require specialized care or treatment that significantly interferes with your ability to look for work or work.

(d) Required to be in the home to care for another adult with disabilities when:

(i) The adult with disabilities cannot be left alone for significant periods of time; and

(ii) No adult other than yourself is available and able to provide the care; and

(iii) The adult with the disability is related to you; and

(iv) The disability is verified by documentation from DDD, DVR, HCS, MHD, and/or a RSN, or evidence from another medical or mental health professional.

(2) Who reviews and approves an exemption?

(a) If it appears that you may qualify for an exemption or you ask for an exemption, your case manager or social worker will review the information and we will use the case staffing process to determine whether the exemption will be approved. Case staffing is a process to bring together a team of multidisciplinary experts including relevant professionals and the client to identify participant issues, review case history and information, and recommend solutions.

(b) If additional medical or other documentation is needed to determine if you are exempt, your IRP will allow between thirty days and up to ninety if approved to gather the necessary documentation.

(c) Information needed to verify your exemption should meet the standards for verification described in WAC 388-490-0005. If you need help gathering information to verify your exemption, you can ask us for help. If you have been identified as needing NSA services, under chapter 388-472 WAC, your accommodation plan should include information on how we will assist you with getting the verification needed.

(d) After the case staffing, we will send you a notice that tells you whether your exemption was approved, how to request a fair hearing if you disagree with the decision, and any changes to your IRP that were made as a result of the case staffing.

(3) Can I participate in WorkFirst while I am exempt?

(a) You may choose to participate in WorkFirst while you are exempt.

(b) Your WorkFirst case manager may refer you to other service providers who may help you improve your skills and move into employment.

(c) If you decide later to stop participating, and you still qualify for an exemption, you will be put back into exempt status with no financial penalty.

(4) Does an exemption from participation affect my sixty-month time limit for receiving TANF/SFA benefits?

An exemption from participation does not affect your sixty-month time limit (described in WAC 388-484-0005) for receiving TANF/SFA benefits. Even if exempt from participation, each month you receive a TANF/SFA grant counts toward your sixty-month limit.

(5) How long will my exemption last?

Unless you are an older caretaker relative, your exemption will be reviewed at least every twelve months to make sure that you still meet the criteria for an exemption. Your exemption will continue as long as you continue to meet the criteria for an exemption.

(6) What happens when I am no longer exempt?

If you are no longer exempt, then:

(a) You will become a mandatory participant under WAC 388-310-0400; and

(b) If you have received sixty or more months of TANF/SFA, your case will be reviewed for an extension. (See WAC 388-484-0006 for a description of TANF/SFA time limit extensions.)

(7) For time-limited extensions, see WAC 388-484-0006.

[Statutory Authority: RCW 74.08.090, 74.04.050, and 74.08A.340. 03-24-057, § 388-310-0350, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-310-0350, filed 5/31/02, effective 6/1/02.]

WAC 388-310-0400 WorkFirst—Entering the WorkFirst program as a mandatory participant. (1) What happens when I enter the WorkFirst program as a mandatory participant?

If you are a mandatory participant, you must follow instructions as written in your individual responsibility plan (see WAC 388-310-0500), which is written after you have participated in a comprehensive evaluation of elements related to your employability. If you have been identified as someone who needs necessary supplemental accommodation (NSA) services (defined in chapter 388-472 WAC) your case manager will first develop an accommodation plan to help you access WorkFirst services. The case manager will use the accommodation plan to help develop your IRP with you. If you have been identified as a victim of family violence (defined in WAC 388-61-001), you and your case manager will develop an IRP to help you with your situation, including referrals to appropriate services.

If you are a mandatory participant, your case manager will refer you to WorkFirst activities unless any of the following applies to you:

(a) You work thirty-two or more hours a week. **"Work"** means to engage in any legal, income generating activity which is taxable under the United States tax code or which would be taxable with or without a treaty between an Indian Nation and the United States;

(b) You work sixteen or more hours a week in the federal or state work study program and you attend a Washington state community or technical college at least half time;

(c) You work twenty or more hours a week in unsubsidized employment and attend a Washington state community or technical college at least half time;

(d) You are under the age of eighteen, have not completed high school, GED or its equivalent and are in school full time;

(e) You are eighteen or nineteen years of age and are attending high school or an equivalent full time;

(f) You are pregnant or have a child under the age of twelve months, and are participating in other pregnancy to employment activities. See WAC 388-310-1450;

(g) Your situation prevents you from looking for a job and you are conducting activities identified on your IRP to help you with your situation. (For example, you may be unable to look for a job while you have health problems or you are homeless); or

(h) Your situation prevents you from looking for work because you are a victim of family violence and you are conducting activities on your IRP to help you with your situation.

(2) How will I know what my participation requirements are?

(a) Your individual responsibility plan will describe what you need to do to be able to enter job search or other WorkFirst activities and then find a job (see WAC 388-310-0500 and 388-310-0700).

(b) If you enter the pregnancy to employment pathway (described in WAC 388-310-1450(2)), you must take part in an assessment.

(3) What happens if I do not follow my WorkFirst requirements?

If you do not participate in creating an individual responsibility plan, job search, or in the activities listed in your individual responsibility plan, and you do not have a good reason, the department will follow the sanction rules in WAC 388-310-1600.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-08-044, § 388-310-0400, filed 3/30/06, effective 6/1/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0400, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-0400, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0400, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-0400, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0400, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0500 WorkFirst—Individual responsibility plan. (1) What is the purpose of my individual responsibility plan?

The purpose of your individual responsibility plan is to give you a written statement that describes:

(a) What your responsibilities are; and

(b) Which WorkFirst activities you are required to participate in; and

(c) What services you will receive so you are able to participate.

(2) What is included in my individual responsibility plan?

Your individual responsibility plan includes the following:

(a) What WorkFirst activities you must do and the participation requirements for those activities including the amount of time you will spend doing the activities, a start and end date for each activity and the requirement to participate fully.

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(b) Any other specific requirements that are tied to the WorkFirst work activity. For example, you might be required to learn English as part of your work experience activity.

(c) What services we will provide to help you participate in the activity. For example, you may require support services (such as help with paying for transportation) or help with paying childcare.

(d) Your statement that you recognize the need to become and remain employed as quickly as possible.

(3) How is my individual responsibility plan developed?

You and your case manager will work together and use information gathered from your comprehensive evaluation (see WAC 388-310-0700) to develop your individual responsibility plan and decide what activities will be included in it. Then, your case manager will assign you to specific WorkFirst activities that will help you find employment.

(4) What happens after my individual responsibility plan is completed?

Once your individual responsibility plan is completed:

(a) You will sign and get a copy of your individual responsibility plan.

(b) You and your case manager will review your plan as necessary over the coming months to make sure your plan continues to meet your employment needs. You will sign and get a copy of your individual responsibility plan every time it is reviewed and changed.

(5) What should I do if I cannot go to a required WorkFirst appointment or activity because of a temporary situation outside of my control?

If you cannot participate because of a temporary situation outside of your control, you must call the telephone number shown on your individual responsibility plan on the same day you were to report to explain your situation. You will be given an excused absence. Some examples of excused absences include:

(a) You, your children or other family members are ill;

(b) Your transportation or child care arrangements break down and you cannot make new arrangements in time to comply;

(c) A significant person in your life died; or

(d) A family violence situation arose or worsened.

(6) What happens if I don't call in on the same day I am unable to attend to get an excused absence?

If you do not call in on the same day you are unable to attend to get an excused absence, it will be considered an unexcused absence.

If you exceed the number of unexcused absences allowed on your individual responsibility plan, without good cause, your case manager will begin the sanction process. (See WAC 388-310-1600 for more details.)

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-08-044, § 388-310-0500, filed 3/30/06, effective 6/1/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0500, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-0500, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-0500, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0600 WorkFirst—Job search. (1) What is job search?

Job search is an opportunity to learn and use skills you need to find and keep a job. Job search may include:

- (a) Classroom instruction; and/or
- (b) Structured job search that helps you find job openings, complete applications, practice interviews and apply other skills and abilities with a job search specialist or a group of fellow job-seekers; and/or
- (c) Preemployment training; and/or
- (d) High-wage/high-demand training.

(2) What is preemployment training?

Preemployment training helps you learn skills you need for an identified entry level job that pays more than average entry level wages.

(a) Preemployment training is an acceptable job search activity when an employer or industry commits to hiring or giving hiring preference to WorkFirst participants who successfully complete preemployment training.

(b) You can find out about current preemployment training opportunities by asking your job service specialist, your case manager or staff at your local community and technical college.

(3) What is high-wage/high-demand training?

(a) There are two types of high-wage/high-demand (HWHD) full-time training options for TANF recipients to complete a certificate or degree that will lead to employment in a high-wage/high-demand occupation:

(i) Information technology, health care or other professional-technical programs: This option allows you to start and finish a one-year or shorter state community or technical college training program in the information technology, health care fields or other professional-technical programs that meet high-wage high-demand criteria; and/or

(ii) Certificate/degree completion: This option allows you to finish up the last year of any certificate or degree program in a high-wage/high-demand field on an exception basis. The high-wage/high-demand criteria for this option is based on median income and high-demand occupations within the local labor market as determined by employment security department.

(b) For both types of HWHD training, the training can be approved one-time only (barring an approved exception to policy). There is no work requirement with either option for the twelve months of training time.

(c) To qualify for HWHD training, you must also:

- (i) Meet all of the prerequisites for the course;
- (ii) Obtain the certificate or degree within twelve calendar months;
- (iii) Participate full time in the training program and make satisfactory progress;
- (iv) Work with colocated ESD staff during the last quarter of training for job placement; and
- (v) Return to job search once you complete the educational program if still unemployed.

(4) Who provides me with job search?

You get job search from the employment security department or another organization under contract with WorkFirst to provide these services.

(5) How long do I stay in job search?

Periods of job search will start with a review of the work skills assessment portion of your comprehensive evaluation and may last up to twelve continuous weeks. Job search specialists will monitor your progress. By the end of the first four weeks, a job search specialist will determine whether you should continue in job search. Job search will end when:

- (a) You find a full-time job; or
- (b) You become exempt from WorkFirst requirements (see WAC 388-310-0300); or
- (c) Your situation changes and the case manager changes the activities on your IRP to fit your new circumstances (see WAC 388-310-0400); or
- (d) After fully participating in job search, and based on your experience in looking for work in the local labor market, it is determined that you need additional skills and/or experience to find a job; or
- (e) You have not found a job at the end of the job search period.

(f) You have not found a job at the end of the job search period.

(6) What happens at the end of job search if I have not found a job?

At the end of each job search period, you will be referred back to your case manager who will, at a minimum, review and update the DSHS portion of your comprehensive evaluation if you have not found a job. You and your case manager will also modify your individual responsibility plan.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 06-08-044, § 388-310-0600, filed 3/30/06, effective 6/1/06; 05-16-107, § 388-310-0600, filed 8/2/05, effective 9/2/05. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-15-067, § 388-310-0600, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090, 74.04.050, 02-04-058, § 388-310-0600, filed 1/30/02, effective 3/2/02. Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW, 00-16-055, § 388-310-0600, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-0600, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0700 WorkFirst—Comprehensive evaluation. (1) Why do I receive a comprehensive evaluation?

You participate in a comprehensive evaluation with your case manager and other WorkFirst staff to determine:

- (a) Your employment strengths, your educational background, family situation and other factors; and
- (b) Which WorkFirst activities you need to become employed.

(2) What is the comprehensive evaluation and when will it be used?

(a) The comprehensive evaluation is a series of questions, answers and evaluations focused on your strengths, job skills, education and other relevant elements. The results of the comprehensive evaluation are used to determine your ability to find and keep a job in your local labor market and what WorkFirst activities will help you prepare for and find work. It includes:

(i) An employability evaluation with your case manager, discussing important issues that can affect your ability to find a job, like child care, family violence or substance abuse. Your case manager will also ask you a few questions to find out if you might benefit from engaging in financial literacy activities such as money management training or any other

type of credit counseling service. If so, we will tell you how to get this information;

(ii) A work skills assessment to review your education, employment history, employment strengths and job skills; and

(iii) Educational and other evaluations.

(b) You and your case manager and/or social worker use the information and recommendations from these evaluations to create or modify your individual responsibility plan, adding activities that help you become employable.

(c) After your comprehensive evaluation, you may receive more assessments to find out if you need additional services.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.08A.340, and 2006 c 107. 06-24-023, § 388-310-0700, filed 11/29/06, effective 12/30/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 06-08-044, § 388-310-0700, filed 3/30/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, 00-06-062, § 388-310-0700, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-0700, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0800 WorkFirst—Support services.

(1) Who can get support services?

People who can get support services include:

(a) WorkFirst participants who receive a TANF cash grant;

(b) Sanctioned WorkFirst participants during the required participation before the sanction is lifted or applicants who were terminated by a sanction review panel who are doing activities required to reopen cash assistance (WAC 388-310-1600);

(c) Unmarried or pregnant minors who are income eligible to receive TANF and are:

(i) Living in a department approved living arrangement (WAC 388-486-0005) and are meeting the school requirements (WAC 388-486-0010); or

(ii) Are actively working with a social worker and need support services to remove the barriers that are preventing them from living in a department approved living arrangements and/or meeting the school requirements.

(d) Former WorkFirst recipients who are working at least twenty hours or more per week for up to six months after leaving TANF if they need support services to meet a temporary emergency. This can include up to four weeks of support services if they lose a job and are looking for another one (see also WAC 388-310-1800); or

(e) American Indians who receive a TANF cash grant and have identified specific needs due to location or employment.

(2) Why do I receive support services?

Although not an entitlement, you may receive support services for the following reasons:

(a) To help you participate in work and WorkFirst activities that lead to independence.

(b) To help you to participate in job search, accept a job, keep working, advance in your job, and/or increase your wages.

(c) You can also get help in paying your child care expenses through the working connections child care assistance program. (Chapter 388-290 WAC describes the rules for this child care assistance program.)

(3) What type of support services may I receive and what limits apply?

There is a limit of three thousand dollars per person per program year (July 1st to June 30th) for WorkFirst support services you may receive. Most types of support services have dollar limits.

The chart below shows the types of support services that are available for the different activities (as indicated by an "x") and the limits that apply.

Definitions:

- Work-related activities include looking for work or participating in workplace activities, such as community jobs or a work experience position.

- Safety-related activities include meeting significant or emergency family safety needs, such as dealing with family violence. When approved, safety-related support services can exceed the dollar or category limits listed below.

- Some support services are available if you need them for other required activities in your IRP.

Type of support service	Limit	• Work	•• Safety	••• Other
Reasonable accommodation for employment	\$1,000 for each request	x		
Clothing/uniforms	\$75 per adult per program year	x		
Diapers	\$50 per child per month	x		
Haircut	\$40 per each request	x		
Lunch	Same rate as established by OFM for state employees	x		
Personal hygiene	\$50 per adult per program year	x		
Professional, trade, association, union and bonds	\$300 for each fee	x		
Relocation related to employment (can include rent, housing, and deposits)	\$1,000 per program year	x		
Short-term lodging and meals in connection with job interviews/tests	Same rate as established by OFM for state employees	x		
Tools/equipment	\$500 per program year	x		
Car repair needed to restore car to operable condition	\$250 per program year	x	x	
License/fees	\$130 per program year	x	x	

Type of support service	Limit	• Work	•• Safety	••• Other
Mileage, transportation, and/or public transportation	Same rate as established by OFM for state employees	x	x	
Transportation allotment	Up to: \$25 for immediate need, or \$40 twice a month if you live within 40 miles of your local WorkFirst office, or \$60 twice a month if you live more than 40 miles from your local WorkFirst office.	x	x	
Counseling	No limit	x	x	x
Educational expenses	\$300 for each request if it is an approved activity in your IRP and you do not qualify for sufficient student financial aid to meet the cost	x		x
Medical exams (not covered by Medicaid)	\$150 per exam	x	x	x
Public transportation	\$150 per month	x	x	x
Testing-diagnostic	\$200 each	x	x	x

(4) What are the other requirements to receive support services?

Other restrictions on receiving support services are determined by the department or its agents. They will decide what support services you receive, as follows:

- (a) It is within available funds; and
- (b) It does not assist, promote, or deter religious activity; and
- (c) There is no other way to meet the cost.

(5) What happens to my support services if I do not participate as required?

The department will give you ten days notice, following the rules in WAC 388-310-1600, then discontinue your support services until you participate as required.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.260, chapter 74.08A RCW. 06-10-035, § 388-310-0800, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340. 05-02-014, § 388-310-0800, filed 12/27/04, effective 1/27/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340, and 2003 c 10 § 207. 03-21-154, § 388-310-0800, filed 10/22/03, effective 10/27/03. Statutory Authority: RCW 74.08.090, 74.04.050, 78.08A.340, and [WSR] 99-14-043. 02-11-130, § 388-310-0800, filed 5/21/02, effective 7/1/02; 01-17-053, § 388-310-0800, filed 8/13/01, effective 9/1/01. Statutory Authority: RCW 74.08.090, 74.04.050, and 78.08A.340. 00-13-106, § 388-310-0800, filed 6/21/00, effective 7/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-14-043, § 388-310-0800, filed 6/30/99, effective 7/31/99; 97-20-129, § 388-310-0800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0900 WorkFirst—Basic education. (1) What is basic education?

Basic education is high school completion, classes to prepare for general equivalency diploma (GED), testing to acquire GED certification, adult basic education (ABE) or English as a second language (ESL) training.

(2) When do I participate in basic education as part of WorkFirst?

You may participate in basic education as part of WorkFirst under any of the following circumstances:

- (a) You are twenty years of age or older and your comprehensive evaluation shows you need this education to become employed or get a better job and:
 - (i) You are enrolled in an approved WorkFirst work activity for at least twenty hours per week; or
 - vocational education with any approved WorkFirst work

[Title 388 WAC—p. 770]

(ii) You have fully participated in job search without finding a job.

(b) You may be required to participate if you are a mandatory participant, a parent eighteen or nineteen years of age, you do not have a high school diploma or GED certificate and you need this education in order to find employment.

(c) You will be required to be in high school or a GED certification program if you are a mandatory participant, sixteen or seventeen years old and you do not have a high school diploma or GED certificate.

(d) Employment security department (ESD) has determined that you are a seasonal worker (that is, your usual pattern of employment is based on recurring cycle of seasonal employment). Under WorkFirst, seasonal workers qualify for full-time education and training during the off season.

(e) You are enrolled in the pregnancy to employment pathway and your comprehensive evaluation shows basic education would help you find and keep employment. (See WAC 388-310-1450.)

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-08-048, § 388-310-0900, filed 3/30/06, effective 5/1/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-0900, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-15-009, § 388-310-0900, filed 7/6/01, effective 8/6/01; 99-10-027, § 388-310-0900, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-0900, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1000 WorkFirst—Vocational education. (1) What is vocational education?

Vocational education is training that leads to a degree or certificate in a specific occupation and is offered by an accredited:

- (a) Public and private technical college or school;
- (b) Community college; or
- (c) Tribal college.

(2) When can vocational education be included in my individual responsibility plan?

We may add vocational education to your individual responsibility plan for up to twelve months if:

- (a) Your comprehensive evaluation shows you need this education to become employed or get a better job and you participate full time in vocational education or by combining activity; or

(2007 Ed.)

(b) Employment security department (ESD) has determined that you are a seasonal worker (that is, your usual pattern of employment is based on a recurring cycle of seasonal employment). Under WorkFirst, seasonal workers qualify for full-time education and training during the off season; or

(c) You are in an internship or practicum for up to twelve months that is paid or unpaid and required to complete a course of vocational training or to obtain a license or certificate in a high demand field, as determined by the employment security department; or

(d) You have limited English proficiency and you lack job skills that are in demand for entry level jobs in your area; and the vocational education program is the only way that you can acquire the job skills you need to qualify for entry level jobs in your area (because there is no available work experience, preemployment training or on-the-job training that can teach you these skills); or

(e) You are in the Pregnancy to Employment pathway and your comprehensive evaluation shows vocational education would help you find and keep employment. (See WAC 388-310-1450.)

(3) Can I get help with paying the costs of vocational education?

WorkFirst may pay for the costs of your vocational education, such as tuition or books, for up to twelve months, if vocational education is in your individual responsibility plan and there is no other way to pay them. You may also get help with paying your child care costs through the working connections child care program. (See chapter 388-290 WAC for the working connections child care program rules.)

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 06-08-048, § 388-310-1000, filed 3/30/06, effective 5/1/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-15-067, § 388-310-1000, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-15-009, § 388-310-1000, filed 7/6/01, effective 8/6/01; 99-10-027, § 388-310-1000, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1000, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1000, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1050 WorkFirst—Job skills training.

(1) What is job skills training?

Job skills training is training in specific skills directly related to employment, but not tied to a specific occupation. Job skills training programs are generally short term, but differ in what skills are taught and who provides the training. The training may be offered by the following types of organizations that meet the WorkFirst program's standards for service providers:

- (a) Community based organizations;
- (b) Businesses;
- (c) Tribal governments; or
- (d) Public and private community and technical colleges.

(2) When can job skills training be included in my individual responsibility plan?

We may add job skills training in your individual responsibility plan if:

- (a) You are working twenty or more hours a week in paid unsubsidized work; or
- (b) You are working sixteen or more hours per week in a federal or state work-study position; or
- (c) You are working in a subsidized job, like a community jobs position, at least twenty hours per week; or

(2007 Ed.)

(d) Employment security department (ESD) has determined that you are a seasonal worker (that is, your usual pattern of employment is based on a recurring cycle of seasonal employment). Under WorkFirst, seasonal workers qualify for full-time education and training during the off season; or

(e) You lack job skills that are in demand for entry level jobs in your area, and the job skills training is short term and is combined with job search.

(3) Can I get help with paying the costs of job skills training?

WorkFirst may pay your costs, such as tuition or books, if job skills training is in your individual responsibility plan and there is no other way to pay them. You may also get help with paying your child care costs through the working connections child care program. (See chapter 388-290 WAC for the working connections child care program rules.)

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-15-067, § 388-310-1050, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-15-009, § 388-310-1050, filed 7/6/01, effective 8/6/01; 99-10-027, § 388-310-1050, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1050, filed 11/10/98, effective 12/11/98.]

WAC 388-310-1100 WorkFirst—Work experience.

(1) What is work experience?

Work experience (sometimes called WEX) is an activity for mandatory participants that will teach you the basics of holding down a job and give you a chance to practice or expand your work skills. Work experience teaches you these skills by assigning you to unpaid work with:

- (a) A private, nonprofit organization;
- (b) A community or technical college; or
- (c) A federal, state, local or tribal government or district.

(2) What happens when I am enrolled in a work experience activity?

When you are enrolled in a work experience activity:

(a) The organization, government or district that is supervising your work experience position must comply with all applicable state and federal health and safety standards while you are working there.

(b) You may be required to look for work on your own and must accept any paid employment you find that meets the criteria in WAC 388-310-1500.

(3) How long does a work experience assignment last?

Your case manager must review your work experience assignment if it lasts longer than six months. This review will determine whether you need more time to learn the skills and abilities that the work experience assignment was set up to teach you.

[Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1100, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1200 WorkFirst—On-the-job training.

(1) **What is on-the-job training?**
On-the-job training (sometimes called OJT) is skills training provided by an employer at the their place of business. You are paid to both work and spend some time learning new skills to help you do your job better. You may receive the training at your job site or be sent to a classroom (using "release time" from your job) to get some of this training.

(2) When do I qualify for on-the-job training?

You may qualify for on-the-job employment if:

- (a) You lack skills which are in demand in the local labor market; and
- (b) There are employers in your area who can and will provide the training.

(3) Is my employer reimbursed for giving me on-the-job training?

Your employer may be reimbursed for giving you on-the-job training for up to fifty percent of your total gross wages for regular hours of work and preapproved release time for training.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1200, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1300 Community jobs. (1) What is the community jobs program?

Community jobs is a paid work experience that assists you to gain work skills and experience. You are placed in a community job (up to twenty hours per week) where your wages are paid by the community jobs program. If you participate in the program, you are eligible for support services that assist you in moving into a job where your employer pays all your wages.

(2) What is career jump?

Career jump offers job-ready community jobs participants an opportunity to gain paid work experience that leads to a permanent job. This program is a subset of community jobs and will be referred to as such. Career jump places you in a part time (up to twenty hours per week), community job where your earnings are paid by the community jobs program, for up to five months, at which time you will transition to the employer's payroll. You will be provided with support services to assist you in retaining your job through the ninth month of the program. At or before the fifth month, the employment opportunity will be above minimum wage, thirty-two or more hours per week and include wage progression and benefits comparable to other employees.

(3) Who administers the community jobs program?

The state department of community, trade, and economic development (DCTED) administers the community jobs program. DCTED contract with local agencies throughout the state, known as community jobs contractors who develop and manage the community jobs positions, pay the wages, provide support services and act as the "employer of record" while you are enrolled in a community job.

(4) What types of work sites are used to provide community jobs?

The following work sites may be used to provide community jobs:

- (a) Federal, state or local governmental agencies and tribal governments;
- (b) Private and tribal nonprofit businesses, organizations and educational institutions;
- (c) Private for profit businesses for career jump placements.

(5) What are the requirements for the work sites?

Work sites for community jobs and career jump:

- (a) Must assist in strengthening work ethics, improve workplace skills and help you gain skills to move into a job

where the employer pays all your wages. If they do not meet this requirement, they will not be considered for additional community jobs/career jump placements.

(b) We will follow the employment rules described in WAC 388-310-1500. In any situation where training is inconsistent with the terms of a collective bargaining agreement, your community jobs contractor will obtain written approval from the labor organization concerned. Career jump employers will remain neutral with regard to neutralization in the worksite.

(c) You will not be required to do work related to religious, electoral or partisan political activities.

(6) What are the benefits of community jobs?

You benefit from community jobs by:

- (a) Learning work skills;
- (b) Getting work experience;
- (c) Working twenty hours per week, while being paid federal or state minimum wage, whichever is higher; and
- (d) Earning paid personal leave as determined by DCTED.

(7) How do I get into community jobs?

You will be placed into community jobs after you and your DSHS case manager decide:

- (a) You would benefit from community jobs after you have participated in job search without finding a job; and/or
- (b) You need a supportive work environment to help you become more employable.

(8) What happens after I am placed in the community jobs program?

When you are placed in the community jobs program by DSHS:

(a) You will be assigned to a community job by the community jobs contractor for no more than nine months. You will work twenty hours a week and participate in other unpaid activities for twelve to twenty additional hours per week;

(b) Your placement in community jobs will be reviewed by your DSHS case manager every three months during your nine-month placement for the following:

- (i) To ensure you are TANF/SFA eligible; and
- (ii) To verify any earned or unearned income received by you or another member of your assistance unit (that is, you and other people in your household who are included on your cash grant).

(c) Your community jobs contractor will review your case each month to ensure you are following your IRP and IDP, participating full time, and becoming more employable because of your community job;

(d) If you request a different community jobs placement, we do not consider your request a refusal to participate without good cause under WAC 388-310-1600. You may be asked to explain why you want a different placement;

(e) Grievance policies are in place for your protection. You will be required to sign an acknowledgment that you received a copy of this policy at the time of placement with the employer.

(9) How does community jobs affect my TANF benefits?

The amount of your TANF/SFA monthly grant will be determined by following the rules in WAC 388-450-0050 and 388-450-0215 (1), (3), (4), (5) and (6). WAC 388-450-0215(2), does not apply to your community jobs wages.

(10 What can I expect from my career jump placement?

(a) You cannot represent more than ten percent of the total labor force for an employer that has ten or more employees.

(b) No more than one community jobs participant shall be allowed per private for profit worksite supervisor.

(c) You will participate in developing a career progression plan that will include health care benefits comparable to other employees.

(d) You may be eligible for unemployment benefits if you have participated in community jobs' career jump and have worked at least six hundred eighty hours in a base year. You will gain unemployment insurance credits for all hours worked under your career jump placement.

(e) Your employer and your community jobs contractor will be required to follow DCTED's contractual agreements for career jump.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.330, and 74.08A.320. 02-20-073, § 388-310-1300, filed 9/30/02, effective 10/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-08-051, § 388-310-1300, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.08.090, 74.04.050 and 74.08A.320. 98-10-054, § 388-310-1300, filed 4/30/98, effective 5/31/98.]

WAC 388-310-1400 WorkFirst—Community service. (1) What is community service?

Community service includes two types of activities for mandatory participants:

(a) Unpaid work (such as the work performed by volunteer workers) that you perform for a charitable nonprofit organization, federal, state, local or tribal government or district; or

(b) An activity approved by your case manager which benefits you, your family, your community or your tribe. These activities may include traditional activities that perpetuate tribal culture and customs.

(2) What type of community service[s] activities benefit me, my family, my community or my tribe and might be included in my individual responsibility plan?

The following types of community service activities benefit you, your family, your community or your tribe and might be included in your individual responsibility plan:

(a) Caring for a disabled family member;

(b) Caring for a child, if you are fifty-five years old or older and receiving TANF or SFA assistance for the child as a relative (instead of as the child's parent);

(c) Providing childcare for another WorkFirst participant who is doing community service;

(d) Actively participating in a drug or alcohol assessment or treatment program which is certified or contracted by the state under chapter 70.96A RCW;

(e) Participating in family violence counseling or drug or alcohol treatment that will help you become employable or keep your job (this is called "specialized services" in state law);

(f) Participating in the pregnancy to employment pathway; and/or

(g) Job preparation.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-13-030, § 388-310-1400, filed 6/3/05, effective 7/4/05. Statutory Authority: RCW 74.08.090, 74.04.050. 00-06-062, § 388-310-1400, filed 3/1/00, effective 3/1/00; 99-10-027, § 388-310-1400, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1400, filed 10/1/97, effective 11/1/97.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-310-1450 Pregnancy to employment. (1) How do I know if I am eligible to participate in pregnancy to employment?

If you are on TANF and are pregnant or have a child under the age of twelve months, you are a participant in the pregnancy to employment pathway.

(2) What am I required to do while I am in pregnancy to employment?

You will receive an assessment from a DSHS social worker. Based on the results of the assessment you receive as a pregnancy to employment participant, you and your case manager/social worker will decide how you will be required to participate and which activities best meet your needs. The activities you are required to do will depend on where you are in the pregnancy or the age of your child.

(3) What am I required to do while I am pregnant?

(a) In the first and second trimester of pregnancy: Your participation is based upon the results of the assessment you receive and includes work, looking for work or a combination of pregnancy to employment services. You will be required to participate full-time during the first two trimesters of pregnancy unless you have a good reason to participate fewer hours (see WAC 388-310-1600).

(b) In the third trimester of pregnancy: Your participation is voluntary and may include meeting your medical needs.

(4) What am I required to do after my child is born?

You are exempt from participation after the birth of your child and until your child reaches the age of four months. You may volunteer to participate in WorkFirst activities while you are exempt (see WAC 388-310-0300).

(5) Do I have to participate full time once my child reaches age four months?

Once your child reaches four months old, you are required to participate full time unless you qualify for the one-time exemption from full-time participation. This exemption is called a part-time exemption and you can only receive it once for one child who is between four and up to twelve months old.

(6) How do I qualify for the part-time exemption?

Effective June 13, 2002, you can be exempt one-time only, from full-time participation, if you have a child age four months to twelve months old.

(7) If I qualify for the part-time exemption, what will I be required to do?

You will have to participate part-time for up to twenty hours per week (per state law) until your child is reaches twelve months old. During this time, you will be required, based upon the results of your assessment, to participate in one or more of the following:

(a) Instruction or training to improve your parenting skills or child well-being (if available);

(b) Pre-employment or job readiness training;

(c) High school completion or GED program;

(d) Volunteer in a child care facility licensed under chapter 74.15 RCW. The child care facility has to agree to accept you as a volunteer; or

(e) Volunteer to participate in job search or work activities full-time or part-time. If you change your mind about job search or work activities you will be required to participate up to twenty hours in one of the required activities listed above.

(8) What if I have used my one-time part-time exemption from full-time participation?

If you have used your one-time, part-time exemption and you have another child, when that child is between four months and twelve months old, you will be required to participate full-time in one or more of the following activities:

- (a) Work;
- (b) Looking for work; or
- (c) Preparing for work by participating in a combination of activities based upon the results of your assessment.

(9) What services are provided in the pregnancy to employment?

This pathway provides you with services, as available within your community, to help you learn how to work while still meeting your child's needs. You and your case manager will decide which of the variety of services you need, such as help finding:

- (a) Parenting classes;
- (b) Safe and appropriate child care;
- (c) Good health care for yourself and your child; and/or
- (d) Employment services.
- (e) If you are currently employed you will receive the assessment at your next individual responsibility plan review.

(10) What determines which services I will receive and what my participation will be?

- (a) Your assessment results (see WAC 388-310-0700) determine the services, as available within your community, that you will receive;
- (b) An individual responsibility plan will be developed jointly that reflects participation and services available to meet your needs and the needs of your child; and
- (c) Follow up contact every three months to jointly reassess your needs and the services and activities you are participating in, until your child reaches age twelve months.

(11) Will I be sanctioned if I refuse to participate in pregnancy to employment pathway?

(a) If you are a pregnant woman in your third trimester of pregnancy or if you have an infant less than three months old you will not be sanctioned for not participating.

(b) If you are in the first two trimesters of your pregnancy or have a child four months of age or older, you are required to participate and are subject to the WorkFirst sanction rules (see WAC 388-310-1600).

(12) What if I have a child between the ages of four months and twelve months but I have a good reason not to participate?

If you have a good reason not to participate and you claim good cause (WAC 388-310-1600(3)), your needs will be assessed as soon as possible, but no later than ninety days from your request. A good cause determination will establish if you will be required to participate and the types of services that will best meet your needs.

[Statutory Authority: RCW 74.08.090, 74.04.050, 02-14-087, § 388-310-1450, filed 6/28/02, effective 7/29/02; 00-06-062, § 388-310-1450, filed 3/1/00, effective 3/1/00.]

WAC 388-310-1500 WorkFirst—Employment conditions. (1) If I am a mandatory participant, are there any limitations on the type of paid or unpaid employment I must accept?

If you are a mandatory participant, you must accept paid or unpaid employment (including any activity in which an employer-employee relationship exists) unless the employment:

- (a) Is not covered by industrial insurance (described in state law under Title 51 RCW) unless you are employed by a tribal government or a tribal private for-profit business;
- (b) Is available because of a labor dispute;
- (c) Has working hours or conditions that interfere with your religious beliefs or practices (and a reasonable accommodation cannot be made);
- (d) Does not meet federal, state or tribal health and safety standards; or
- (e) Has unreasonable work demands or conditions, such as working for an employer who does not pay you on schedule.

(2) Are there any additional limitations on when I can be required to accept paid employment?

You must accept paid employment unless the job or the employer:

- (a) Pays less than the federal, state, or tribe minimum wage, whichever is higher;
- (b) Does not provide unemployment compensation coverage (described in state law under Title 50 RCW) unless you:
 - (i) Work for a tribal government or tribal for-profit business; or
 - (ii) Are a treaty fishing rights related worker (and exempt under section 7873 of the Internal Revenue code);
- (c) Requires you to resign or refrain from joining a legitimate labor organization; or
- (d) Does not provide you benefits that are equal to those provided to other workers employed in similar jobs.

(3) How many hours of unpaid employment can I be required to perform?

You can be required to work a set number of hours of unpaid employment each month. The number of hours required will not be more than your TANF, SFA or GA-S cash grant divided by the state or federal minimum wage, whichever is higher.

(4) What safeguards are in place to make sure I am not used to displace currently employed workers?

The following safeguards are in place to make sure you are not used to displace currently employed workers:

- (a) You cannot be required to accept paid or unpaid employment which:
 - (i) Results in another employee's job loss, reduced wages, reduced hours of employment or overtime or lost employment benefits;
 - (ii) Impairs existing contracts for services or collective bargaining agreements;
 - (iii) Puts you in a job or assignment, or uses you to fill a vacancy, when:

(A) Any other person is on lay off from the same (or very similar) job within the same organizational unit; or

(B) An employer ends the job of a regular employee (or otherwise reduces its workforce) so you can be hired.

(iv) Reduces current employees' opportunities for promotions.

(b) If a regular employee believes your subsidized or unpaid work activity (such as a community jobs or work experience position) violates any of the rules described above, this employee (or his or her representative) has the right to:

(i) A grievance procedure (described in WAC 388-426-0005); and

(ii) A fair hearing (described in chapter 388-02 WAC).

(5) What other rules apply specifically to subsidized or on-the-job training positions?

If you are in a subsidized or on-the-job training position:

(a) WorkFirst state agencies must stop paying your wage or on-the-job training subsidy to your employer if your employer's worksite or operation becomes involved in a strike, lockout or bona fide labor dispute.

(b) If your wage subsidy or on-the-job training agreement is ended (and we stop paying any subsidies to your employer) because you were used to displace another employee, it will be up to you and the employer to decide whether you can (or want to) keep working there.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-010, § 388-310-1500, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090 and 74.04.050, 99-10-027, § 388-310-1500, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1600 WorkFirst—Sanctions. (1) What WorkFirst requirements do I have to meet?

You must do the following when you are a mandatory WorkFirst participant:

(a) Give the department the information we need to develop your individual responsibility plan (IRP) (see WAC 388-310-0500);

(b) Show that you are participating fully to meet all of the requirements listed on your individual responsibility plan;

(c) Go to scheduled appointments listed in your individual responsibility plan;

(d) Follow the participation and attendance rules of the people who provide your assigned WorkFirst services or activities; and

(e) Accept available paid employment when it meets the criteria in WAC 388-310-1500.

(2) What happens if I don't meet WorkFirst requirements?

(a) If you do not meet WorkFirst requirements, we will send you a letter telling you what you did not do.

(b) You will have ten days to contact us so we can talk with you about the situation. You can contact us in writing, by phone, by going to the appointment described in the letter, or by asking for an individual appointment.

(c) If you do not contact us within ten days, we will make sure you have been screened for family violence and other barriers to participation. We will use existing information to decide whether:

(i) You were unable to do what was required; or

(ii) You were able, but refused, to do what was required.

(d) If you had a good reason not to do a required activity we will work with you and may change the requirements in your individual responsibility plan if a different WorkFirst activity would help you move towards independence and employment sooner. If you have been unable to meet your WorkFirst requirements because of family violence, you and your case manager will develop an IRP to help you with your situation, including referrals to appropriate services.

(e) Before you are placed in sanction:

(i) We will have a case staffing which is a meeting with you, your case manager and other people involved in your case to review your situation and make plans. At your case staffing, we will ensure you were offered the opportunity to participate, discuss what happens if you stay in sanction, discuss how participation helps you and your family and discuss how to end your sanction. You will be notified when your case staffing is going to happen so you can attend. You can invite anyone you want to come with you to your case staffing.

(ii) Effective September 1, 2006, supervisory staff will review your case and must approve the sanction.

(f) If you are sanctioned, we will actively attempt to contact you another way so we can talk to you about the benefits of participation and how to end your sanction.

(3) What is considered a good reason for not being able to do what WorkFirst requires?

You have a good reason if it was not possible to do what WorkFirst requires (or get an excused absence, described in WAC 388-310-0500(5)) due to a significant problem or event outside your control. Some examples of good reasons include, but are not limited to:

(a) You had an emergent or severe physical, mental or emotional condition, confirmed by a licensed health care professional that interfered with your ability to participate;

(b) You were threatened with or subjected to family violence;

(c) You could not locate child care for your children under thirteen years that was:

(i) Affordable (did not cost you more than your co-payment would under the working connections child care program in chapter 388-290 WAC);

(ii) Appropriate (licensed, certified or approved under federal, state or tribal law and regulations for the type of care you use and you were able to choose, within locally available options, who would provide it); and

(iii) Within a reasonable distance (within reach without traveling farther than is normally expected in your community).

(iv) You could not locate other care services for an incapacitated person who lives with you and your children.

(d) You had an immediate legal problem, such as an eviction notice; or

(e) You are a person who gets necessary supplemental accommodation (NSA) services under chapter 388-472 WAC and your limitation kept you from participating. If you have a good reason because you need NSA services, we will review your accommodation plan.

(4) What if we decide that you did not have a good reason for failing to meet WorkFirst requirements?

If we decide that you did not have a good reason for failing to meet WorkFirst requirements, we will send you a letter that tells you:

- (a) What you failed to do;
- (b) That you are in sanction status;
- (c) Penalties that will be applied to your grant;
- (d) When the penalties will be applied;
- (e) How to request a fair hearing if you disagree with this decision; and
- (f) How to end the penalties and get out of sanction status.

(5) What is sanction status?

When you are a mandatory WorkFirst participant, you must follow WorkFirst requirements to qualify for your full grant. If you or someone else on your grant doesn't comply and you can't prove that you had a good reason, you do not qualify for your full grant. This is called being in WorkFirst sanction status.

(6) Are there penalties when you or someone in my household goes into sanction status?

- (a) When someone in your household is in sanction status, we impose penalties. The penalties last until you or the household member meet WorkFirst requirements.
- (b) Your grant is reduced by the person(s) share or forty percent, whichever is more.

(7) How do I end the penalties and get out of sanction status?

To stop the penalties and get out of sanction status:

- (a) You must provide the information we requested to develop your individual responsibility plan; and/or
- (b) Start and continue to do your required WorkFirst activities for four weeks in a row (that is, twenty-eight calendar days).
- (c) When you leave sanction status, your grant will be restored to the level for which you are eligible beginning the first of the month following your four weeks of participation. For example, if you finished your four weeks of participation on June 15, your grant would be restored on July 1.

(8) What if I reapply for TANF or SFA and I was in sanction status when my case closed?

- (a) If your case closes while you are in sanction status and is reopened in six months or less, you will start out in sanction.
- (b) Effective September 1, 2006, if you come back in sanction, you will start out where you left off in sanction. (That is, if you left off in month three of sanction, you will come back on in month four of sanction.)
- (c) If your case has been closed for more than six months, you will not be in sanction status if your case is reopened.

(9) What happens effective September 1, 2006 if I stay in sanction status? Effective September 1, 2006, if you stay in sanction status:

- (a) Your case manager will review your record after you have been in sanction for at least three months in a row to make sure:
 - (i) You knew what was required;
 - (ii) You were told how to end your sanction;

- (iii) We tried to talk to you and to encourage you to participate; and

- (iv) You were given a chance to tell us if you were unable to do what we required.

- (b) Your case manager will invite you to a noncompliance sanction case staffing.

- (i) You will be notified when your noncompliance sanction case staffing is going to happen so you can attend.

- (ii) Your case manager will also invite other people who are working with your family to your noncompliance sanction case staffing, like representatives from tribes, community or technical colleges, employment security, the children's administration or limited-english proficient (LEP) pathway providers.

- (iii) You can invite anyone you want to come with you to your case staffing.

- (c) At your noncompliance sanction case staffing, we will discuss with you:

- (i) How you and your family benefit when you participate in WorkFirst activities;

- (ii) How you can participate, and get out of sanction;

- (iii) That if you continue to refuse to participate, without good cause, a sanction review panel may review your case, and decide to close your case after you have been in sanction status for six months in a row.

- (iv) How you plan to care for and support your children if a sanction review panel closes your case. We will also discuss the safety of your family, as needed, using the guidelines under RCW 26.44.030; and

- (v) How to reapply if a sanction review panel closes your case.

- (d) If you do not come to your noncompliance sanction case staffing, we will make a decision based on the information we have. We will also attempt to visit you at your home so you have another chance to talk to us about the benefits of participation and how to end your sanction.

- (e) If we decide you are refusing to participate without a good reason:

- (i) We will send you information about resources you may need if a sanction review panel closes your case;

- (ii) We will send information to a sanction review panel with a recommendation to close your case. We will only do this after a community services office administrator reviews your case to make sure the sanction is appropriate and we tried to reengage you in the program; and

- (iii) The sanction review panel will review your case and make the final decision.

(10) What is a sanction review panel?

- (a) The sanction review panel is a small group of people who are independent of your local community services office and do a thorough, objective review of your sanction.

- (b) The sanction review panel makes the final decision about whether to close your case after receiving a recommendation from your case manager and reviewing your case to make sure the original sanction was appropriate and we made attempts to reengage you in the program.

(11) What happens when a sanction review panel decides to close my case?

When a sanction review panel decides to close your case, we will send you a letter to tell you:

- (a) What you failed to do;

(b) When your case will be closed;
 (c) How to request a fair hearing if you disagree with this decision;

(d) How to end your penalties and keep your case open (if you are able to participate for four weeks in a row before we close your case); and

(e) How your participation before your case is closed can be used to meet the participation requirement in subsection (12).

(12) What if I reapply for TANF or SFA after a sanction review panel closed my case?

(a) If a sanction review panel closes your case and you apply within six months, you must participate for four weeks in a row before you can receive cash. Once you have met your four week participation requirement, your cash benefits will start, going back to the date we had all the other information we needed to make an eligibility decision.

(b) You will not be required to participate for four weeks in a row before you receive cash if you apply after your case has been closed for six months or longer.

(13) What if my TANF or SFA is closed by a sanction review panel, reopened and I go into sanction again?

(a) When a sanction review panel closes your case, and we reopen your case, we will follow all steps in subsection (9) of this section (like the case review and the non-compliance case staffing) during your second month of sanction.

(b) The sanction review panel may close your case after you are in sanction status for three months in a row.

(c) If your case is closed, and you reapply, we will follow the rules in subsection (12) of this section to reopen your case.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.260, chapter 74.08A RCW. 06-10-035, § 388-310-1600, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 74.08A.340. 04-07-025, § 388-310-1600, filed 3/8/04, effective 5/1/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-15-067, § 388-310-1600, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1600, filed 4/28/99, effective 5/29/99; 98-23-037, § 388-310-1600, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1700 WorkFirst—Self-employment.

(1) What is self-employment?

When you work for yourself and do not have an employer, you are self-employed.

(2) When can I be deferred from job search to pursue self-employment?

(a) To be deferred from job search for self-employment, you must meet all the conditions below:

(i) You must be working at least thirty-two hours a week at your business;

(ii) Your business must generate income for you that is equal to the minimum wage (state or federal, whichever is higher) times thirty-two hours per week after your business expenses are subtracted.

(iii) Your case manager will refer you to a local business resource center, and they must approve your self-employment plan;

(b) If you do not meet all these conditions, you can still be self-employed, but you will also need to participate in job search or other WorkFirst activities.

(2007 Ed.)

(3) What self-employment services can I get?

If you are a mandatory participant and have an approved self-employment plan in your individual responsibility plan, you may get the following self-employment services:

(a) A referral to community resources for technical assistance with your business plan.

(b) Small business training courses through local community organizations or technical and community colleges.

(c) Information on affordable credit, business training and ongoing technical support.

(4) What support services may I receive?

If you have an approved self-employment plan in your individual responsibility plan all support services are available.

(5) Can I get childcare?

Childcare is available if you have an approved self-employment plan in your individual responsibility plan. (See chapter 388-290 WAC for working connections child care rules.)

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-15-067, § 388-310-1700, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1700, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1800 WorkFirst—Post employment services. (1) What is the purpose of post employment services?

Post employment services help low-income parents who are working twenty hours or more a week keep and cope with their current jobs, look for better jobs, gain work skills for a career and become self sufficient.

(2) How do I obtain post employment services?

(a) You can obtain post employment services by:

(i) Asking for a referral from the local community service office;

(ii) Contacting community or technical colleges; or

(iii) Contacting the employment security department.

Employment security department staff may also telephone you if you got a job while you were on TANF or SFA to see if you are interested in receiving these services.

(b) You may qualify for different services (from various state or federal programs) depending on whether you:

(i) Are a mandatory participant (that is, you currently receive TANF or SFA benefits);

(ii) Used to receive TANF or SFA benefits; or

(iii) Have never been on TANF or SFA.

(3) Who provides post employment services and what kind of services do they provide?

(a) The employment security department can help you increase your wages, increase your job skills or find a better job by providing you with:

(i) Employment and career counseling;

(ii) Labor market information;

(iii) Job leads for a better job (sometimes called job development);

(iv) On the job training;

(v) Help with finding a job that matches your interests, abilities and skills (sometimes called job matching); and

(vi) Help with finding a new job after job loss (sometimes called reemployment).

[Title 388 WAC—p. 777]

(b) Any Washington state technical and community college can approve a skill-training program for you that will help you advance up the career ladder. Their staff will talk to you, help you decide what training would work best for you and then help you get enrolled in these programs. The college may approve the following types of training for you at any certified institution:

- (i) High school/GED,
- (ii) Vocational education training,
- (iii) Job skills training,
- (iv) Adult basic education,
- (v) English as a second language training, or
- (vi) Preemployment training.

(4) What other services are available while you receive post employment services?

While you receive post employment services, you may qualify for:

- (a) Working connections childcare if you meet the criteria for this program (described in chapter 388-290 WAC).
- (b) Other support services, such as help in paying for transportation or work expenses.
- (c) Other types of assistance for low-income families such as food stamps, medical assistance or help with getting child support that is due to you and your children.

(5) Who is eligible for post employment service, support services and childcare?

You may qualify for post employment services, support services and child care if you are working twenty hours or more a week, and:

- (a) You are current TANF or SFA recipient. You qualify for:
 - (i) All types of post employment services, unless you are in sanction status;
 - (ii) Tuition assistance from the community and technical college system;
 - (iii) WorkFirst support services; and
 - (iv) Working connections childcare.
- (b) You are a former TANF or SFA recipient. You qualify for:
 - (i) Employment retention services (help with keeping a job) for up to twelve months after exiting TANF or SFA.
 - (ii) Wage and skill progression services (help with finding a better job and/or obtaining better wages) for up to twelve months after exiting TANF or SFA.
 - (iii) Tuition assistance or preemployment training from the community and technical college system;
 - (iv) Working connections childcare assistance; and/or
 - (v) WorkFirst support services for up to six months after exiting TANF or SFA.
- (c) You are a low wage earner (that is, your family income does not exceed one hundred seventy-five percent of the federal poverty level) who has never received TANF or SFA benefits, and are in a community or technical college-approved skill training program. You may qualify for:

- (i) Tuition assistance or preemployment training from the community and technical college system; or
- (ii) Working connections child care while you are in training or school for up to a total of thirty six months.

[Title 388 WAC—p. 778]

(6) What if I lose my job while I am receiving post employment services?

If you now receive or used to receive TANF or SFA, help is available to you for up to four weeks so that you can find another job and continue in your approved post employment.

(a) The employment security department will provide you with reemployment services.

(b) At the same time, your case manager can approve up to four weeks of support services and childcare for you.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340, and 2003 c 10 § 207. 03-21-154, § 388-310-1800, filed 10/22/03, effective 10/27/03. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.-050. 02-15-067, § 388-310-1800, filed 7/11/02, effective 8/1/02. Statutory Authority: RCW 74.08A.340(2), 45 C.F.R. 260.31, RCW 74.08.090, and chapter 74.04 RCW. 00-16-055, § 388-310-1800, filed 7/26/00, effective 8/1/00. Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1800, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1900 WorkFirst—Services for American Indian tribal members and other American Indians.

(1) When might I be referred to a tribal government?

Your case manager may refer you to a tribal government when you are an American Indian who applies for or receives TANF assistance, and:

- (a) You are in the population and service area identified in a tribal government's federally-approved tribal TANF program; or
- (b) The tribal government does not operate its own TANF program, but it works with the local community service office to provide WorkFirst services and activities to meet your needs.

(2) What if I am an American Indian and am not referred to a tribal TANF program or tribal government to receive services?

WorkFirst state agencies and their community partners must give you equitable access to all WorkFirst activities and services.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 99-10-027, § 388-310-1900, filed 4/28/99, effective 5/29/99; 97-20-129, § 388-310-1900, filed 10/1/97, effective 11/1/97.]

WAC 388-310-2000 Individual development accounts (IDA). (1) What are individual development accounts?

Individual development accounts (IDAs) are special savings accounts for people eligible for or receiving TANF or SFA. The IDA's will help families save money for qualified purchases that will help them become financially self-sufficient. Your IDA account may only be used for the following qualified purchase: Acquisition cost for a first home, post-secondary education expenses, or business expenses for self-employment. You may only deposit income that you have earned through work into an IDA, the state matches those funds, helping you reach your goal more quickly.

(2) Who helps you set up an IDA?

The state office of trade and economic development (OTED) administers the IDA program. OTED contracts with local nonprofit agencies to enroll participants in the IDA program, monitor account activity and provide training and other support services while you are enrolled.

(2007 Ed.)

(3) Who can enroll in the IDA program?

To enroll in the IDA program, you must receive (or be eligible to receive) TANF or SFA assistance, or post TANF families with income below one hundred seventy-five percent of the federal poverty level. You may remain enrolled in the program for three years from the date of opening your IDA account.

(4) What happens once you enroll in the IDA program?

Once you've enrolled, your IDA contractor will help you develop an individual savings plan that identifies the steps you must take to earn the match. To earn the match you must:

(a) Attend financial skills classes to learn how to manage your personal finances.

(b) Open your savings account at a financial institution that is participating in the IDA program through an agreement with the IDA contractor.

(c) Deposit savings from earned income into your account on at least a quarterly basis.

(5) How are your IDA matching funds handled?

Your matching funds are held in a separate account until you are ready to make a qualified purchase. The IDA contractor provides you with monthly statements showing the amount of matching funds you have earned.

(6) How much money can you save with an IDA?

The state will give you up to two dollars for every dollar you save, up to a maximum match of four thousand dollars. So, if you save two thousand dollars (the maximum amount allowed), you could earn four thousand dollars in match, for a total of six thousand dollars.

(7) When can you withdraw money from your account?

When you have an IDA, you really have two types of accounts: your own savings account and a trust account holding your match funds.

(a) You can withdraw your own savings at any time - it's your money; but you will forfeit any match that was earned on those funds and could jeopardize your ability to stay in the program. You also need to report any withdrawals to your DSHS case manager if you are receiving any type of public assistance benefits.

(b) You cannot withdraw your match until you are ready to purchase your asset and have met all of the requirements in your individual savings plan. At that time, the IDA contractor will withdraw the matching funds and pay them directly to the person or organization that you are purchasing your asset from (such as the mortgage company, college, or bank).

(8) Will having an IDA affect your eligibility for other public assistance programs?

The funds held in your IDA cannot be taken into consideration when determining if you qualify for TANF, Social Security, Food Stamps, or Medicaid. However, if you withdraw savings from your IDA other than to purchase your asset, or if you leave the IDA program early, your eligibility could be affected. See WAC 388-470-0045 for more details about how IDAs affect your eligibility for other types of public assistance benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-010, § 388-310-2000, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050, 74.08.090, 74.08A.220, 01-03-042, § 388-310-2000, filed 1/9/01, effective 2/9/01.]

(2007 Ed.)

Chapter 388-400 WAC

PROGRAM SUMMARY

WAC

388-400-0005	Who is eligible for temporary assistance for needy families?
388-400-0010	Who is eligible for state family assistance?
388-400-0025	Who is eligible for general assistance-unemployable benefits?
388-400-0030	Who is eligible for refugee cash assistance?
388-400-0035	Refugee medical assistance—Summary of eligibility requirements.
388-400-0040	Am I eligible for benefits through the Washington Basic Food program?
388-400-0045	If I am not eligible for federally-funded benefits through Washington Basic Food program because of my alien status, can I receive state-funded Basic Food?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-400-0015	General assistance for children—Summary of eligibility requirements. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0015, filed 7/31/98, effective 9/1/98.] Repealed by 01-03-121, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1.
388-400-0020	General assistance for pregnant women—General eligibility requirements. [Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-08-050, § 388-400-0020, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0020, filed 7/31/98, effective 9/1/98.] Repealed by 01-07-001, filed 3/7/01, effective 5/1/01. Statutory Authority: RCW 74.04.050, 74.04.057.

WAC 388-400-0005 Who is eligible for temporary assistance for needy families? (1) You can get temporary assistance for needy families (TANF), if you:

(a) Can be in a TANF/SFA assistance unit as allowed under WAC 388-408-0015 through 388-408-0030;

(b) Meet the citizenship/alien status requirements of WAC 388-424-0010;

(c) Live in the state of Washington. A child must live with a caretaker relative, guardian, or custodian who meets the state residency requirements of WAC 388-468-0005;

(d) Do not live in a public institution unless specifically allowed under RCW 74.08.025;

(e) Meet TANF/SFA:

(i) Income requirements under chapter 388-450 WAC;

(ii) Resource requirements under chapter 388-470 WAC; and

(iii) Transfer of property requirements under chapter 388-488 WAC.

(f) Assign your rights to child support as required under WAC 388-422-0005;

(g) Cooperate with the division of child support (DCS) as required under WAC 388-422-0010 by helping them:

(i) Prove who is the father of children applying for or getting TANF or SFA; and

(ii) Collect child support.

(h) Tell us your Social Security number as required under WAC 388-476-0005;

(i) Cooperate in a review of your eligibility as required under WAC 388-434-0005;

(j) Cooperate in a quality assurance review as required under WAC 388-464-0001;

(k) Participate in the WorkFirst program as required under chapter 388-310 WAC;

(l) Report changes of circumstances as required under WAC 388-418-0005; and

(m) Complete a mid-certification review and provide proof of any changes as required under WAC 388-418-0011.

(2) If you are an adult, you must have an eligible child living with you or you must be pregnant and meet the requirements of WAC 388-462-0010.

(3) If you are an unmarried pregnant teen or teen parent:

(a) Your living arrangements must meet the requirements of WAC 388-486-0005; and

(b) You must attend school as required under WAC 388-486-0010.

(4) In addition to rules listed in subsection (1) of this section, a child must meet the following rules to get TANF:

(a) Meet the age requirements under WAC 388-404-0005; and

(b) Live in the home of a relative, court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis* as required under WAC 388-454-0005; or

(c) If the child lives with a parent or other adult relative that provides care for the child, that adult cannot have used up their sixty-month lifetime limit of TANF or SFA cash benefits as defined in WAC 388-484-0005.

(5) You cannot get TANF if you have been:

(a) Convicted of certain felonies and other crimes under WAC 388-442-0010; or

(b) Convicted of unlawful practices to get public assistance under WAC 388-446-0005 or 388-446-0010.

(6) If you are a client in a household which is eligible for a tribal TANF program, you cannot receive state and tribal TANF in the same month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 06-13-043, § 388-400-0005, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 05-14-100, § 388-400-0005, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 2004 c 54, 04-23-027, § 388-400-0005, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 04-15-057, § 388-400-0005, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1, 01-03-121, § 388-400-0005, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510, 00-05-007, § 388-400-0005, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-400-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0010 Who is eligible for state family assistance? (1) To be eligible for state family assistance (SFA), aliens must meet Washington state residency requirements as listed in WAC 388-468-0005 and immigrant eligibility requirements as listed in WAC 388-424-0015.

(2) You are eligible for SFA if you are not eligible for temporary assistance for needy families for the following reasons:

(a) You are a qualified alien and have been in the United States for less than five years as described in WAC 388-424-0006;

(b) You are an alien who is permanently residing in the United States under color of law (PRUCOL) as defined in WAC 388-424-0001;

(c) You are a nineteen or twenty-year-old student that meets the education requirements of WAC 388-404-0005;

(d) You are a caretaker relative of a nineteen or twenty-year-old student that meets the education requirements of WAC 388-404-0005; or

(e) You are a pregnant woman who has been convicted of misrepresenting their residence in order to receive benefits from two or more states at the same time.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.025, 74.08.090 and 21 U.S.C. 862a (d)(1)(A), 05-21-100, § 388-400-0010, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 04-15-057, § 388-400-0010, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510, 00-05-007, § 388-400-0010, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-400-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0025 Who is eligible for general assistance-unemployable benefits? (1) You can get general assistance-unemployable (GAU) benefits if you:

(a) Are incapacitated as required under WAC 388-448-0010 through 388-448-0120;

(b) Are at least eighteen years old or, if under eighteen, a member of a married couple;

(c) Are in financial need according to GAU income and resource rules in chapters 388-450, 388-470 and 388-488 WAC;

(d) Meet the general assistance citizenship/alien status requirements under WAC 388-424-0015(2);

(e) Provide a Social Security number as required under WAC 388-476-0005;

(f) Reside in the state of Washington as required under WAC 388-468-0005;

(g) Undergo a treatment and referral assessment as provided under WAC 388-448-0130 through 388-448-0150;

(h) Assign interim assistance as provided under WAC 388-448-0210;

(i) Report changes of circumstances as required under WAC 388-418-0005; and

(j) Complete a mid-certification review and provide proof of any changes as required under WAC 388-418-0011.

(2) You cannot get GAU benefits if:

(a) You are eligible for temporary assistance for needy families (TANF) benefits;

(b) You are eligible for state family assistance (SFA) benefits unless you are not eligible under WAC 388-400-0010;

(c) You have the ability to, but refuse to meet a TANF or SFA eligibility rule;

(d) You are eligible for supplemental security income (SSI) benefits;

(e) You are an ineligible spouse of an SSI recipient; or

(f) Social Security Administration (SSA) denied your application for benefits or terminated your benefits for failing to follow a SSI program rule or application requirement.

(3) We determine who is in your assistance unit according to WAC 388-408-0010.

(4) A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it.

If you live in a public institution, you may be eligible for GAU depending on the type of institution you are in.

(a) If you reside in a public institution and are otherwise eligible for GAU, you may be eligible for general assistance if you are:

- (i) A patient in a public medical institution; or
- (ii) A patient in a public mental institution and are:
 - (A) Sixty-five years of age or older; or
 - (B) Twenty years of age or younger.

(b) You are not eligible for GAU when you are in the custody of or confined in a public institution such as a state penitentiary or county jail including placement:

- (i) In a work release program; or
- (ii) Outside of the institution including home detention.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-13-043, § 388-400-0025, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 2004 c 54. 04-23-027, § 388-400-0025, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-400-0025, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.04.057, 74.08.090. 00-15-017, § 388-400-0025, filed 7/10/00, effective 9/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0030 Who is eligible for refugee cash assistance? (1) To be eligible for refugee cash assistance (RCA), you must:

(a) Provide the name of the voluntary agency (VOLAG) which resettled you;

(b) Meet the immigration status requirements of WAC 388-466-0005;

(c) Meet employment and training requirements of WAC 388-466-0150;

(d) Meet income and resource requirements of WAC 388-466-0140; and

(e) Report changes of circumstances as required under WAC 388-418-0005.

(2) You are not eligible to receive RCA if you:

(a) Are eligible for temporary assistance for needy families (TANF) or Supplemental Security Income;

(b) Have been denied TANF or have been terminated from TANF due to intentional noncompliance with TANF eligibility requirements; or

(c) Are a full-time student in an institution of higher education.

(3) We determine your eligibility and benefit level for RCA using the TANF payment standards under WAC 388-478-0020.

(4) If you are eligible for RCA you may also be eligible for additional requirements for emergent needs under WAC 388-436-0002.

(5) If you meet the requirements of this section you are eligible for refugee cash assistance only during the eight-month period beginning in the first month you entered the United States (WAC 388-466-0120).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-19-135, § 388-400-0030, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.320, and 7 C.F.R. § 400.65, § 400.66, § 400.67, § 400.68, and § 400.69. 02-09-051, § 388-400-0030, filed 4/12/02, effective 5/13/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 01-06-031, § 388-400-0030, filed 3/2/01, effective 4/1/01; 98-16-044, § 388-400-0030, filed 7/31/98, effective 9/1/98.]

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WAC 388-400-0035 Refugee medical assistance—Summary of eligibility requirements. (1) To be eligible for refugee medical assistance (RMA), you must:

(a) Provide the name of the voluntary agency (VOLAG) which resettled you;

(b) Meet the immigration status requirements of WAC 388-466-0005;

(c) Meet monthly income standards up to two hundred percent of federal poverty level (FPL). Spenddown is available for applicants whose income exceeds two hundred percent of FPL (see WAC 388-519-0110);

(d) Receive refugee cash assistance (RCA); or

(e) Be eligible for, but choose not to apply for or receive RCA.

(2) You are not eligible to receive RMA if you are:

(a) Eligible for Medicaid; or

(b) A full-time student in institution of higher education unless the educational activity is part of a department-approved employability plan.

(3) Refugee families, including families with children who are United States citizens, are treated as single assistance units according to chapter 388-408 WAC.

(4) If you are meeting the requirements of this section, you are eligible for RMA only during the eight-month period beginning in the first month you entered the United States (see WAC 388-466-0130).

(5) A recipient of RMA whose earned income goes above the income standard remains eligible for RMA benefits until the end of the RMA eligibility period.

(6) A refugee recipient of Medicaid, whose eligibility ended due to excess earned income, is transferred to RMA without eligibility determination for the remainder of the RMA eligibility period.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.320, and 74.20A.310. 01-13-046, § 388-400-0035, filed 6/14/01, effective 7/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0040 Am I eligible for benefits through the Washington Basic Food program? The Washington Basic Food program (Basic Food) is a nutrition program to help low-income individuals and families buy food. This rule is a summary of the rules for Basic Food.

(1) When you apply for Basic Food, we decide who is in your assistance unit (AU) based on the requirements under WAC 388-408-0034 and 388-408-0035.

(2) To be eligible for Basic Food benefits, your AU must meet the eligibility requirements of the most current version of the Food Stamp Act of 1977.

(3) To be eligible for **federal** Basic Food benefits, each AU member must meet the citizenship or alien status requirements for federal benefits as described under WAC 388-424-0020.

(4) An AU member who is not eligible for federal benefits may be eligible for **state-funded** Basic Food benefits if they meet the requirements described under WAC 388-400-0045.

(5) To be eligible for **federal** or **state** Basic Food benefits, each AU member must:

(a) Be a resident of the state of Washington as required under WAC 388-468-0005;

(b) Meet the citizenship or alien status requirements of either WAC 388-424-0020 or 388-424-0025;

(c) Give us their Social Security number as required under WAC 388-476-0005;

(d) Give us proof of identity as required under WAC 388-490-0005;

(e) Participate in the food stamp employment and training program (FSE&T) as required under chapter 388-444 WAC; and

(f) Meet the eligibility criteria for strikers as described under WAC 388-480-0001.

(6) To be eligible for Basic Food, your AU must:

(a) Have countable income at or below gross and net income standards as described under WAC 388-478-0060;

(b) Have countable resources at or below your AU's resource limit under WAC 388-470-0005 unless your AU is categorically eligible under WAC 388-414-0001;

(c) Report changes of circumstances as required under WAC 388-418-0005; and

(d) Complete a mid-certification review and provide proof of any changes if required under WAC 388-418-0011.

(7) If your AU has income under the gross income standard, we deduct certain expenses from your income under WAC 388-450-0185 before we calculate your Basic Food benefits.

(8) If an eligible person in your AU is elderly or disabled, some rules may help your AU to be eligible for Basic Food or to receive more Basic Food benefits. These include:

(a) Resources limits and excluding certain resources under chapter 388-470 WAC;

(b) An excess shelter deduction over the limit set for AUs without an elderly or disabled individual under WAC 388-450-0190;

(c) A deduction for out-of-pocket medical expenses for the elderly or disabled individual if they are over thirty-five dollars a month under WAC 388-450-0200; and

(d) Being exempt from the **gross monthly income** standard under WAC 388-478-0060.

(9) For Basic Food, **elderly** means a person who is age sixty or older;

(10) For Basic Food, **disabled** means a person who:

(a) Receives SSI;

(b) Receives disability payments or blindness payments under Title I, II, XIV, or XVI of the Social Security Act;

(c) Receives disability retirement benefits from a state, local or federal government agency because of a disability considered permanent under section 221(i) of the Social Security Act;

(d) Receives disability benefits from the Railroad Retirement Act under sections 2 (a)(1)(iv) and (v) and:

(i) Meets Title XIX disability requirements; or

(ii) Is eligible for Medicare.

(e) Receives disability-related medical assistance under Title XIX of the Social Security Act;

(f) Is a veteran and receives disability payments based on one hundred percent disability;

(g) Is a spouse of a veteran and;

(i) Either needs an attendant or is permanently house-bound; or

(ii) Has a disability under section 221(i) of the Social Security Act and is eligible for death or pension payments under Title 38 of the USC.

(11) If a person in your AU attends an institution of higher education and does not meet the requirements to be an eligible student under WAC 388-482-0005, we do not count this person as a member of your AU.

(12) If your AU currently receives food benefits under WASHCAP or lives on or near an Indian reservation and receives benefits from a tribal food distribution program approved by Food and Nutrition Service (FNS), your AU is not eligible for food assistance benefits through the Washington Basic Food program.

(13) If an AU member is ineligible for any of the following reasons, we count the ineligible person's income as described under WAC 388-450-0140:

(a) Able-bodied adults without dependents who are no longer eligible under WAC 388-444-0030;

(b) Persons fleeing a felony prosecution, conviction, or confinement under WAC 388-442-0010;

(c) Persons who do not attest to citizenship or alien status as defined in WAC 388-424-0001;

(d) Persons who are ineligible aliens under WAC 388-424-0020;

(e) Persons disqualified for an intentional program violation under WAC 388-446-0015;

(f) Persons who do not provide a Social Security number when required under WAC 388-476-0005; or

(g) Persons who failed to meet work requirements under chapter 388-444 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-13-043, § 388-400-0040, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-21-025, § 388-400-0040, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-400-0040, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-14-040, § 388-400-0040, filed 6/29/04, effective 7/30/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-028, § 388-400-0040, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0045 If I am not eligible for federally-funded benefits through Washington Basic Food program because of my alien status, can I receive state-funded Basic Food? (1) If you are not eligible for federally-funded Basic Food benefits because you do not meet the alien status requirements under WAC 388-424-0020, you may be eligible for state-funded Basic Food if you meet both of the following requirements:

(a) You are a Washington state resident; and

(b) You meet the immigrant eligibility requirements under WAC 388-424-0025.

(2) State-funded Basic Food follows the same eligibility rules as federally-funded Basic Food except for rules related to alien status. A summary of the rules for Basic Food is found in WAC 388-400-0040.

(3) Some assistance units (AUs) may receive a combined benefit of both state and federal Basic Food benefits. Your AU's maximum allotment of Basic Food benefits is found under WAC 388-478-0060.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-028, § 388-400-0045, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0045, filed 7/31/98, effective 9/1/98.]

Chapter 388-404 WAC AGE REQUIREMENTS

WAC

388-404-0005	How does a child's age and attendance in school affect their eligibility for TANF and SFA?
388-404-0010	Age requirement for GA-U and ADATSA.
388-404-0015	Definition of elderly person for food and cash assistance programs.

WAC 388-404-0005 How does a child's age and attendance in school affect their eligibility for TANF and SFA? (1) To be eligible for temporary assistance for needy families (TANF) or state family assistance (SFA), a child must be:

- (a) Under age eighteen; or
- (b) Under age nineteen, and participating full-time in a secondary school program or the same level of vocational or technical training.
 - (i) "Participating" means the educational or training institution finds that the child:
 - (A) Meets the school's attendance requirements; and
 - (B) Is making acceptable progress in finishing the program.
 - (ii) The educational or training institution sets the definition of "full-time" attendance and the number of classes a child must take.
 - (iii) A secondary education includes high school, a GED program, and state-approved home schools.
- (2) If a child age eighteen or older has already met the requirements to finish the educational program, the child is no longer eligible for TANF or SFA.

(3) If the child does not qualify for assistance under subsection (1) of this section, they may qualify for SFA if the child is under age twenty-one and:

- (a) Gets an education due to their disability as stated in RCW 28A.155.020; or
- (b) Participates full-time in a secondary education program or an equal level of vocational training as defined in (1)(b) above.
- (4) If a child that gets SFA is age nineteen or over, they are not eligible for family medical or SFA-related medical.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-404-0005, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-404-0005, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-404-0010 Age requirement for GA-U and ADATSA. To be eligible for general assistance - unemployable (GA-U) or the ADATSA program a person must be:

- (1) At least eighteen years of age or older; or
- (2) For GA-U only, if under eighteen years of age, a member of a married couple:
 - (a) Residing together, or
 - (b) Residing apart solely because a spouse is:
 - (i) On a visit of ninety days or less;

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- (ii) In a public or private institution;
- (iii) Receiving care in a hospital, long-term care facility, or chemical dependency treatment facility; or
- (iv) On active duty in the uniformed military services of the United States.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-404-0015 Definition of elderly person for food and cash assistance programs. For food and cash assistance, "elderly person" means a person sixty years of age or older.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0015, filed 7/31/98, effective 9/1/98.]

Chapter 388-406 WAC APPLICATIONS

WAC

388-406-0005	Can I apply for cash, medical, or Basic Food?
388-406-0010	How do I apply for benefits?
388-406-0012	What is the date of my application and how does it affect my benefits?
388-406-0015	Can I get Basic Food right away?
388-406-0021	How does being a migrant or seasonal farmworker affect my application for Basic Food?
388-406-0030	Do I need to submit other information after I apply for benefits?
388-406-0035	How long does the department have to process my application?
388-406-0040	What happens if the processing of my application is delayed?
388-406-0045	Is there a good reason my application for cash or medical assistance has not been processed?
388-406-0050	How do I know when my application is processed?
388-406-0055	When do my benefits start?
388-406-0060	What happens when my application is denied?
388-406-0065	Can I still get benefits even after my application is denied?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-406-0020	Destitute household definition. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0020, filed 7/31/98, effective 9/1/98.] Repealed by 99-24-008, filed 11/19/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-406-0025	Applicant to provide information needed to determine eligibility. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0025, filed 7/31/98, effective 9/1/98.] Repealed by 02-11-137, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.

WAC 388-406-0005 Can I apply for cash, medical, or Basic Food? (1) You can apply for any benefit the department offers, including cash assistance, medical assistance, or Basic Food.

(2) You must meet certain eligibility requirements in order to receive a program benefit.

(3) You can apply for someone else if you are:

- (a) A legal guardian, caretaker, or authorized representative applying for:
 - (i) A dependent child;
 - (ii) An incapacitated person; or
 - (iii) Someone who is deceased.

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(b) Applying for someone who cannot apply for some other reason. We may ask why the applicant is unable to apply on their own behalf.

(4) If you get Supplemental Security Income (SSI), you do not need to apply for medical benefits. We automatically open medical benefits for you.

(5) A person or agency may apply for GAU or medical assistance for you if:

- (a) You temporarily live out-of-state; and
- (b) You are a Washington state resident.

(6) When you are confined or incarcerated in a Washington State public institution, you may apply for cash or medical assistance within forty-five days prior to your expected release date if you meet the following criteria:

(a) You are confined by or in the following public institutions:

- (i) Department of Corrections;
- (ii) City or county jail; or
- (iii) Institution for Mental Diseases (IMD).

(b) Staff at the public institution provide medical records including diagnosis by a mental health professional that you have a mental disorder (as defined in the Diagnostic and Statistical Manual of Psychiatric Disorders, most recent edition) that affects your thoughts, mood or behavior so severely that it prevents you from performing any kind of work.

(7) The department will make an eligibility determination for medical assistance prior to your release from confinement and will authorize medical benefits upon your release from confinement when you:

- (a) Meet the criteria of subsection (6) in this section; and
- (b) Were receiving Medicaid or General Assistance benefits immediately before confinement or within the five years prior to confinement.

(8) If you meet the criteria in subsection (6) but did not receive Medicaid or General Assistance benefits within the past five years, the department will process your request for medical assistance within the time frames in WAC 388-406-0035.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.09.555, 06-08-047, § 388-406-0005, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 03-22-039, § 388-406-0005, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090, 02-11-137, § 388-406-0005, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-406-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0405 and 388-504-0410.]

WAC 388-406-0010 How do I apply for benefits? (1)

You can apply for cash assistance, medical assistance, or Basic Food by giving us an application form in person, by mail, by fax, or by completing an online application.

(2) If your entire assistance unit (AU) gets or is applying for Supplemental Security Income (SSI), your AU can file an application for Basic Food at the local Social Security Administration District Office (SSADO).

(3) If you are incapacitated, a dependent child, or cannot apply for benefits on your own for some other reason, a legal guardian, caretaker, or authorized representative can apply for you.

(4) You can apply for cash assistance, medical assistance, or Basic Food with just one application form.

(5) If you apply for benefits at a local office, we accept your application on the same day you come in. If you apply at an office that does not serve the area where you live, we send your application to the appropriate office by the next business day so that office receives your application on the same day we send it.

(6) We accept your application for benefits if it has at least:

(a) For cash or medical assistance, the name, address, and signatures of the responsible adult AU members or person applying for you. A minor child may sign if there is no adult in the AU. Signatures must be either handwritten, electronic or digital as defined by the department, or a mark if witnessed by another person; or

(b) For Basic Food, the name, address, and signature of a responsible member of your AU or person applying for you as an authorized representative under WAC 388-460-0005.

(7) As a part of the application process, we may require you to:

(a) Complete an interview if one is required under WAC 388-452-0005;

(b) Meet WorkFirst participation requirements for four weeks in a row if required under WAC 388-310-1600(12);

(c) Give us the information we need to decide if you are eligible as required under WAC 388-406-0030; and

(d) Give us proof of information as required under WAC 388-490-0005 so we can determine if you are eligible.

(8) If you are eligible for necessary supplemental accommodation (NSA) services under chapter 388-472 WAC, we help you meet the requirements of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW, 06-10-034, § 388-406-0010, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 03-22-039, § 388-406-0010, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090, 02-11-137, § 388-406-0010, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-406-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0405.]

WAC 388-406-0012 What is the date of my application and how does it affect my benefits? The date of your application affects when your benefits start. The date of your application is the date any field office receives your application unless:

(1) Your entire assistance unit gets or applies for Supplemental Security Income (SSI) and applies for Basic Food at the local Social Security office. The date of application is the date Social Security gets your application; or

(2) You apply outside of normal business hours, including applications you submitted online, dropped off, or sent to us by fax. The date of your application is the next business day.

(3) You request Basic Food benefits when you have applied for benefits through another department program, but we have not made a decision on the application. We call this a "pending application." If you ask for Basic Food benefits when you have a pending application for another program:

(a) We use your application for the other program, but we use the date you requested food benefits as your date of application for Basic Food; and

(b) You must provide us the necessary information to determine if you are eligible for Basic Food, even if we did not need this information for the other program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0012, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-11-137, § 388-406-0012, filed 5/21/02, effective 7/1/02.]

WAC 388-406-0015 Can I get Basic Food right away? (1) When the department gets your Basic Food application, we look at your circumstances at the time you applied to see if you can get benefits within five calendar days. This is called "expedited service."

(2) To get expedited service, you must provide proof of who you are and meet one of the following conditions:

(a) Have gross monthly income (before taxes), minus exclusions as defined in WAC 388-450-0015, of under one hundred fifty dollars **and** have available cash of one hundred dollars or less; or

(b) Have gross monthly income (before taxes), minus exclusions as defined in WAC 388-450-0015, **plus** available cash of less than your total shelter costs (rent or mortgage and the utility allowance you are eligible for under WAC 388-450-0195); or

(c) Be a destitute migrant or seasonal farm worker household, under WAC 388-406-0021, **and** your household's available cash is one hundred dollars or less.

(3) If you are eligible for expedited service and are not required to have an office interview under WAC 388-452-0005, you can have a telephone interview and still get benefits within five days.

(4) If you are applying for Basic Food, "day one" of your five-day expedited service period starts on the:

(a) Day after the date you filed your application;

(b) Date you are released from a public institution; or

(c) Date of your interview if you:

(i) Waived your expedited interview and we decide you are eligible for expedited service during your rescheduled interview; or

(ii) Were screened as ineligible for expedited service and we later determine you are eligible for the service during your interview.

(5) If you get expedited service, we only require verification of your identity to provide your first benefit issuance within five days. Other required verifications may be postponed.

(6) All postponed verification must be provided for your ongoing eligibility to be determined and any additional benefits to issue. If you applied:

(a) On or before the 15th of the month, we issue one month's benefits and you have up to thirty days from the date of application to give us any postponed verification; or

(b) On or after the 16th of the month, we issue two months' benefits and you have until the end of the second month to give us any postponed verification.

(7) If we can determine ongoing eligibility at your interview and do not need to postpone any required verifications, we will assign you a regular certification period as described in WAC 388-416-0005.

(2007 Ed.)

(8) If you have received expedited service in the past, you can get this service again if you meet the requirements listed in subsection (2) above and you:

(a) Gave us all the information we needed to determine ongoing eligibility for your last expedited service benefit period; or

(b) Were certified under normal processing standards after your last expedited certification.

(9) If you reapply for benefits:

(a) Before your certification period ends, you are not eligible for expedited service;

(b) After your certification period ends, your five-day expedited service period is the same as a new application;

(c) While you receive transitional food assistance as described in chapter 388-489 WAC, you are not eligible for expedited service.

(10) If you are denied expedited service, you can ask for a department review of our decision. We review the decision within two working days.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-22-075, § 388-406-0015, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 03-22-061, § 388-406-0015, filed 11/3/03, effective 12/4/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 20 C.F.R. 416.2130. 02-20-068, § 388-406-0015, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-036, § 388-406-0015, filed 8/28/01, effective 10/1/01. Statutory Authority: RCW 74.04.510 and Section 11 (e)(9) of the Food Stamp Act. 00-06-015, § 388-406-0015, filed 2/22/00, effective 4/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0015, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0021 How does being a migrant or seasonal farmworker affect my application for Basic Food? The rules in this section apply to Basic Food assistance.

(1) A migrant farmworker is a person who travels away from home on a regular basis, usually with a group of other workers, to seek employment in an agriculturally related activity. A migrant assistance unit is an assistance unit that travels for this purpose.

(2) A migrant assistance unit (AU) is an AU that travels for this purpose.

(3) A seasonal farmworker is a person who:

(a) Does agricultural work on a farm for edible crops; and

(b) Is not required to be away from their permanent place of residence overnight in order to perform this work.

(4) Agricultural work is field work in either planting, cultivating, or harvesting a crop.

(5) We consider your AU a seasonal farmworker AU if it receives its only countable income from:

(a) Seasonal farmwork;

(b) Unemployment compensation between seasons; or

(c) Interest your AU earns on a checking or savings account.

(6) Your migrant or seasonal farmworker is destitute if:

(a) Your AU received your income for the month of application before the date you applied for benefits and the source of this income no longer provides income; or

(b) Your AU's income for the month of application is from a new source and your AU will not receive more than

twenty-five dollars during the ten calendar days from the date you applied for benefits.

(7) If someone in your AU changes jobs but still works for the same employer, we consider them to be receiving income from the same source.

(8) If your AU is a migrant or seasonal farmworker AU, and your certification period ends, we do not prorate your benefits for the first month of your new certification period unless your certification period ended more than a month before you turned in your application to recertify your benefits.

(9) If your migrant or seasonal farmworker AU is destitute:

(a) We may exclude some of your income for the month you applied for benefits under WAC 488-450-0230; and

(b) We budget your AU's income for the month you applied for benefits using the anticipating monthly method under WAC 388-450-0215.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0021, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-406-0021, filed 11/19/99, effective 1/1/00.]

WAC 388-406-0030 Do I need to submit other information after I apply for benefits? (1) When we get your application for benefits, we decide if other information is needed to determine your eligibility for benefits. If so, we give you:

(a) A written request for what is needed and for proof if required under WAC 388-490-0005; and

(b) At least ten calendar days to give us the information.

(2) If you ask orally or in writing for additional time to give us requested information, then we give you at least ten additional calendar days.

(3) If you give us some of the information we requested, we give you:

(a) A written request for what is needed to determine eligibility; and

(b) At least ten additional calendar days to give us the information.

(4) If you are eligible for necessary supplemental accommodation (NSA) services under chapter 388-472 WAC, we help you comply with the requirements of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-11-137, § 388-406-0030, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0035 How long does the department have to process my application? (1) We must process your application as quickly as possible. We must respond promptly to your application and to any information you give us. We cannot delay processing your request by using the time limits stated in this section as a waiting period for determining eligibility.

(2) Unless your application is delayed under WAC 388-406-0040, we process your application for benefits within thirty calendar days, except:

(a) If you are pregnant, we must process your application for medical within fifteen working days;

(b) If you are applying for general assistance (GA-U), alcohol or drug addiction treatment (ADATSA), or medical assistance, we must process your application within forty-five calendar days; and

(c) If you are applying for medical assistance that requires a disability decision, we must process your application within sixty calendar days.

(3) For calculating time limits, "day one" is the date following the date:

(a) The department received your application for benefits under WAC 388-406-0010;

(b) Social Security gets a request for food benefits from a Basic Food assistance unit in which all members either get or are applying for Supplemental Security Income (SSI);

(c) You are released from an institution if you get or are authorized to get SSI and request Basic Food through Social Security prior to your release.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0035, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-11-137, § 388-406-0035, filed 5/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0470.]

WAC 388-406-0040 What happens if the processing of my application is delayed? (1) We process your application for benefits as soon as possible. We do not intentionally delay processing your application for benefits for any reason. If we have enough information to decide eligibility for:

(a) Basic Food, we promptly process your request for benefits even if we need more information to determine eligibility for cash or medical;

(b) Medical assistance, we promptly process your request for medical even if we need more information to determine eligibility for cash or Basic Food.

(2) If your application for Basic Food assistance is not processed within the first thirty days and we have enough information to determine eligibility, we promptly process your application. If additional information is needed to determine eligibility, we give you:

(a) A written request for the additional information; and

(b) An additional thirty days to provide the information.

(3) If we have not processed your application for Basic Food by the sixtieth day and you are responsible for the delay, we deny your request for benefits. If we are responsible for the delay, we:

(a) Promptly process your request if we have the information needed to determine eligibility; or

(b) Deny your request if we don't have enough information to determine eligibility. If we deny your request we notify you of your right to file a new application and that you may be entitled to benefits lost. If you reapply by the sixtieth day of your first application and are eligible, we give you benefits lost from:

(i) The date of your first application if we caused the delay in the first thirty days; or

(ii) The month following the month of your first application if you caused the delay in the first thirty days.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0040, filed 10/28/03, effective 12/1/03. Statutory Authority:

ity: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0040, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0040, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

WAC 388-406-0045 Is there a good reason my application for cash or medical assistance has not been processed? If your application for cash or medical assistance is not processed within the time limits under WAC 388-406-0035, the department must decide if there is a good reason for the delay. This good reason is also called "good cause."

(1) We do not have a good reason for not processing your application for TANF or SFA within thirty days if:

(a) We did not give or send you a notice of what information we needed to determine your eligibility within twenty days from the date of your application;

(b) We did not give or send you a notice that we needed additional information or action within five calendar days of the date we learned that more information was needed to determine eligibility;

(c) We did not process your application within five calendar days from getting the information needed to decide eligibility; and

(d) We decide good cause exists but do not document our decision in the case record on or before the time limit for processing the application ends.

(2) We do have a good reason for not processing your application timely if:

(a) You do not give us the information or take an action needed for us to determine eligibility;

(b) We have an emergency beyond our control; or

(c) There is no other available verification for us to determine eligibility and the eligibility decision depends on information that has been delayed such as:

(i) Medical documentation;

(ii) For cash assistance, extensive property appraisals; or

(iii) Out-of-state documents or correspondence.

(3) For medical assistance, good cause exists only when the department otherwise acted promptly at all stages of the application process.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0045, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0045, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

WAC 388-406-0050 How do I know when my application is processed? (1) Your application is processed when:

(a) We approve or deny benefits; and

(b) We give or send you a letter telling you if you are eligible to get benefits.

(2) Any letters we send you must meet the requirements under chapter 388-458 WAC.

(3) We send you a letter of withdrawal under WAC 388-458-0006 if you voluntarily withdraw an application verbally, in sign language, or in writing.

(4) We send you a letter of denial according to the requirements of WAC 388-406-0060.

(2007 Ed.)

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0050, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-406-0050, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2505.]

WAC 388-406-0055 When do my benefits start? The date we approve your application affects the amount of benefits you get. If you are eligible for:

(1) Cash assistance, your benefits start:

(a) The date we have enough information to make an eligibility decision; or

(b) No later than the thirtieth day for TANF, SFA, or RCA; or

(c) No later than the forty-fifth day for general assistance (GAU).

(2) Basic Food, your benefits start from the date you applied unless:

(a) You are recertified for Basic Food. If you are recertified for Basic Food, we determine the date your benefits start under WAC 388-434-0010;

(b) You applied for Basic Food while living in an institution. If you apply for Basic Food while living in an institution, the date you are released from the institution determines your start date as follows. If you are expected to leave the institution:

(i) Within thirty days of the date we receive your application, your benefits start on the date you leave the institution; or

(ii) More than thirty days from the date we receive your application, we deny your application for Basic Food. You may apply for Basic Food again when your date of release from the institution is closer.

(c) We were unable to process your application within thirty days because of a delay on your part. If you caused the delay, but submit required verification by the end of the second thirty-day period, we approve your benefits starting the first day of the month following the month you applied for benefits. We start your benefits from this date even if we denied your application for Basic Food.

(d) We initially denied your application for Basic Food and your assistance unit (AU) becomes categorically eligible (CE) within sixty days from the date you applied. If your AU becoming CE under WAC 388-414-0001 makes you eligible for Basic Food, the date we approve Basic Food is the date your AU became CE.

(e) You are approved for transitional food assistance under chapter 388-489 WAC. We determine the date transitional benefits start as described under WAC 388-489-0015.

(f) You receive transitional food assistance with people you used to live with, and are now approved to receive Basic Food in a different assistance unit:

(i) We must give the other assistance unit ten days notice as described under WAC 388-458-0025 before we remove you from the transitional food assistance benefits.

(ii) Your Basic Food benefits start the first of the month after we remove you from the transitional benefits. For example, if we remove you from transitional benefits on November 30th, you are eligible for Basic Food on December 1st.

(3) Medical assistance, the date your benefits start is stated in chapter 388-416 WAC.

[Title 388 WAC—p. 787]

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-406-0055, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0055, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0055, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0060 What happens when my application is denied? (1) We (the department) deny your application for cash, medical, or Basic Food benefits if:

(a) You do not show for your interview appointment for cash or Basic Food if required under WAC 388-452-0005, you have not rescheduled, and your application is over thirty days old; or

(b) We do not have the information we need to determine your eligibility within ten days of requesting the information from your assistance unit (AU) under WAC 388-414-0001, and you did not ask for additional time to give us the information; or

(c) Your entire AU does not meet certain eligibility criteria to get benefits; or

(d) For Basic Food, your application has not been processed by the sixtieth day because of a delay on your part.

(2) If we deny your application, you do not get benefits unless:

(a) You mistakenly apply for benefits you already get; or

(b) We reconsider your eligibility under WAC 388-406-0065 and you are eligible to get benefits.

(3) We can reconsider if you are eligible for benefits under the requirements of WAC 388-406-0065 even after your application is denied.

(4) We give or send a letter to you explaining why your application was denied as required under WAC 388-458-0011.

(5) If you disagree with our decision about your application, you can ask for a fair hearing. If we deny your application because we do not have enough information to decide that you are eligible, the hearing issue is whether you are eligible using:

(a) Information we already have; and

(b) Any more information you can give us.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0060, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0060, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.057 and C.F.R. 273.2(h1d), waiver October 10, 1984. 00-13-076, § 388-406-0060, filed 6/19/00, effective 7/20/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0060, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0485.]

WAC 388-406-0065 Can I still get benefits even after my application is denied? (1) If we (the department) deny your application for benefits, we can redetermine your eligibility for benefits without a new application if:

(a) For cash or medical assistance, you give us the information we need within thirty days from the date we denied your application;

(b) You stop participating as required to reopen cash assistance under WAC 388-310-1600(12) due to one of the good reasons described in WAC 388-310-1600(3) or because

you get an excused absence, as described in WAC 388-310-0500(5);

(c) For Basic Food:

(i) You give us the information we need within sixty days of the date you applied for benefits; or

(ii) You become categorically eligible for Basic Food under WAC 388-414-0001 within sixty days of the date you applied for benefits.

(2) For medical assistance, if the thirty days to reconsider your application under subsection (1) of this section has ended you can still get benefits without a new application if:

(a) You request a fair hearing timely; and

(b) You give us the information needed to determine eligibility and you are eligible.

(3) If you are eligible for cash or Basic Food, we decide the date your benefits start according to WAC 388-406-0055. If you are eligible for medical assistance, we decide the date your benefits start according to chapter 388-416 WAC. For all programs the eligibility date is based on the date of your original application that was denied.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW. 06-10-034, § 388-406-0065, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0065, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-406-0065, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0065, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0485.]

Chapter 388-408 WAC ASSISTANCE UNITS

WAC

388-408-0005	What is a cash assistance unit?
388-408-0010	Who is in my assistance unit for general assistance?
388-408-0015	Who must be in my assistance unit for temporary assistance for needy families (TANF) or state family assistance (SFA)?
388-408-0020	When am I not allowed to be in a TANF or SFA assistance unit?
388-408-0025	When can I choose who is in my TANF or SFA assistance unit?
388-408-0030	What children must be in the same TANF or SFA assistance unit?
388-408-0034	What is an assistance unit for Basic Food?
388-408-0035	Who is in my assistance unit for Basic Food?
388-408-0040	How does living in an institution affect my eligibility for Basic Food?
388-408-0045	Am I eligible for Basic Food if I live in a shelter for battered women and children?
388-408-0050	Does the department consider me homeless for Basic Food benefits?
388-408-0055	Medical assistance units.

WAC 388-408-0005 What is a cash assistance unit?

(1) For all sections of this chapter:

(a) "**We**" means the department of social and health services.

(b) "**You**" means a person that is applying for or getting benefits from the department.

(c) "**Assistance unit**" or "**AU**" is the group of people who live together and whose income or resources we count to decide your eligibility for benefits and the amount of benefits you get.

(2) For GA-U, we decide who is in the AU under WAC 388-408-0010.

(3) For TANF or SFA, we decide who is in the AU by taking the following steps:

(a) We start with who must be in the AU under WAC 388-408-0015;

(b) We add those you choose to have in the AU under WAC 388-408-0025; and

(c) We remove those who are not allowed in the AU under WAC 388-408-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 03-17-066, § 388-408-0005, filed 8/18/03, effective 9/18/03. Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0005, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0010 Who is in my assistance unit for general assistance? (1) If you are an adult that is incapacitated as defined in WAC 388-448-0001, you can be in a GA-U AU;

(2) If you are married and live with your spouse, we decide who to include in the AU based on who is incapacitated:

(a) If you are both incapacitated as defined in WAC 388-448-0001, we include both of you in the same AU.

(b) If only one spouse is incapacitated, we include only the incapacitated spouse in the AU. We count some of the income of the spouse that is not in the AU as income to the AU under WAC 388-450-0135.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0010, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-408-0010, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0015 Who must be in my assistance unit for temporary assistance for needy families (TANF) or state family assistance (SFA)? If you live with any of the following people, we must include them in your TANF, SFA, or combination TANF/SFA AU:

(1) The child you are applying for and:

(a) The child's full, half or adoptive sibling(s);

(b) The child's natural or adoptive parent(s) or stepparent(s); and

(c) If you are a pregnant minor or minor who is a parent and you live with your parent(s), we include your parent(s) if they:

(i) Need assistance; and

(ii) Provide the primary care for you, your child, or your siblings. We count full, half, or adoptive siblings as your sibling.

(2) If you are pregnant and you do not have a dependent child living with you, we include only you in the AU.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0015, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-408-0015, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0020 When am I not allowed to be in a TANF or SFA assistance unit? Some people cannot be in an AU for TANF or SFA. This section describes who cannot

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be in your TANF or SFA AU and how this will affect your benefits.

(1) We do not include the following people in your TANF or SFA AU:

(a) An adopted child if:

(i) The child gets federal, state, or local adoption assistance; and

(ii) Including the child in the AU and counting the adoption assistance income would reduce your AU's benefits.

(b) A minor parent or child who has been placed in Title IV-E, state, or locally-funded foster care unless the placement is a temporary absence under WAC 388-454-0015;

(c) An adult parent in a two-parent household when:

(i) The other parent is unmarried and under the age of eighteen; and

(ii) We decide that your living arrangement is not appropriate under WAC 388-486-0005.

(d) A court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis* (in the place of a parent) if they are not a relative of one of the children in the AU as defined under WAC 388-454-0010; or

(e) Someone who gets SSI benefits.

(2) If someone that lives with you cannot be in the AU:

(a) We do not count them as a member of the AU when we determine the AU's payment standard; and

(b) We do not count their income unless they are financially responsible for a member of the AU under WAC 388-450-0095 through 388-450-0130.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0020, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-408-0020, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0025 When can I choose who is in my TANF or SFA assistance unit? If you are a child's parent or other caretaker relative (a relative who cares for the child's basic needs as defined in WAC 388-454-0010), use the table below to find who you may choose to include or exclude in your TANF or SFA AU. If you include a child in your AU, it could cause you to get more or less benefits. If someone is not allowed in the AU under WAC 388-408-0020, you cannot choose to include them in your TANF or SFA AU.

(1) If you are the parent of the child, you may choose whether or not to include:	(a) Yourself in the AU if the child gets SSI; and (b) The child in the AU if: (i) You already receive TANF or SFA; (ii) You are not married to the child's other parent; and (iii) The child lives with both parents.
(2) If you are not the child's parent, and do not live with the parents of the child, you may choose to:	(a) Include yourself if you are a relative defined in WAC 388-454-0010; (b) Include someone else that cares for the child and is a relative defined in WAC 388-454-0010; or (c) Receive a grant for the child only.
(3) If you are the child's parent or caretaker relative, you may choose whether or not to include any of the following children:	(a) Brothers or sisters of a child who gets SSI; (b) Stepsisters and stepbrothers of a child; and (c) Other children that are not the child's brother or sister.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-02-017, § 388-408-0025, filed 12/27/04, effective 1/27/05. Statutory Author-

ity: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0025, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0030 What children must be in the same TANF or SFA assistance unit? A child who applies for or gets TANF or SFA must be in the same AU as other children who get TANF or SFA and live with the same:

- (1) Caretaker relative;
 - (2) Court-ordered guardian or court-ordered custodian;
- or
- (3) Adult acting *in loco parentis*.

[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-408-0030, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0034 What is an assistance unit for Basic Food? For all sections of this chapter:

"We" means the department of social and health services;

"You" means any person applying for or receiving benefits from the department including minor children;

"Assistance unit" or **"AU"** is the group of people who live together and whose income and resources we count to decide if you are eligible for benefits and the amount of benefits you get.

"Boarder" means a person who:

- (1) We decide pays a reasonable amount for lodging and meals; or
- (2) Is in foster care.

"Live-in attendant" means a person who lives in the home and provides medical, housekeeping, childcare, or similar personal services an AU member needs because:

- (1) A member is aged, incapacitated, or disabled;
- (2) A member of the AU is ill; or
- (3) A minor child in the AU needs childcare.

"Parent" means a natural, step, or adoptive parent. A stepparent is not a parent to a child if the marriage to the child's natural parent ends due to divorce or death.

A person who lives with you pays a **"reasonable amount"** for meals if:

- (1) You provide two or more meals a day and they pay at least the maximum allotment under WAC 388-478-0060 for their AU size; or
- (2) You provide one meal a day and they pay at least two-thirds the maximum allotment under WAC 388-478-0060 for their AU size.

"Roomer" means a person who pays for lodging, but not meals;

A person has a **"separate residence"** from an AU if they have separate living, cooking, and sanitation facilities.

"Spouse" means your husband or wife through a legally recognized marriage.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-06-025, § 388-408-0034, filed 2/23/04, effective 4/1/04; 03-19-118, § 388-408-0034, filed 9/16/03, effective 11/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0034, filed 10/16/01, effective 12/1/01.]

WAC 388-408-0035 Who is in my assistance unit for Basic Food? (1) For Basic Food, a person must be in your assistance unit (AU) if they live in the same home as you and:

- (a) Regularly buy food or prepare meals with you; or
- (b) You provide meals for them and they pay less than a reasonable amount for meals.

(2) If the following people live with you, they must be in your AU even if you do not usually buy or prepare food together:

- (a) Your spouse;
- (b) Your parents if you are under age twenty-two (even if you are married);
- (c) Your children under age twenty-two;
- (d) The parent of a child who must be in your AU;
- (e) A child under age eighteen who doesn't live with their parent unless the child:

- (i) Is emancipated;
- (ii) Gets a TANF grant in their own name; or
- (iii) Is not financially dependent on an adult in the AU because they get and have control of income of at least the TANF payment standard under WAC 388-478-0020(2) before taxes or other withholdings.

(3) If any of the people in subsections (1) or (2) already receive transitional food assistance under chapter 388-489 WAC, you can only receive benefits if they choose to reapply for Basic Food as described in WAC 388-489-0020.

(4) If you live in an institution where you may be eligible for Basic Food under WAC 388-408-0040, we decide who is in your AU as follows:

- (a) If the facility is acting as your authorized representative under WAC 388-460-0015, we include you and anyone who must be in your AU under subsection (2) of this rule; or
- (b) If you apply for benefits on your own, we include you, anyone who must be in your AU under subsection (2) of this rule, and other residents you choose to apply with.

(5) Anyone who must be in your AU under subsection (1) or (2) is an ineligible AU member if they:

- (a) Are disqualified for an intentional program violation (IPV) under WAC 388-446-0015;
- (b) Do not meet ABAWD work requirements under WAC 388-444-0030.

(c) Do not meet work requirements under WAC 388-444-0055;

(d) Do not provide a Social Security number under WAC 388-476-0005;

(e) Do not meet the citizenship or alien status requirements under chapter 388-424 WAC;

(f) Are fleeing a felony charge or violating a condition of parole or probation under WAC 388-442-0010.

(6) If your AU has an ineligible member:

- (a) We count the ineligible member's income as part of your AU's income under WAC 388-450-0140;
- (b) We count all the ineligible members resources to your AU; and

(c) We do not use the ineligible member to determine your AU's size for the maximum income amount or allotment under WAC 388-478-0060.

(7) If the following people live in the same home as you, you can choose if we include them in your AU:

- (a) A permanently disabled person who is age sixty or over and cannot make their own meals if the total income of

everyone else in the home (not counting the elderly and disabled person's spouse) is not more than the one hundred sixty-five percent standard under WAC 388-478-0060;

(b) A boarder. If you do not include a boarder in your AU, the boarder cannot get Basic Food benefits in a separate AU;

(c) A person placed in your home for foster care. If you do not include this person in your AU, they cannot get Basic Food benefits in a separate AU;

(d) Roomers; or

(e) Live-in attendants even if they buy or prepare food with you.

(8) If someone in your AU moves out of your home for at least a full issuance month, they are not eligible for benefits as a part of your AU, unless you receive transitional food assistance.

(9) For transitional food assistance, your TFA AU includes the people who were in your Basic Food AU for the last month you received:

(a) Temporary assistance for needy families;

(b) State family assistance; or

(c) Tribal TANF benefits.

(10) If someone received Basic Food or food stamps in another AU or another state, they cannot receive benefits in your AU for the same period of time with one exception. If you already received Basic Food, food stamp, or transitional food assistance benefits:

(a) In another state, you are not eligible for Basic Food for the period of time covered by the benefits you received from the other state; or

(b) In another AU, you are not eligible for Basic Food in a different AU for the same period of time;

(c) In another AU, but you left the AU to live in a shelter for battered women and children under WAC 388-408-0045, you may be eligible to receive benefits in a separate AU.

(11) The following people who live in your home are not members of your AU. If they are eligible for Basic Food, they may be a separate AU:

(a) Someone who usually buys and prepares food separately from your AU if they are not required to be in your AU; or

(b) Someone who lives in a separate residence.

(12) A student who is ineligible for Basic Food under WAC 388-482-0005 is not a member of your AU.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-19-061, § 388-408-0035, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-14-040, § 388-408-0035, filed 6/29/04, effective 7/30/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-06-025, § 388-408-0035, filed 2/23/04, effective 4/1/04; 03-19-118, § 388-408-0035, filed 9/16/03, effective 11/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0035, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0040 How does living in an institution affect my eligibility for Basic Food? (1) For Basic Food, an "institution" means a place where people live that provides residents more than half of three meals daily as a part of their normal services.

(2) Most residents of institutions are not eligible for Basic Food.

(2007 Ed.)

(3) If you live in one of the following institutions, you may be eligible for Basic Food even if the institution provides the majority of your meals:

(a) Federally subsidized housing for the elderly;

(b) Qualified drug and alcohol treatment centers when an employee of the treatment center is the authorized representative as described under WAC 388-460-0010;

(c) Qualified DDD group homes for persons with disabilities;

(d) A shelter for battered women and children when the resident left the home that included the abuser; or

(e) Nonprofit shelters for the homeless.

(4) A qualified DDD group home is a nonprofit residential facility that:

(a) Houses sixteen or fewer persons with disabilities as defined under WAC 388-400-0040(6); and

(b) Is certified by the division of developmental disabilities (DDD).

(5) A qualified drug and alcohol treatment center is a residential facility that is:

(a) Authorized as a retailer by the U.S. Department of Agriculture, Food and Nutrition Service; or

(b) Operated by a private nonprofit organization; and

(c) Certified by the division of alcohol and substance abuse (DASA) as:

(i) Receiving funds under part B of title XIX of the Public Health Service Act;

(ii) Eligible to receive funds under part B of title XIX of the Public Health Service Act, but does not receive these funds; or

(iii) Operating to further the purposes of part B of the Public Health Service Act to provide treatment and rehabilitation of drug addicts or alcoholics.

(6) Elderly or disabled individuals and their spouses may use Basic Food benefits to buy meals from the following meal providers if FNS has approved them to accept Basic Food benefits:

(a) Communal dining facility; or

(b) Nonprofit meal delivery service.

(7) If you are homeless, you may use your Basic Food benefits to buy prepared meals from nonprofit organizations the department has certified as meal providers for the homeless.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 7 U.S.C. 2012 and 7 C.F.R. 273.1. 06-24-024, § 388-408-0040, filed 11/29/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.055 [74.04.055], 74.04.057, 74.04.510. 03-19-118, § 388-408-0040, filed 9/16/03, effective 11/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0040, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0045 Am I eligible for Basic Food if I live in a shelter for battered women and children? (1) You may be eligible for Basic Food benefits if you live in a shelter for battered women and children.

(2) If you live in a shelter for battered women and children and you left an assistance unit (AU) that included the abuser, as a separate AU for Basic Food:

(a) You may get additional amount of Basic Food benefits even if you received benefits with the abuser.

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(b) The department will decide your eligibility and benefits based on:

- (i) The income and resources you have access to; and
- (ii) The expenses you are responsible for.

[Statutory Authority: RCW 74.04.050, 74.04.055 [74.04.055], 74.04.057, 74.04.510. 03-19-118, § 388-408-0045, filed 9/16/03, effective 11/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0045, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0050 Does the department consider me homeless for Basic Food benefits? The department considers you as homeless if you do not have a regular nighttime residence or when you stay primarily in a:

- (1) Supervised shelter that provides temporary living or sleeping quarters;
- (2) Halfway house that provides a temporary residence for persons going into or coming out of an institution;
- (3) Residence of another person that is temporary and the client has lived there for ninety days or less; or
- (4) A place not usually used as sleeping quarters for humans.

[Statutory Authority: RCW 74.04.050, 74.04.055 [74.04.055], 74.04.057, 74.04.510. 03-19-118, § 388-408-0050, filed 9/16/03, effective 11/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-060, § 388-408-0050, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0055 Medical assistance units. (1) One or more medical assistance units (MAU) is established for individuals living in the same household based on the type of medical program, each individual's relationship to other family members, and the individual's financial responsibility for the other family members.

(2) Financial responsibility applies only to spouses and to parents, as follows:

(a) Married persons, living together are financially responsible for each other;

(b) Persons who meet the definition of a natural, adoptive, or step-parent described in WAC 388-454-0010 are financially responsible for their unmarried, minor children living in the same household; and

(c) Minor children are not financially responsible for their parents or for their siblings.

(3) When determining eligibility for family, pregnancy, or children's medical programs, separate MAUs are required for family members living in the same household in the following situations:

(a) A pregnant minor, regardless of whether she lives with her parent(s);

(b) A child with earned or unearned income;

(c) A child with resources which make another family member ineligible for medical assistance;

(d) A child of unmarried parents when both parents reside with the child;

(e) Each unmarried parent of a child in common, plus any of their children who are not in separate MAUs;

(f) A caretaker relative that is not financially responsible for the support of the child;

(4) For a family with multiple MAUs established based on the criteria described in subsection (3) of this section, a parent's:

(a) Income up to one hundred percent of the Federal Poverty Level (FPL) is allocated to the parent and other members of the parent's MAU. The excess is allocated to their children in separate MAUs.

(b) Resources are allocated equally to the parent and all persons in the parent's household for whom the parent is financially responsible. This includes family members in separate MAUs.

(5) The exceptions to the income allocations described in subsection (4) of this section are as follows:

(a) Only the parent's income actually contributed to a pregnant minor is considered income to the minor.

(b) A parent's financial responsibility is limited when the minor child is receiving inpatient chemical dependency or mental health treatment. Only the income a parent chooses to contribute to the child is considered available when:

(i) The treatment is expected to last ninety days or more;

(ii) The child is in court-ordered, out-of-home care in accordance with chapter 13.34 RCW; or

(iii) The department determines the parents are not exercising responsibility for the care and control of the child.

(6) When determining eligibility for an SSI-related medical program, a separate MAU is required for:

(a) SSI recipients;

(b) An SSI-related person who has not been found eligible for family medical under this chapter; or

(c) The purpose of applying medical income standards for an:

(i) SSI-related applicant whose spouse is not relatable to SSI or is not applying for SSI-related medical; and

(ii) Ineligible spouse of an SSI recipient.

(7) For a person in a separate MAU, based on the criteria described in subsection (6) of this section, the income and resource allocations described in subsection (4) of this section are not used. The SSI-related individual's eligibility is determined using the allocations or deeming rules in chapter 388-475 WAC.

(8) Countable income for medical programs:

(a) For SSI individuals is described in chapter 388-475 WAC; or

(b) For family medical, pregnancy medical, and children's medical is described in WAC 388-450-0210.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 06-04-021, § 388-408-0055, filed 1/23/06, effective 2/23/06. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-408-0055, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610, 388-506-0630 and 388-507-0730.]

Chapter 388-410 WAC BENEFIT ERROR

WAC

388-410-0001
388-410-0005

What is a cash/medical assistance overpayment?
Cash and medical assistance overpayment amount and liability.

388-410-0010

Repayment of grant overpayment occurring prior to April 3, 1982, and resulting department error.

388-410-0015	Recovery of cash assistance overpayments by mandatory grant deduction.
388-410-0020	What happens if I receive more Basic Food or WASHCAP benefits than I am supposed to receive?
388-410-0025	Am I responsible for an overpayment in my assistance unit?
388-410-0030	How does the department calculate and set up my Basic Food or WASHCAP overpayment?
388-410-0033	How and when does the department collect a Basic Food or WASHCAP overpayment?
388-410-0035	Alien and alien sponsor cash, and food assistance overpayments.
388-410-0040	Cash and food assistance underpayments.

WAC 388-410-0001 What is a cash/medical assistance overpayment? (1) An overpayment is any cash or medical assistance paid that is more than the assistance unit was eligible to receive.

(2) There are two types of cash/medical overpayments:

(a) Intentional overpayments, presumed to exist if you willfully or knowingly:

(i) Fail to report a change you must tell us about under WAC 388-418-0005 within the time frames under WAC 388-418-0007; or

(ii) Misstate or fail to reveal a fact affecting eligibility as specified in WAC 388-446-0001.

(b) Unintentional overpayments, which includes all other client-caused and all department-caused overpayments.

(3) If you request a fair hearing and the fair hearing decision is in favor of the department, then:

(a) Some or all of the continued assistance you get before the fair hearing decision must be paid back to the department (see WAC 388-418-0020); and

(b) The amount of assistance you must pay back will be limited to sixty days of assistance, starting with the day after the department receives your hearing request.

(4) If you receive child support payments directly from the noncustodial parent, you must turn these payments over to the division of child support (DCS). These payments are not cash assistance overpayments.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 05-08-124, § 388-410-0001, filed 4/5/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-010, § 388-410-0001, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.510 and 7 C.F.R. 273.9 (d)(6), 99-24-131, § 388-410-0001, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-410-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0005 Cash and medical assistance overpayment amount and liability. (1) The amount of overpayment for cash and medical assistance households is determined by the amount of assistance received to which the assistance unit was not entitled.

(2) Cash and medical assistance overpayments are recovered from:

(a) Any individual member of an overpaid assistance unit, whether or not the member is currently a recipient; or

(b) Any assistance unit of which a member of the overpaid assistance unit has subsequently become a member.

(3) A cash or medical assistance overpayment is not recovered from:

(a) A nonneedy caretaker relative or guardian who received no financial benefit from the payment of assistance; or

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(b) A person not receiving assistance when an unintentional overpayment of less than thirty-five dollars is discovered and/or computed.

(4) Overpayments resulting from incorrectly received cash assistance are reduced by:

(a) Cash assistance a household would have been eligible to receive from any other category of cash assistance during the period of ineligibility; and

(b) Child support the department collected for the month of overpayment in excess of the amount specified in (a) of this subsection; or

(c) Any existing grant underpayments.

(5) A cash assistance overpayment cannot be reduced by a medical or food assistance underpayment.

(6) A medical assistance overpayment cannot be reduced by a cash or food assistance underpayment.

(7) An underpayment from one assistance unit cannot be credited to another assistance unit to offset an overpayment.

(8) All overpayments occurring after January 1, 1982 are required to be repaid by mandatory grant deduction except where recovery is inequitable as specified in WAC 388-410-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-410-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0010 Repayment of grant overpayment occurring prior to April 3, 1982, and resulting department error. (1) An assistance unit will not be held liable for an overpayment occurring prior to April 3, 1982, which was caused by departmental error, until the department determines recovery would not be inequitable. Recovery is considered inequitable if:

(a) The department informed the recipient or the recipient's authorized representative that the recipient was entitled to part or all of the financial assistance or services overpaid; or

(b) The department acted in a manner which would reasonably lead the recipient to believe he/she was eligible to receive the assistance or services overpaid; and

(c) The recipient retained or accepted the assistance with the understanding that he/she had the right to rely upon the information received from the department; and

(d) The recipient would suffer an injury if the department were allowed to refuse to recognize the department's admission, statement, act or omission; and

(e) Injury as used in this section includes liability for repayment of a debt due the state.

(2) If the department determines recovery would be inequitable:

(a) The recipient is not liable for repayment;

(b) The overpayment is not a debt due the state; and

(c) The recipient is so informed.

(3) If recovery would not be inequitable, the recipient will be notified:

(a) Of the specific reason why recovery is not inequitable;

(b) That the recipient is liable for repayment of the debt;

(c) Whether the overpayment is subject to a mandatory deduction from the current grant; and

(d) Of the right to contest the decision.

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[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0015 Recovery of cash assistance overpayments by mandatory grant deduction. (1) All overpayments of cash assistance are recovered by means of a mandatory deduction from future continuing assistance grants except as specified by WAC 388-410-0010.

(2) All members of an overpaid assistance unit are responsible for repayment of an overpayment. Repayment may be from:

- (a) Resources and/or income; or
- (b) Deductions from subsequent grants; and
- (c) An assistance unit member's estate.

(3) The mandatory grant deduction of an intentional overpayment is ten percent of the monthly grant payment standard.

(4) A monthly grant deduction of up to one hundred percent of the grant can be established when:

- (a) The overpayment is intentional;
- (b) The client has liquid resources available but refuses to use these resources in full or partial satisfaction of the overpayment; and

(c) The amount of income and resources remaining available to the assistance unit is not less than ninety percent of the grant payment standard.

(5) An unintentional overpayment is recovered by grant deduction of five percent of the monthly grant payment standard unless the client voluntarily requests a larger deduction in writing.

(6) A monthly deduction for overpayment recovery can be established against the clothing and incidental grant of a recipient in a nursing facility, intermediate care facility, or hospital. A monthly deduction cannot be established against

the vendor payment to the nursing facility, intermediate care facility or hospital.

(7) When the monthly grant deduction is equal to or more than the current grant for which the client is eligible had no overpayment occurred, the grant is suspended.

(8) No more than the total amount of an overpayment may be collected by mandatory deduction from a client's public assistance grant. The client will receive compensation for an underpayment resulting from any erroneous monthly deduction.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0020 What happens if I receive more Basic Food or WASHCAP benefits than I am supposed to receive? (1) If you receive more Basic Food or WASHCAP benefits than you were supposed to receive, your assistance unit (AU) has an overpayment. There are three types of overpayments:

(a) **Administrative error overpayment:** When you received too many benefits because the department made a mistake.

(b) **Inadvertent household error overpayment:** When you received too many benefits because you made a mistake or didn't understand what you were supposed to do.

(c) **Intentional program violation (IPV) overpayment:** When you received too many benefits because you broke a food stamp rule on purpose. If you have an IPV, you could be disqualified from receiving Basic Food or WASHCAP benefits under chapter 388-446 WAC.

(2) We must discover an overpayment within certain time frames for us to establish and collect an overpayment. If we do not discover that you received too many benefits within the time frame described below based on the type of overpayment, we will not set up an overpayment:

(a) Administrative error overpayment:	(b) Inadvertent household error overpayment:	(c) Intentional program violation overpayment:
We must discover the overpayment within twelve months of the date you were overpaid.	We must discover the overpayment within twenty-four months of the date you were overpaid.	We must discover the overpayment within seventy-two months of the date you were overpaid.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 06-20-062, § 388-410-0020, filed 9/29/06, effective 11/1/06. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 7 C.F.R. 273.18, 02-06-090, § 388-410-0020, filed 3/1/02, effective 4/1/02. Statutory Authority: RCW 74.04.510, 01-14-032, § 388-410-0020, filed 6/28/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0025 Am I responsible for an overpayment in my assistance unit? If your assistance unit (AU) received more Basic Food or WASHCAP benefits than it was supposed to receive, your AU has an overpayment. If you have an overpayment, we determine the amount you were overpaid and set up a claim to recover this overpayment.

(1) We set up an overpayment for the full amount your AU was overpaid for every adult AU member at the time your AU was overpaid.

(2) Each adult member is responsible for the whole overpayment until we recover the entire amount of the overpayment. We do not collect more than the amount your AU was overpaid.

(3) If we determine you are responsible for an overpayment, you are responsible for the overpayment even if you

are now in a different AU than you were when you had the overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 06-20-062, § 388-410-0025, filed 9/29/06, effective 11/1/06. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 7 C.F.R. 273.18, 02-06-090, § 388-410-0025, filed 3/1/02, effective 4/1/02. Statutory Authority: RCW 74.04.510, 01-14-032, § 388-410-0025, filed 6/28/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0030 How does the department calculate and set up my Basic Food or WASHCAP overpayment? (1) We calculate the amount of your Basic Food or WASHCAP overpayment by counting the difference between:

- (a) The benefits your assistance unit (AU) received; and

(b) The benefits your AU should have received.

(2) To calculate the benefits your AU should have received, we determine what we would have authorized if we:

(a) Had correct and complete information; and

(b) Followed all the necessary procedures to determine your AU's eligibility and benefits.

(3) If you did not report your earned income as required under WAC 388-418-0005 and 388-418-0007, you do not receive the earned income deduction under WAC 388-450-0185 when we calculate your overpayment amount.

(4) If we paid you too few Basic Food or WASHCAP benefits for a period of time, we will use the amount we underpaid your AU to reduce your overpayment if:

(a) We have **not** already issued you benefits to replace what you were underpaid; and

(b) We have **not** used this amount to reduce another overpayment.

(5) We **must** set up an inadvertent household error or administrative error overpayment if:

(a) We discovered the overpayment through the federal quality control process;

(b) You currently receive Basic Food or WASHCAP benefits; or

(c) The overpayment is over one hundred twenty-five dollars and you do not currently receive Basic Food or WASHCAP benefits.

(6) If you have an inadvertent household error that we referred for prosecution or an administrative disqualification hearing, we will not set up and start collecting the overpayment if doing so could negatively impact this process.

(7) We set up an intentional program violation overpayment based on the results of an administrative disqualification hearing (chapter 388-02 WAC) unless:

(a) Your AU has repaid the overpayment; or

(b) We have referred your inadvertent household error for prosecution and collecting the overpayment could negatively impact this process.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-20-062, § 388-410-0030, filed 9/29/06, effective 11/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 03-21-027, § 388-410-0030, filed 10/7/03, effective 12/1/03; 03-01-005, § 388-410-0030, filed 12/4/02, effective 2/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 7 C.F.R. 273.18. 02-06-090, § 388-410-0030, filed 3/1/02, effective 4/1/02. Statutory Authority: RCW 74.04.510. 01-14-032, § 388-410-0030, filed 6/28/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0033 How and when does the department collect a Basic Food or WASHCAP overpayment?

(1) When we set up an overpayment because you received more Basic Food or WASHCAP benefits than you were supposed to receive, we start to collect the benefits you were overpaid. This includes when we:

(a) Modify an established overpayment to an amount we would not have to set up under WAC 388-410-0030(5); or

(b) Set up an overpayment that we do not have to set up under WAC 388-410-0030(5).

(2) You can repay your overpayment by:

(a) Paying the entire amount at once;

(b) Having us take the amount of your overpayment out of your EBT account;

(c) Making regular payments under a scheduled repayment agreement as described in subsection (4) of this section; or

(d) Having your current Basic Food or WASHCAP benefits reduced.

(3) If you have an inactive EBT account and we cancelled Basic Food or WASHCAP benefits in the account under WAC 388-412-0025, we use the cancelled benefits to reduce the amount of your overpayment.

(4) If your AU currently receives Basic Food or WASHCAP benefits, you can repay your overpayment by making monthly payments. The payments must be more than we would recover through us reducing your benefits. Your AU or the department can request a change to the agreement if necessary.

(5) If you are responsible for repaying an administrative or inadvertent household error overpayment, we automatically reduce your monthly benefits unless you:

(a) Pay the overpayment all at once;

(b) Set up a repayment agreement with us; or

(c) Request a hearing and continued benefits within ninety days of the date you received your collection action notice.

(6) If you are responsible for an intentional program violation (IPV) overpayment, you must tell us how you want to repay this overpayment within ten days of the date you receive your collection action notice. If you do not do this, we will reduce your current monthly benefits.

(7) If you receive ongoing Basic Food or WASHCAP benefits, we can reduce your monthly benefits to repay the overpayment. We do not reduce your first Basic Food or WASHCAP allotment when we first approve your application for benefits.

(a) If you have an administrative or inadvertent household error overpayment, we reduce your benefits by the greater of:

(i) Ten percent of your monthly benefits; or

(ii) Ten dollars per month.

(b) If you have an IPV overpayment, we reduce your benefits by the greater of:

(i) Twenty percent of your monthly benefits; or

(ii) Twenty dollars per month.

(8) If you do not meet the terms of a repayment agreement with the department, we automatically reduce your current benefits unless you:

(a) Pay all overdue payments to bring your repayment agreement current; or

(b) Ask us to consider a change to the repayment schedule.

(9) If your overpayment claim is past due for one hundred eighty or more days, we refer your overpayment for federal collection. A federal collection includes reducing your income tax refund, social security benefits, or federal wages. We do not count your overpayment as past due if you:

(a) Repay the entire overpayment by the due date;

(b) Have your monthly benefits reduced to repay the overpayment; or

(c) Meet the requirements of your scheduled repayment agreement.

(10) If you no longer receive Basic Food or WASHCAP benefits, we can garnish your wages, file a lien against your personal or real property, attach other benefits, or otherwise access your property to collect the overpayment amount.

(11) We suspend collection on an overpayment if:

(a) We cannot find the responsible AU members; or

(b) The cost of collecting the overpayment would likely be more than the amount we would recover.

(12) We can negotiate the amount of an overpayment if the amount you offer is close to what we could expect to receive from you before we can no longer legally collect the overpayment from you.

(13) We write off unpaid overpayments and release any related liens when:

(a) We can not possibly collect any more funds;

(b) We agreed to accept a partial payment that left an unpaid balance after this payment; or

(c) There is an unpaid balance left after an overpayment case has been suspended for three consecutive years unless a collection may be possible through the Treasury Offset Program.

(14) If your AU has an overpayment from another state, we can collect this overpayment if the state where you were overpaid does not plan to collect it and they give us the following:

(a) A copy of the overpayment calculation and overpayment notice made for the client; and

(b) Proof that you received the overpayment notice.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 06-20-062, § 388-410-0033, filed 9/29/06, effective 11/1/06. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 7 C.F.R. 273.18, 02-06-090, § 388-410-0033, filed 3/1/02, effective 4/1/02.]

WAC 388-410-0035 Alien and alien sponsor cash, and food assistance overpayments. (1) An alien and their sponsor are jointly and individually liable for any overpayment of cash or food assistance made to the alien during the three years after the alien's entry into the United States.

(2) When an overpayment to a sponsored alien results from incorrect information provided by the alien's sponsor, both the alien and the sponsor are liable for repayment.

(3) When the alien's sponsor had good cause for reporting the incorrect information, the sponsored alien is solely liable for an inadvertent household error overpayment.

(4) When good cause does not exist, collection action is initiated against:

(a) The alien's sponsor; or

(b) The sponsored alien's assistance unit; or

(c) Of the two, the one considered most likely to repay first.

(5) Collection action is initiated against an alien's sponsor for an inadvertent household error when:

(a) A department representative contacts the sponsor in person or by phone; and

(b) The sponsor is informed in writing there will be no responsibility for repayment if good cause for reporting incorrect information causing the overpayment can be demonstrated.

(6) Collection action is initiated against the sponsored alien's assistance unit for an inadvertent household error when:

(a) Collection action is taken first against the alien's sponsor; and

(b) The alien's sponsor does not respond within thirty days; or

(c) The sponsored alien provides incorrect information concerning the sponsor or sponsor's spouse through misunderstanding or unintended error.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-410-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0040 Cash and food assistance underpayments. (1) All cash assistance underpayments not credited against an overpayment are repaid upon discovery to any current or former recipient.

(2) All food assistance benefits underpaid are restored when:

(a) An underpayment was caused by department error;

(b) An administrative disqualification for intentional program violation was reversed;

(c) A rule or instruction specifies restoration of unpaid benefits; or

(d) A court action finds benefits were wrongfully withheld.

(3) A client is eligible for restoration of underpaid benefits for any of the twelve months prior to:

(a) The month the client requests restoration;

(b) The month the department discovers an underpayment;

(c) The date the household makes a fair hearing request when a request for restoration of benefits was not received; or

(d) The date court action was started when the client has taken no other action to obtain restoration of benefits.

(4) The client may request a fair hearing if they disagree with the amount of benefits the department determines were underpaid.

(5) If household composition changes prior to the department's restoration of an underpayment, the underpayment is paid to:

(a) First, the household containing a majority of the persons who were household members at the time of the underpayment; or

(b) Second, the household containing the head of the household at the time of the underpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-410-0040, filed 7/31/98, effective 9/1/98.]

Chapter 388-412 WAC BENEFIT ISSUANCES

WAC

388-412-0005	General information about your cash benefits.
388-412-0010	Endorsing the warrant.
388-412-0015	General information about your Basic Food allotments.
388-412-0020	When do I get my benefits?
388-412-0025	How do I get my benefits?
388-412-0030	Returning a warrant.
388-412-0035	Loss, theft, destruction or nonreceipt of a warrant issued to clients and vendors.
388-412-0040	Can I get my benefits replaced?

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

388-412-0045 General information about cash and food assistance issued by electronic benefits transfer. [Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0045, filed 12/31/98, effective 1/31/99.] Repealed by 01-18-054, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.510 and 74.08.090.

WAC 388-412-0005 General information about your cash benefits. (1) Each separate cash assistance unit (AU) gets a separate benefit amount. If several AUs live in the same house, each AU gets a separate benefit amount.

(2) You cannot receive the same type of benefits in:

(a) Two states in the same month;

(b) Two AUs in the same month; unless

(c) You left the AU to live in a shelter for battered women and children. See WAC 388-408-0045.

(3) If you are married and both you and your spouse get general assistance, you and your spouse are one AU.

(4) Your grant is rounded down to the next whole dollar amount unless:

(a) You get a clothing and personal incidental (CPI) allowance; or

(b) Your benefits are reduced to pay an overpayment.

(5) We do not issue any cash benefits if you are eligible for less than ten dollars unless:

(a) You get a CPI allowance;

(b) Your benefits are reduced to pay an overpayment; or

(c) You get Supplemental Social Security (SSI) interim assistance payments.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-02-015, § 388-412-0005, filed 12/27/04, effective 1/27/05. Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-054, § 388-412-0005, filed 8/30/01, effective 9/30/01; 99-16-024, § 388-412-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0005, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0010 Endorsing the warrant. (1) Clients must endorse their warrants unless they have executed a power of attorney. If a client has given someone else a power of attorney, the client must give the department a copy.

(2) If a client is unable to sign the warrant, it must be endorsed by the client's mark or thumb print witnessed by two people. The witnesses must give their names and addresses to the person that cashes the warrant.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0015 General information about your Basic Food allotments. (1) Your monthly Basic Food benefits are called an allotment. An allotment is the total dollar value of benefits your eligible assistance unit (AU) gets for a calendar month.

(2) You cannot receive the same type of benefit in:

(a) Two states in the same month;

(b) Two AUs in the same month, unless;

(c) You left the AU to live in a shelter for battered women and children. See WAC 388-408-0045.

(3) If your AU does not have any countable net income, you get the maximum allotment for the number of eligible people in your AU. See WAC 388-478-0060 for the maximum allotments.

(4) If your AU has countable net income under WAC 388-450-0162, we calculate, your allotment by:

(a) Multiplying your AU's countable net monthly income by thirty percent;

(b) Rounding this amount up to the next whole dollar; and

(c) Subtracting the result from the maximum allotment.

(5) If we determine you are eligible for Basic Food, your first month's benefits are from the date you applied for benefits through the end of the month of your application. If there was a delay in processing your application, we determine when your benefits start under WAC 388-406-0055. This is called proration and is based on a thirty-day month.

(6) If you apply for benefits on or after the sixteenth of the month, and we determine you are eligible for Basic Food, we issue both your first and second months benefits in one allotment if you are eligible for both months.

(7) If your prorated benefits for the first month are under ten dollars, you will not receive an allotment for the first month.

(8) If your AU has one or two members, your monthly allotment will be at least ten dollars unless:

(a) It is the first month of your certification period;

(b) Your AU is eligible for only a partial month; and

(c) We reduced your first month's allotment below ten dollars based on the date you became eligible for Basic Food under WAC 388-406-0055.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-02-016, § 388-412-0015, filed 12/27/04, effective 1/27/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-412-0015, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-054, § 388-412-0015, filed 8/30/01, effective 9/30/01; 99-16-024, § 388-412-0015, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0020 When do I get my benefits? (1) If you get your cash benefits on an electronic benefits card (EBT), you get your cash benefits deposited on the first of each month.

(2) If you get your cash benefits deposited directly to your bank account, electronic funds transfer (EFT); your money is deposited on the first working day of the month. When the first of the month is a federal holiday or a Sunday, the benefits are deposited the following day.

(3) If you get Basic Food, your benefits are issued by the tenth day of each month. The day you get your benefits is the same as the last number of your assistance unit (AU) number for Basic Food. If the last number of your AU number is zero, you get your benefits on the tenth.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-412-0020, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.510 and 74.08.090. 02-18-105, § 388-412-0020, filed 9/3/02, effective 10/4/02; 01-18-054, § 388-412-0020, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0020,

filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0025 How do I get my benefits? (1)

Your cash benefits are sent to you by either:

(a) Electronic benefit transfer (EBT) card, which is a direct deposit into a DSHS account that you access with a debit card called the Washington EBT Quest card;

(b) Electronic funds transfer (EFT), which is a direct deposit into your own bank account;

(c) A check to a payee who is not approved for direct deposit; or

(d) A check to you if you get:

(i) Diversion cash assistance (DCA) that cannot be paid directly to a vendor;

(ii) Additional requirements for emergent needs (AREN) that cannot be paid directly to a vendor;

(iii) Ongoing additional requirements (OAR) that cannot be paid directly to a vendor;

(iv) Clothing and personal incidentals (CPI) payments; or

(v) State supplemental payment (SSP) and you do not receive your benefit through EFT.

(2) You use a Quest debit card to access your benefits in your EBT account. You get a personal identification number (PIN) that you must enter when using this card.

(3) Your Basic Food benefits are deposited into your EBT account on the day of the month defined in WAC 388-412-0020.

(4) We establish an EBT account for each AU that receives their benefits by EBT.

(5) We cancel your cash and Basic Food benefits when you do not use your EBT account for three hundred sixty-five days.

(a) Basic Food benefits that were canceled because you did not use them for three hundred sixty-five days cannot be replaced.

(b) Cash benefits that were canceled because you did not use them for three hundred sixty-five days may be replaced. You have two years to contact the department of revenue in order to replace your cash benefits. You can contact department of revenue at 1-888-328-9271. After that time, you must contact the state treasurer to claim any canceled funds.

(6) You must use your cash and Basic Food benefits from your EBT account. We do not convert cash or Basic Food benefits to checks.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-17-089, § 388-412-0025, filed 8/12/05, effective 9/12/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-412-0025, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.510 and 74.08.090. 02-18-105, § 388-412-0025, filed 9/3/02, effective 10/4/02; 01-18-054, § 388-412-0025, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0030 Returning a warrant. (1)

A person who has possession of a warrant payable to a deceased payee must return the warrant to the department for cancellation.

(2) A person who has possession of a warrant payable to an assistance unit payee who has left the home and is not

likely to return during the month to endorse the warrant, must return the warrant to the CSO. The warrant may be reissued to another eligible payee for the assistance unit.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0030, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0035 Loss, theft, destruction or non-receipt of a warrant issued to clients and vendors. The following applies to replacements of warrants issued to clients and to vendors.

(1) The department does not replace a warrant or the cash proceeds from a warrant which was endorsed by a client or vendor.

(2) Clients or vendors asking for a replacement of a warrant which was not endorsed by them must:

(a) Complete a notarized affidavit;

(b) Provide all facts surrounding the loss, theft, destruction or nonreceipt of the warrant; and

(c) File a report with the police or the post office, as appropriate.

(3) If a client is eligible to receive a replacement, the warrant is issued:

(a) On or before the tenth of the month in which the warrant was due; or

(b) Within five working days of the date the decision is made to replace the warrant, whichever is later.

(4) A client or vendor is issued the full amount of the original warrant if the warrant is replaced.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0035, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0040 Can I get my benefits replaced?

Under certain conditions, we may replace your benefits.

(1) You may get your EBT benefits replaced if:

(a) We make a mistake that causes you to lose benefits;

(b) Both your EBT card and personal identification number (PIN) are stolen from the mail; you never had the ability to use the benefits; and you lost benefits;

(c) You left a drug or alcohol treatment on or before the fifteenth of the month and the facility does not have enough Basic Food benefits in their EBT account for one-half of the allotment that they owe you;

(d) Your EBT benefits that were recently deposited into an inactive EBT account were canceled by mistake along with your state benefits; or

(e) Your food that was purchased with Basic Food benefits was destroyed in a disaster.

(2) If you want a replacement, you must:

(a) Report the loss to your local office within ten days from the date of the loss; and

(b) Sign a department affidavit form stating you had a loss of benefits.

(3) For Basic Food, we replace the loss up to a one-month benefit amount.

(4) We will not replace your benefits if your loss is for a reason other than shoes listed in subsection (1) above or:

- (a) We decided that your request is fraudulent;
 - (b) Your Basic Food benefits were lost, stolen or misplaced after you received them;
 - (c) You already got two countable replacements of Basic Food benefits within the last five months; or
 - (d) You got disaster food stamp benefits for the same month you requested a replacement for Basic Food.
- (5) Your replacement does not count if:
- (a) Your benefits are returned to us; or
 - (b) We replaced your benefits because we made an error.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-412-0040, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.510 and 74.08.090. 01-18-054, § 388-412-0040, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0040, filed 7/31/98, effective 9/1/98.]

Chapter 388-414 WAC CATEGORICAL ELIGIBILITY FOR FOOD ASSISTANCE

WAC

388-414-0001 Do I have to meet all eligibility requirements for Basic Food?

WAC 388-414-0001 Do I have to meet all eligibility requirements for Basic Food? (1) What is "categorically eligible" (CE)?

(a) Being **categorically eligible (CE)** means that you have already met requirements for the program. If you are CE, you do not have to meet every program requirement to be eligible for Basic Food.

(b) If your assistance unit (AU) is CE, you automatically meet the following requirements for Basic Food:

- (i) Residency under WAC 388-468-0005;
- (ii) Countable resource limit under WAC 388-470-0005;
- (iii) Maximum gross monthly income under WAC 388-478-0060; and
- (iv) Maximum net monthly income under WAC 388-478-0060.

(c) If your AU is CE and the information is available from another program, you do not need to provide the following for Basic Food:

- (i) Social Security number information under WAC 388-476-0005; and
- (ii) Sponsored alien information under WAC 388-450-0155.

(d) Being CE does not mean that your AU is guaranteed to get Basic Food benefits. If your AU is CE:

- (i) You must still meet the other Basic Food program requirements under WAC 388-400-0040; and
- (ii) If you meet the other program requirements, we must budget your AU's income to determine the amount of benefits your AU will receive.

(2) Who is categorically eligible for Basic Food?

Your Basic Food AU is CE when:

(a) **Every member** of your AU gets either general assistance (GA), Alcohol and Drug Abuse Treatment Support Act (ADATSA), or Supplemental Security Income (SSI) cash benefits on their own behalf;

(b) Any member of your AU gets or is authorized to get payments from the following programs because we have determined that the entire AU benefits from someone receiving the assistance:

(i) Temporary assistance for needy families (TANF) cash assistance;

(ii) State family assistance (SFA); or

(iii) Diversion cash assistance (DCA). You are CE for the month you receive DCA and the three following months as long as you have one adult relative caretaker with a dependent child in the Basic Food AU.

(c) Your AU's income that we don't exclude under WAC 388-450-0015 is not over the maximum gross monthly income under WAC 388-478-0060. If your income is not over the gross monthly income limit, we provide your AU information about department programs and referral to resources in the community.

(3) Who is not CE even if my AU meets the above criteria?

(a) Even if your AU is CE, members of your AU are not eligible for Basic Food if they:

(i) Are not eligible because of their alien or student status;

(ii) Were disqualified from Basic Food under WAC 388-444-0055 for failing work requirements;

(iii) Are not eligible for failing to provide or apply for a Social Security number;

(iv) Receive SSI in a cash-out state (state where SSI payments are increased to include the value of the client's food stamp allotment); or

(v) Live in an institution not eligible for Basic Food under WAC 388-408-0040.

(b) If a person in your AU is not eligible for Basic Food, we do not include them as an **eligible member** of your CE AU.

(c) Your AU is not CE if:

(i) Your AU is not eligible because of striker requirements under WAC 388-480-0001;

(ii) Your AU is ineligible for knowingly transferring countable resources in order to qualify for benefits under WAC 388-488-0010;

(iii) Your AU refused to cooperate in providing information that is needed to determine your eligibility;

(iv) The head of household for your AU failed to meet work requirements; or

(v) Anyone in your AU is disqualified because of an intentional program violation under WAC 388-446-0015.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-23-081, § 388-414-0001, filed 11/15/05, effective 1/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 24. 04-14-038, § 388-414-0001, filed 6/29/04, effective 8/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-07-139, § 388-414-0001, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.08.090, 74.04.510. 01-07-054, § 388-414-0001, filed 3/16/01, effective 3/29/01; 00-11-035, § 388-414-0001, filed 5/10/00, effective 8/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-414-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-416 WAC
CERTIFICATION PERIODS

WAC

388-416-0005	How long can I get Basic Food?
388-416-0010	Medical certification periods for recipients of cash assistance programs.
388-416-0015	Certification periods for categorically needy (CN) medical and state children's health insurance program (SCHIP).
388-416-0020	Certification periods for noninstitutionalized medically needy (MN) program.
388-416-0035	Medicare savings program certification periods.

**DISPOSITION OF SECTIONS FORMERLY
 CODIFIED IN THIS CHAPTER**

388-416-0025	Certification period for children's health program. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0970, 388-519-1905, 388-521-2106 and 388-522-2210.] Repealed by 02-17-030, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415.
388-416-0030	Certification periods for the medically indigent (MI) program. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0030, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2140.] Repealed by 04-07-141, filed 3/22/04, effective 4/22/04. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 1st sp.s. c 25.

WAC 388-416-0005 How long can I get Basic Food?

(1) The length of time the department determines your assistance unit (AU) is eligible to get Basic Food is called a certification period. The department may certify your AU for up to:

- (a) **Six months** if your AU:
 - (i) Includes an able-bodied adult without dependents (ABAWD) who receives Basic Food in your AU and your AU does not live in an exempt area as described in WAC 388-444-0030;
 - (ii) Includes a person who receives ADATSA benefits as described in chapter 388-800 WAC;
 - (iii) Is considered homeless under WAC 388-408-0050; or
 - (iv) Includes a migrant or seasonal farmworker as described under WAC 388-406-0021.
- (b) **Twenty-four months** if all adults in your AU are elderly persons or individuals with disabilities and no one in your AU has earned income.

(c) **Twelve months** if your AU does not meet any of the conditions for six or twenty-four months.

(2) If you receive transitional food assistance, we set your certification period as described under WAC 388-489-0015.

(3) If your AU is homeless **or** includes an ABAWD when you live in a nonexempt area, we may shorten your certification period.

(4) We terminate your Basic Food benefits when:

- (a) We get proof of a change that makes your AU ineligible; or
- (b) We get information that your AU is ineligible; and
- (c) You do not provide needed information to verify your AU's circumstances.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-416-0005, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055,

[Title 388 WAC—p. 800]

74.04.057, 74.08.090. 05-08-124, § 388-416-0005, filed 4/5/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-19-134, § 388-416-0005, filed 9/21/04, effective 10/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-416-0005, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-11-107, § 388-416-0005, filed 5/21/01, effective 7/1/01; 99-16-024, § 388-416-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-416-0010 Medical certification periods for recipients of cash assistance programs. (1) The certification period for medical services begins on the first day of the month of application when the client is determined eligible for cash assistance for one of the following programs:

- (a) Temporary assistance for needy families (TANF);
- (b) Supplemental Security Income (SSI); or
- (c) Refugee assistance.

(2) The certification period for the medical programs associated with the cash programs in subsection (1) of this section continues as long as eligibility for these programs lasts. When a client's cash assistance is terminated, eligibility for medical assistance is continued until eligibility is redetermined as described in WAC 388-418-0025.

(3) The certification period for medical can begin up to three months prior to the month of application for clients described in subsection (1) of this section if the conditions in WAC 388-416-0015(6) apply.

(4) The certification period for medical care services begins on the date eligibility begins for the following cash assistance programs:

- (a) General assistance for unemployable persons (GA-U); or
- (b) Alcohol and drug abuse treatment and support act (ADATSA) programs, when the client is either receiving a grant or waiting for treatment to begin.

(5) The certification period for medical care services for clients in subsection (4) of this section runs concurrently with the period of eligibility for the client's cash assistance program.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-416-0010, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2110, 388-521-2120, 388-522-2210 and 388-524-2420.]

WAC 388-416-0015 Certification periods for categorically needy (CN) medical and state children's health insurance program (SCHIP). (1) A certification period is the period of time a person is determined eligible for a categorically needy (CN) medical program. Unless otherwise stated in this section, the certification period begins on the first day of the month of application and continues to the last day of the last month of the certification period.

(2) For a child eligible for the newborn medical program, the certification period begins on the child's date of birth and continues through the end of the month of the child's first birthday.

(3) For a woman eligible for a medical program based on pregnancy, the certification period ends the last day of the month that includes the sixtieth day from the day the pregnancy ends.

(2007 Ed.)

(4) For families the certification period is twelve months with a six-month report required as a condition of eligibility as described in WAC 388-418-0011.

(5) For children, the certification period is twelve months. Eligibility is continuous without regard to changes in circumstances other than aging out of the program, moving out of state or death. When the medical assistance unit is also receiving benefits under a cash or food assistance program, the medical certification period is updated to begin anew at each:

- (a) Approved application for cash or food assistance; or
- (b) Completed eligibility review.

(6) For an SSI-related person the certification period is twelve months.

(7) When the child turns nineteen the certification period ends even if the twelve-month period is not over. The certification period may be extended past the end of the month the child turns nineteen when:

(a) The child is receiving inpatient services on the last day of the month the child turns nineteen;

(b) The inpatient stay continues into the following month or months; and

(c) The child remains eligible except for exceeding age nineteen.

(8) A retroactive certification period can begin up to three months immediately before the month of application when:

(a) The client would have been eligible for medical assistance if the client had applied; and

(b) The client received covered medical services as described in WAC 388-501-0060 and 388-501-0065.

(9) If the client is eligible only during the three-month retroactive period, that period is the only period of certification.

(10) Any months of a retroactive certification period are added to the designated certification periods described in this section.

(11) For a child determined eligible for SCHIP medical benefits as described in chapter 388-542 WAC:

(a) The certification periods are described in subsections (1), (5), and (7) of this section;

(b) There is not a retroactive eligibility period as described in subsections (8), (9), and (10); and

(c) For a child who has creditable coverage at the time of application, the certification period begins on the first of the month after the child's creditable coverage is no longer in effect, if:

(i) All other SCHIP eligibility factors are met; and

(ii) An eligibility decision is made per WAC 388-406-0035.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-416-0015, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-19-031, § 388-416-0015, filed 9/12/05, effective 10/13/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-21-064, § 388-416-0015, filed 10/18/04, effective 11/18/04. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 c 10. 04-03-019, § 388-416-0015, filed 1/12/04, effective 2/12/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.09.450. 00-08-002, § 388-416-0015, filed 3/22/00, effective 5/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0015, filed 7/31/98, effective 9/1/98. Formerly 388-509-0970, 388-521-2105, 388-522-2210 and 388-522-2230.]

(2007 Ed.)

WAC 388-416-0020 Certification periods for noninstitutionalized medically needy (MN) program. (1) The certification period for the noninstitutionalized medically needy (MN) program begins:

(a) On the first day of the month in which hospital expenses equal the spenddown amount; or

(b) On the day that spenddown is met, when hospital expenses are less than the spenddown amount or no hospital expenses are involved.

(2) The certification period continues through the last day of the final month of the base period as described in chapter 388-519 WAC.

(3) The certification period can begin up to three months immediately prior to the month of application as described in chapter 388-519 WAC.

(4) The certification period for MN clients with income below the medically needy income level (MNIL) is twelve months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2105 and 388-521-2130.]

WAC 388-416-0035 Medicare savings program certification periods. Certification periods for the different kinds of Medicare savings programs are not all the same. The chart below explains the differences.

Medicare Savings Program	Certification Period	Start Date
QMB (qualified Medicare beneficiary) S03	12 months	On the first day of the month following QMB eligibility determination
SLMB (Special low income Medicare beneficiary) S05	12 months	Up to three months prior to the certification period if on the first day of the first month of certification, the person: • Is or has been enrolled in Medicare Part B; and • Meets SLMB eligibility requirements.
QDWI (Qualified disabled working individual) S04	12 months	Up to three months prior to the certification period if on the first day of the first month of certification, the person: • Is or has been enrolled in Medicare Part A; and • Meets QDWI eligibility requirements.
QI-1 (Qualified individual) S06	Thru the end of the calendar year following QI-1 eligibility determination	Up to three months prior to the certification period if on the first day of the first month of certification, the person: • Is or has been enrolled in Medicare Part B; and • Meets QI-1 eligibility requirements.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 42 U.S.C. 1396a(a) (Section 1902 (n)(2) of the Social Security Act of 1924). 05-01-126, § 388-416-0035, filed 12/15/04, effective 1/15/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-

044, § 388-416-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2150, 388-521-2155 and 388-521-2160.]

Chapter 388-418 WAC CHANGE OF CIRCUMSTANCE

WAC

388-418-0005	How will I know what changes I must report?
388-418-0007	When do I have to report changes in my circumstances?
388-418-0011	What is a mid-certification review, and do I have to complete one in order to keep receiving benefits?
388-418-0020	How does the department determine the date a change affects my benefits?
388-418-0025	Effect of changes on medical program eligibility.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-418-0010	Requesting information or action needed. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0010, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-418-0012	Prospective eligibility for food assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-418-0012, filed 7/26/99, effective 9/1/99.] Repealed by 00-07-077, filed 3/14/00, effective 5/1/00. Statutory Authority: RCW 74.08.090.
388-418-0015	Recipient fails to provide requested information or take requested action. [Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0015, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-418-0030	Notifying a recipient of intent to reduce, suspend or terminate assistance. [Statutory Authority: RCW 74.08.-090 and 74.04.510. 99-16-024, § 388-418-0030, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0030, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2205 and 388-525-2570.] Repealed by 99-23-034, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-418-0005 How will I know what changes I must report? You must report changes to the department based on the kinds of assistance you receive. The set of changes you must report for people in your assistance unit under chapter 388-408 WAC is based on the benefits you receive that require you to report the most changes. It is the first program that you receive benefits from in the list below.

For example:

If you receive long term care and Basic Food benefits, you tell us about changes based on the long term care requirements because it is the first program in the list below you receive benefits from.

(1) If you receive long term care benefits such as Basic, Basic Plus, chore, community protection, COPEs, nursing home, Hospice, or medically needy waiver, you must tell us if you have a change of:

- (a) Address;
- (b) Marital status;
- (c) Living arrangement;
- (d) Income;
- (e) Resources;
- (f) Medical expenses; and

(g) If we allow you expenses for your spouse or dependents, you must report changes in their income or shelter cost.

(2) If you receive medical benefits based on age, blindness, or disability (SSI-related medical), or ADATSA benefits, you need to tell us if:

- (a) You move;
- (b) A family member moves into or out of your home;
- (c) Your resources change; or
- (d) Your income changes. This includes the income of you, your spouse or your child living with you.

(3) If you receive Basic Food and all adults in your assistance unit are elderly persons or individuals with disabilities and have no earned income, you need to tell us if:

- (a) You move;
- (b) You start getting money from a new source;
- (c) Your income changes by more than fifty dollars;
- (d) Your liquid resources, such as your cash on hand or bank accounts, are more than two thousand dollars; or

(e) Someone moves into or out of your home.

(4) If you receive cash benefits, you need to tell us if:

- (a) You move;
- (b) Someone moves out of your home;
- (c) Your total gross monthly income goes over the:
 - (i) Payment standard under WAC 388-478-0030 if you receive general assistance; or
 - (ii) Earned income limit under WAC 388-478-0035 and 388-450-0165 for all other programs;
- (d) You have liquid resources more than four thousand dollars; or

(e) You have a change in employment. Tell us if you:

- (i) Get a job or change employers;
 - (ii) Change from part-time to full-time or full-time to part-time;
 - (iii) Have a change in your hourly wage rate or salary; or
 - (iv) Stop working.
- (5) If you receive family medical benefits, you need to tell us if:

- (a) You move;
- (b) A family member moves out of your home; or
- (c) If your income goes up or down by one hundred dollars or more a month and you expect this income change will continue for at least two months.

(6) If you receive Basic Food benefits, you need to tell us if:

- (a) You move;
- (b) Your total gross monthly income is more than the gross monthly income limit under WAC 388-478-0060; or
- (c) Anyone who receives food benefits in your assistance unit must meet work requirements under WAC 388-444-0030 and their hours at work go below twenty hours per week.

(7) If you receive children's medical benefits, you need to tell us if:

- (a) You move; or
- (b) A family member moves out of the house.

(8) If you receive pregnancy medical benefits, you need to tell us if:

- (a) You move; or
- (b) You are no longer pregnant.

(9) If you receive other medical benefits, you need to tell us if:

- (a) You move; or
- (b) A family member moves out of the home.

(10) If you receive transitional food assistance, you do not have to report any changes in your circumstances.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-418-0005, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 44.04.280. 05-09-021, § 388-418-0005, filed 4/12/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-21-026, § 388-418-0005, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-06-026, § 388-418-0005, filed 2/23/04, effective 3/25/04; 03-21-028, § 388-418-0005, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-11-109, § 388-418-0005, filed 5/21/01, effective 7/1/01; 99-23-034, § 388-418-0005, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0007 When do I have to report changes in my circumstances? (1) If your household has a change of circumstances you are **not required to report** under WAC 388-418-0005, you do not need to contact us about this change. If you tell us about this change, we take action based on the new information. This includes:

- (a) Asking for more information we need to determine your eligibility and benefits under WAC 388-490-0005;
- (b) Increasing your benefits when we have proof of a change that makes you eligible for more benefits; or
- (c) Reducing or stopping your benefits based on the change.

(2) If you **are applying for** benefits and have had a change:

(a) After the date you applied but before your interview, you must report the change during your interview; or

(b) After you have been interviewed, you must report changes that we require someone who receives benefits to report as described under WAC 388-418-0005. You must report this change by the tenth day of the month following the month the change happened.

(3) If you **receive** cash assistance, medical, or Basic Food, you must report changes required under WAC 388-418-0005 by the tenth day of the month following the month the change happened.

(4) For a change in income, the date a change happened is the date you receive income based on this change. For example, the date of your first paycheck for a new job, or the date of a paycheck showing a change in your wage or salary.

(5) If we require you to complete a mid-certification review, you must complete the review to inform us of your circumstances as described under WAC 388-418-0011 in order to keep receiving benefits.

(6) If you receive TANF/SFA, and you learn that a child in your assistance unit (AU) will be gone from your home longer than ninety days, you must tell us about this within five calendar days from the date you learn this information.

(a) If you do not report this within five days, the child's caretaker is not eligible for cash benefits for one month; and

(b) We continue to budget the ineligible person's countable income as described in WAC 388-450-0162 to determine the benefits for the people still in the AU.

(7) If you report changes late, you may receive the wrong amount or wrong type of benefits. If you receive more benefits than you are eligible for, you may have to pay them back as described in chapter 388-410 WAC.

(2007 Ed.)

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-13-043, § 388-418-0007, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 05-11-074, § 388-418-0007, filed 5/17/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-19-134, § 388-418-0007, filed 9/21/04, effective 10/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-028, § 388-418-0007, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-11-109, § 388-418-0007, filed 5/21/01, effective 7/1/01.]

WAC 388-418-0011 What is a mid-certification review, and do I have to complete one in order to keep receiving benefits? (1) A **mid-certification review (MCR)** is a form we send you to ask about your current circumstances. We use the answers you give us to decide if you are still eligible for benefits and to calculate your monthly benefits.

(2) If you receive cash assistance, family-related medical, or Basic Food benefits, you must complete a mid-certification review unless you meet one of the exceptions below:

(a) You **do not** have to complete a mid-certification review for cash assistance if you:

- (i) Only receive Refugee Cash Assistance as described under WAC 388-400-0030; or
- (ii) Have a review period of six months or less.

(b) You **do not** have to complete a mid-certification review for Basic food if:

- (i) Your assistance unit has a certification period of six months or less; or
- (ii) All adults in your assistance unit are elderly or disabled and have no earned income.

(3) **When we send the review form:**

If you must complete a MCR...	We send your review form...
(a) For one program such as Basic Food or Family Medical.	In the fifth month of your certification or review period. You must complete your review by the 10th day of month six.
(b) For two or more programs, and all program have a 12-month certification or review period.	In the fifth month of your certification or review period. You must complete your review by the 10th day of month six.
(c) For Basic Food and another program when either program has a certification or review period between six and twelve months.	In the fifth month of your Basic Food certification period when you receive Basic Food and another program. You must complete your review by the 10th day of month six of your Basic Food certification.

(4) If you must complete a mid-certification review, we send you the review form with questions about your current circumstances. You can choose to complete the review in on [one] of the following ways:

(a) **Complete the form and return it to us.** For us to count your mid-certification review complete, you must take all of the steps below:

(i) Complete [Complete] the review form, telling us about changes in your circumstances we ask about;

(ii) Sign and date the form;

(iii) Give us proof of any changes you report. If you report a change that will increase your benefits without giving proof of this change, we will not increase your benefits;

(iv) If you receive family medical benefits, give us proof of your income even if it has not changed; and

(v) Mail or turn in the completed form and any required proof to us by the due date on the review.

(b) Complete the mid-certification review over the phone. For us to count your mid-certification review as complete, you must take all of the steps below:

(i) Contact us at the phone number on the review form, telling us about changes in your circumstances we ask about;

(ii) Give us proof of any changes you report. We may be able to verify some information over the phone. If you report a change that will increase your benefits without giving proof of this change, we will not increase your benefits;

(iii) If you receive family medical benefits, give us proof of your income even if it has not changed;

(iv) If you receive Temporary Assistance for Needy Families and you are working or self employed, you must give us proof of your income and the hours you work even if it has not changed; and

(v) Mail or turn in any required proof to us by the due date on the review.

(c) Complete the application process for another program. If we approve an application for another program in the month you must complete your mid-certification review, we use the application to complete your review when the same person is head of household for the application and the mid-certification review.

(5) If your benefits change because of what we learned in your mid-certification review, the change takes effect the next month even if this does not give you ten days notice before we change your benefits.

(6) If you do not complete your required mid-certification review, we stop your benefits at the end of the month the review was due.

(7) Late reviews. If you complete the mid-certification review after the last day of the month the review was due, we process the review as described below based on when we receive the review:

(a) Mid-certification reviews you complete by the last day of the month after the month the review was due: We determine your eligibility for ongoing benefits. If you are eligible, we reinstate your benefits based on the information in the review.

(b) Mid-certification reviews you complete after the last day of the month after the month the review was due: We treat this review as a request to send you an application. For us to determine if you are eligible for benefits, you must complete the application process as described in chapter 388-406 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 06-24-025 and 07-01-023, § 388-418-0011, filed 11/29/06 and 12/8/06, effective 10/1/07; 06-13-043, § 388-418-0011, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 05-09-020, § 388-418-0011, filed 4/12/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54, 04-19-134, § 388-418-0011, filed 9/21/04, effective 10/1/04.]

WAC 388-418-0020 How does the department determine the date a change affects my benefits? (1) Unless oth-

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erwise specified, the rules in this chapter refer to cash, medical assistance, and Basic Food benefits.

(2) If you report a change that happened between the date you applied for benefits and the date we interview you under WAC 388-452-0005, we take this change into consideration when we process your application for benefits.

(3) If we learn about a change in your circumstances from another person, agency, or by matching with any number of systems, we determine the impact this change has on your benefits. We may request additional information under WAC 388-490-0005 or update your benefits based on this information.

(4) For programs other than pregnancy medical and children's medical, if you report a change in your income that we expect to continue at least a month beyond the month when you reported the change, we recalculate the income we estimated under WAC 388-450-0215 based on this change. Changes in income during a certification period do not affect pregnancy medical or children's medical assistance.

(5) When a change causes an increase in benefits, you must provide proof of the change before we adjust your benefits.

(a) If you give us the proof within ten days from the date we requested it, we increase your benefits starting the month after the month you reported the change.

(b) If you give us the proof more than ten days after the date we requested it, we increase your benefits starting the month after the month we got the proof.

(c) If you are eligible for more benefits and we have already sent you benefits for that month, we provide you the additional benefits within ten days of the day we got the proof.

(6) When a change causes a decrease in benefits, we reduce your benefit amount without asking for proof.

(a) If you report a change within the time limits in WAC 388-418-0007, and you are not reporting this as part of a mid-certification review, we decrease your benefits starting the first month following the advance notice period. The advance notice period:

(i) Begins on the day we send you a letter about the change, and

(ii) Is determined according to the rules in WAC 388-458-0025.

(b) If you do not report a change you must tell us about under WAC 388-418-0005, or you report a change later than we require under WAC 388-418-0007, we determine your eligibility as if you had reported this on time. If you received more benefits than you should, we set up an overpayment as described under chapter 388-410 WAC.

(7) If we are not sure how the change will affect your benefits, we send you a letter as described in WAC 388-458-0020 requesting information from you.

(a) We give you ten days to provide the information. If you need more time, you can ask for it.

(b) If you do not give us the information in time, we will stop your benefits after giving you advance notice, if required, as described in WAC 388-458-0030.

(8) Within ten days of the day we learn about a change, we send advance notice according to the rules in chapter 388-458 WAC and take necessary action to provide you the correct benefits. If you request a hearing about a proposed

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decrease in benefits before the effective date or within the notice period as described in WAC 388-458-0040, we wait to take action on the change.

(9) If you disagree with a decision we made to change your benefits, you may request a fair hearing under chapter 388-02 WAC. The fair hearing rules in chapter 388-02 WAC do not apply for a "mass change." A mass change is when we change the rules that impact all recipients and applicants.

(10) When you request a hearing and receive continued benefits:

(a) We keep giving you the same benefits you got before the advance notice of reduction until the earliest of the following events occur:

(i) For Basic Food only, your certification period expires;

(ii) The end of the month the fair hearing decision is mailed;

(iii) You state in writing that you do not want continued benefits;

(iv) You withdraw your fair hearing request in writing; or

(v) You abandon your fair hearing request; or

(vi) An administrative law judge issues a written order that ends continued benefits prior to the fair hearing.

(b) We establish an overpayment claim according to the rules in chapter 388-410 WAC when the hearing decision agrees with the action we took.

(11) Some changes have a specific effective date as follows:

(a) When cash assistance benefits increase because a person is added to your assistance unit, we use the effective date rules for applications in WAC 388-406-0055.

(b) When cash assistance benefits increase because you start paying shelter costs, we use the date the change occurred.

(c) When a change in law or regulation changes the benefit amount, we use the date specified by the law or regulation.

(d) When institutional medical assistance participation changes, we calculate the new participation amount beginning with the month your income or allowable expense changes.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 06-13-043, § 388-418-0020, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 05-09-020, § 388-418-0020, filed 4/12/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54, 04-19-134, § 388-418-0020, filed 9/21/04, effective 10/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 03-21-028, § 388-418-0020, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090, 74.04.057, and 74.04.510, 02-14-086, § 388-418-0020, filed 6/28/02, effective 7/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510, 99-23-034, § 388-418-0020, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-418-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0025 Effect of changes on medical program eligibility. (1) You continue to be eligible for Medicaid until the department determines your ineligibility or eligibility for another medical program. This applies to you if, during a certification period, you become ineligible for, or are terminated from, or request termination from:

(a) A CN Medicaid program; or

(b) Any of the following cash grants:

(i) TANF;

(ii) SSI; or

(iii) GA-X. See WAC 388-434-0005 for changes reported during eligibility review.

(2) If you become ineligible for refugee cash assistance, refugee medical assistance can be continued through the eight-month limit, as described in WAC 388-400-0035(4).

(3) If you receive a TANF cash grant or family medical, you are eligible for a medical extension, as described under WAC 388-523-0100, when your cash grant or family medical program is terminated as a result of:

(a) Earned income; or

(b) Collection of child or spousal support.

(4) A change in income during a certification period does affect eligibility for all medical programs except:

(a) Pregnant women's medical programs;

(b) Children's medical for newborns (F05);

(c) Children's medical benefits (F06);

(d) Children's health program (F08); or

(e) The first six months of the medical extension benefits.

(5) For a child receiving benefits under SCHIP as described in chapter 388-542 WAC, the department must redetermine eligibility for a Medicaid program when the family reports:

(a) Family income has decreased to less than two hundred percent federal poverty level (FPL);

(b) The child becomes pregnant;

(c) A change in family size; or

(d) The child receives SSI.

[Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415, 05-23-013, § 388-418-0025, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 c 10, 04-03-019, § 388-418-0025, filed 1/12/04, effective 2/12/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-418-0025, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.09.450, 00-08-002, § 388-418-0025, filed 3/22/00, effective 5/1/00. Statutory Authority: RCW 74.04.050, 74.04.057 and Section 4731 of the BBA (Public Law 105-33), 99-10-064, § 388-418-0025, filed 5/3/99, effective 6/3/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-418-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0840, 388-509-0920, 388-509-0960, 388-522-2205 and 388-522-2210.]

Chapter 388-420 WAC

CHEMICAL DEPENDENCY FOOD ASSISTANCE

WAC

388-420-010

Alcohol and drug treatment centers.

WAC 388-420-010 Alcohol and drug treatment centers. (1) Food assistance is only available to a resident of a drug or alcohol treatment center when the treatment center is:

(a) Administered by a public or private nonprofit agency; and

(b) Certified by the division of alcohol and substance abuse (DASA).

(2) A resident is considered a one person assistance unit. However if the resident's spouse or child is also living in the treatment center, the spouse or child is included in the resident's assistance unit.

(3) The resident must have a designated employee of the treatment center act as an authorized representative as specified in chapter 388-460 WAC.

(4) The authorized representative receives and uses the food assistance benefits for meals the resident is served in the treatment center.

(5) The authorized representative also has responsibilities as specified in chapter 388-460 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-420-010, filed 7/31/98, effective 9/1/98.]

Chapter 388-422 WAC CHILD SUPPORT

WAC

388-422-0005	What happens to my child, spousal and medical support when I get public assistance?
388-422-0010	Do I have to cooperate with the division of child support (DCS)?
388-422-0020	What if you are afraid that cooperating with the division of child support (DCS) may be dangerous for you or the child in your care?
388-422-0030	What happens if my support is more than my TANF or SFA cash benefit?

WAC 388-422-0005 What happens to my child, spousal and medical support when I get public assistance? (1) The following definitions apply to this chapter:

(a) **"We"** means the department of social and health services.

(b) **"You"** means a person applying for or getting benefits from us.

(c) **"Benefits"** mean family medical and related alien emergency medical (AEM), TANF or SFA cash assistance.

(d) **"Support"** means the money paid to meet a support order whether it is called child support, spousal support, alimony, maintenance, or medical support.

(e) **"Medical support"** means either or both:

(i) The set dollar amount for health care costs in a support order; or

(ii) Health insurance coverage for a dependent child.

(f) **"Assistance unit"** or **"AU"** means the group of people who live together and whose income and resources we count to decide your eligibility for benefits and the amount of those benefits.

(2) When you apply for TANF or SFA cash benefits, you assign your rights to current support and back support (also called **"arrear"**) under WAC 388-14A-2036. You permanently assign to the state your current support for the months you get assistance. Support for months before you begin receiving assistance is temporarily assigned to the state. For more information about permanently and temporarily assigned support see:

(a) Permanently assigned arrears, WAC 388-14A-2037.

(b) Temporarily assigned arrears, WAC 388-14A-2038.

(3) You assign your rights to medical support under WAC 388-505-0540 when you apply for or get benefits from the following:

(a) Family medical; or

(b) Children's medical.

(4) You assign your rights to support when you sign the application for benefits, or when you get cash or medical benefits.

(5) If you have a good reason (WAC 388-422-0020) DCS may not be able to establish or collect child support (WAC 388-14A-2060).

(6) If you receive any support payments before you assign your rights to support, we count this as unearned income to your AU (WAC 388-450-0025).

(7) If you receive any direct support payments after you assign your rights to support, you must send the support payments to the division of child support (DCS) under WAC 388-14A-2040(3).

(8) If you keep any support payments you receive after you assign your rights to support, DCS may collect this money from you (WAC 388-14A-5505).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-19-041, § 388-422-0005, filed 9/11/02, effective 10/12/02; 98-16-044, § 388-422-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0560.]

WAC 388-422-0010 Do I have to cooperate with the division of child support (DCS)? (1) When you get benefits, you must cooperate with DCS as required to establish or collect child support, unless you have a good reason for not cooperating.

(2) DCS defines what cooperating with them to establish or collect child support means in WAC 388-14A-2040.

(3) If you are a two-parent household, you and the other parent must help DCS establish paternity for each child in your AU, if necessary.

(4) DCS determines whether you are cooperating with them. See WAC 388-14A-2041(1) for reasons why DCS might determine that you are not cooperating.

(5) If you get TANF or SFA and do not have a good reason for not cooperating with DCS, we:

(a) Reduce your cash benefits by twenty-five percent; and

(b) Stop your medical benefits unless you are pregnant. The children in your AU will continue to get medical.

(6) If you get family medical and do not have a good reason for not cooperating with DCS, your medical will stop unless you are pregnant. The children in your AU will continue to get medical.

(7) If you are afraid that cooperating with DCS may be dangerous for you or a child in your care, see WAC 388-14A-2045 for a definition of what a good reason to not cooperate with DCS is. We also call this **"good cause."**

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-19-041, § 388-422-0010, filed 9/11/02, effective 10/12/02; 98-16-044, § 388-422-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0560.]

WAC 388-422-0020 What if you are afraid that cooperating with the division of child support (DCS) may be dangerous for you or the child in your care? (1) You can be excused from cooperating with DCS when you have a good reason. A good reason not to cooperate is also called good cause. You have a good reason when you can prove that:

(a) Cooperating with DCS would result in serious physical or emotional harm to you or the child in your care.

(b) Establishing paternity or getting support would be harmful to the child who:

- (i) Was conceived as a result of incest or rape; or
- (ii) Is the subject of legal adoption proceedings pending before a superior court; or

(iii) Is the subject of ongoing discussions between you and a public or licensed child placement agency to decide whether you will keep the child or put the child up for adoption. The discussions cannot have gone on for more than three months.

(2) Once you claim good cause, you have twenty days to give us the information that proves you have good cause not to cooperate with DCS. This information can include official records, sworn statements, or other information that supports your good cause claim. If you need to, you may ask for:

- (a) More time to give proof; or
- (b) Help in getting proof.

(3) While we review your good cause claim, DCS does not take any action to establish or enforce support on your case.

(4) You have the right to:

(a) Be told of your right to claim good cause for not cooperating with DCS;

(b) Get benefits while we are deciding your good cause claim, as long as you have given the proof needed to make a decision;

(c) Get a decision within thirty days from the date you made your good cause claim, as long as you have given the proof needed to make a decision within twenty days; and

(d) Get information about how to request a fair hearing if we deny your good cause claim.

(5) If we approve your good cause claim, we periodically review the claim depending on your circumstances.

(6) To see what DCS does when good cause is approved see WAC 388-14A-2060.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 02-19-041, § 388-422-0020, filed 9/11/02, effective 10/12/02; 98-16-044, § 388-422-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0570 and 388-505-0560.]

WAC 388-422-0030 What happens if my support is more than my TANF or SFA cash benefit? (1) If DCS collects current support that is more than your TANF or SFA cash benefit for two months in a row, your cash benefit stops at the end of the third month.

(2) You can read WAC 388-418-0025 for information on continued medical benefits.

(3) You may be able to get continued food assistance benefits.

(4) You can read WAC 388-310-0800 to see what kinds of support services you may be able to get.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 02-19-041, § 388-422-0030, filed 9/11/02, effective 10/12/02; 98-16-044, § 388-422-0030, filed 7/31/98, effective 9/1/98.]

Chapter 388-424 WAC CITIZENSHIP/ALIEN STATUS

WAC

388-424-0001	Citizenship and alien status—Definitions.
388-424-0006	Citizenship and alien status—Date of entry.
388-424-0007	Citizenship and alien status—Armed services or veteran status.
388-424-0008	Citizenship and alien status—Work quarters.

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388-424-0009	Citizenship and alien status—Social Security number (SSN) requirements.
388-424-0010	Citizenship and alien status—Eligibility restrictions for the temporary assistance for needy families program and medical benefits, including nonemergency Medicaid and the state children's health insurance program (CHIP).
388-424-0015	Immigrant eligibility restrictions for the state family assistance, general assistance, and ADATSA programs.
388-424-0016	Citizenship and alien status—Immigrant eligibility restrictions for state medical benefits.
388-424-0020	How does my alien status impact my eligibility for the federally-funded Washington Basic Food program benefits?
388-424-0025	How does my alien status impact my eligibility for state-funded benefits under the Washington Basic Food program?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-424-0005	The effect of citizenship and alien status on eligibility for benefits. [Statutory Authority: RCW 74.08.090 and 74.08A.100, 99-17-023, § 388-424-0005, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-424-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520, 388-518-1805 and 388-510-1020.] Repealed by 04-15-004, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090.
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WAC 388-424-0001 Citizenship and alien status—Definitions. "American Indians" born outside the United States. American Indians born outside the U.S. are eligible for benefits without regard to immigration status or date of entry if:

(1) They were born in Canada and are of fifty percent American Indian blood (but need not belong to a federally-recognized tribe); or

(2) They are members of a federally-recognized Indian tribe or Alaskan Native village or corporation.

"Hmong or Highland Lao." These are members of the Hmong or Highland Laotian tribe, which rendered military assistance to the U.S. during the Vietnam era (August 5, 1964 to May 7, 1975), and are "lawfully present" in the United States. This category also includes the spouse (including unremarried widow or widower) or unmarried dependent child of such tribe members.

"Nonimmigrants." These individuals are allowed to enter the U.S. for a specific purpose, usually for a limited time. Examples include:

- (1) Tourists,
- (2) Students,
- (3) Business visitors.

"PRUCOL" (Permanently residing under color of law) aliens. These are individuals who:

- (1) Are not "qualified aliens" as described below; and
- (2) Intend to reside indefinitely in the U.S.; and
- (3) United States Citizenship and Immigration Services or USCIS (formerly the Immigration and Naturalization Service or INS) knows are residing in the U.S. and is not taking steps to enforce their departure.

"Qualified aliens." Federal law defines the following groups as "qualified aliens." All those not listed below are considered "nonqualified":

- (1) **Abused spouses or children,** parents of abused children, or children of abused spouses, who have either:

(a) A pending or approved I-130 petition or application to immigrate as an immediate relative of a U.S. citizen or as the spouse or unmarried son or daughter of a Lawful Permanent Resident (LPR) - see definition of LPR below; or

(b) A notice of "prima facie" approval of a pending self-petition under the Violence Against Women Act (VAWA); or

(c) Proof of a pending application for suspension of deportation or cancellation of removal under VAWA; and

(d) The alien no longer resides with the person who committed the abuse.

(e) Children of an abused spouse do not need their own separate pending or approved petition but are included in their parent's petition if it was filed before they turned age twenty-one. Children of abused persons who meet the conditions above retain their "qualified alien" status even after they turn age twenty-one.

(f) An abused person who has initiated a self-petition under VAWA but has not received notice of prima facie approval is not a "qualified alien" but is considered PRUCOL. An abused person who continues to reside with the person who committed the domestic violence is also PRUCOL. For a definition of PRUCOL, see above.

(2) **Amerasians** who were born to U.S. citizen armed services members in Southeast Asia during the Vietnam war.

(3) Individuals who have been granted **asylum** under Section 208 of the Immigration and Nationality Act (INA).

(4) Individuals who were admitted to the U.S. as **conditional entrants** under Section 203 (a)(7) of the INA prior to April 1, 1980.

(5) **Cuban/Haitian entrants**. These are nationals of Cuba or Haiti who were paroled into the U.S. or given other special status.

(6) Individuals who are **lawful permanent residents** (LPRs) under the INA.

(7) Persons who have been granted **parole** into the U.S. for at least a period of one year (or indefinitely) under Section 212 (d)(5) of the INA, including "public interest" parolees.

(8) Individuals who are admitted to the U.S. as **refugees** under Section 207 of the INA.

(9) Persons granted **withholding of deportation or removal** under Sections 243(h) (dated 1995) or 241 (b)(3) (dated 2003) of the INA.

"Undocumented aliens." These are persons who either:

- (1) Entered the U.S. without inspection at the border, or
- (2) Were lawfully admitted but have lost their status.

"U.S. citizens."

(1) The following individuals are considered to be citizens of the U.S.:

(a) Persons born in the U.S. or its territories (Guam, Puerto Rico, and the U.S. Virgin Islands; also residents of the Northern Mariana Islands who elected to become U.S. citizens); or

(b) Legal immigrants who have naturalized after immigrating to the U.S.

(2) Persons born abroad to at least one U.S. citizen parent may be U.S. citizens under certain conditions.

(3) Individuals under the age of eighteen automatically become citizens when they meet the following three conditions on or after February 27, 2001:

- (a) The child is a lawful permanent resident (LPR);

(b) At least one of the parents is a U.S. citizen by birth or naturalization; and

(c) The child resides in the U.S. in the legal and physical custody of the citizen parent.

(4) For those individuals who turned eighteen before February 27, 2001, the child would automatically be a citizen if still under eighteen when he or she began lawful permanent residence in the U.S. and both parents had naturalized. Such a child could have derived citizenship when only one parent had naturalized if the other parent were dead, a U.S. citizen by birth, or the parents were legally separated and the naturalizing parent had custody.

"U.S. nationals." A U.S. national is a person who owes permanent allegiance to the U.S. and may enter and work in the U.S. without restriction. The following are the only persons classified as U.S. nationals:

(1) Persons born in American Samoa or Swain's Island after December 24, 1952; and

(2) Residents of the Northern Mariana Islands who did not elect to become U.S. citizens.

"Victims of trafficking." According to federal law, victims of trafficking have been subject to one of the following:

(1) Sex trafficking, in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained eighteen years of age; or

(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

(3) Under federal law, persons who have been certified or approved as victims of trafficking by the federal Office of Refugee Resettlement (ORR) are to be treated the same as refugees in their eligibility for public assistance.

(4) Immediate family members of victims are also eligible for public assistance benefits as refugees. Immediate family members are the spouse or child of a victim of any age and the parent or minor sibling if the victim is under twenty-one years old.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0001, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0006 Citizenship and alien status—

Date of entry. (1) A person who physically entered the U.S. prior to August 22, 1996 and who continuously resided in the U.S. prior to becoming a "qualified alien" (as defined in WAC 388-424-0001) is not subject to the five-year bar on TANF, nonemergency Medicaid, and SCHIP.

(2) A person who entered the U.S. prior to August 22, 1996 but became "qualified" on or after August 22, 1996, or who physically entered the U.S. on or after August 22, 1996 and who requires five years of residency to be eligible for federal Basic Food, can only count years of residence during which they were a "qualified alien."

(3) A person who physically entered the U.S. on or after August 22, 1996 is subject to the five-year bar on TANF, nonemergency Medicaid, and SCHIP unless exempt. The five-year bar starts on the date that "qualified" status is obtained.

(4) The following "qualified aliens," as defined in WAC 388-424-0001, are exempt from the five-year bar:

- (a) Amerasian lawful permanent residents;
- (b) Asylees;
- (c) Conditional entrants;
- (d) Cuban/Haitian entrants;
- (e) Persons granted withholding of deportation or removal;
- (f) Refugees;
- (g) Victims of trafficking who have been certified or had their eligibility approved by the office of refugee resettlement (ORR);

(h) Lawful permanent residents, parolees, or battered aliens, as defined in WAC 388-424-0001, who are also an armed services member or veteran as described in WAC 388-424-0007.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-16-055, § 388-424-0006, filed 7/28/05, effective 8/28/05; 04-15-004, § 388-424-0006, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0007 Citizenship and alien status—Armed services or veteran status. (1) An immigrant in one of the following categories is considered a member of the armed forces or a veteran for purposes of establishing eligibility for federal means-tested benefits as defined in WAC 388-424-0008:

- (a) On active duty in the U.S. military, other than active duty for training; or
- (b) An honorably discharged U.S. veteran; or
- (c) A veteran of the military forces of the Philippines who served prior to July 1, 1946, as described in Title 38, Section 107 of the U.S. Code; or
- (d) The spouse, un-remarried widow or widower, or unmarried dependent child of a veteran or active duty service member.

(2) An immigrant as described in subsection (1) above is not subject to the five-year bar on TANF, nonemergency Medicaid, and SCHIP (see WAC 388-424-0010).

(3) An immigrant as described in subsection (1) above who is also a "qualified alien" as described in WAC 388-424-0020 (1)(b)(i) is eligible for federal Basic Food.

(4) An immigrant is not subject to sponsor deeming in state funded programs (see WAC 388-450-0156 (4)(c)) if in any of the categories in subsection (1) above or if:

- (a) Employed by an agency of the U.S. government or served in the armed forces of an allied country during a military conflict between the U.S. and a military opponent; or
- (b) The spouse, un-remarried widow or widower, or unmarried dependent child of a person in subsection (4)(a) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0007, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0008 Citizenship and alien status—Work quarters. (1) For purposes of determining Social Security work quarters, the following are considered federal means-tested benefits: Temporary assistance for needy families (TANF), nonemergency Medicaid, state children's health insurance program (SCHIP), Supplemental Security Income (SSI), and federal Basic Food.

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(2) An immigrant can receive credit for work quarters by:

- (a) Earning enough money to qualify for work quarters;
- (b) Getting credit for work quarters earned by a parent or step parent while the alien was under eighteen (including quarters earned before the alien was born); and
- (c) Getting credit for work quarters earned by a spouse during the marriage (including a now deceased spouse) or during a period when a couple "hold themselves out" as married.

(3) An immigrant may receive credit for work quarters earned while residing in the U.S. regardless of their (or their family member's) immigration status at the time the money was earned.

(4) An immigrant cannot receive credit for a work quarter on or after January 1, 1997 if the person earning or being credited with the work quarter received a federal means-tested benefit during the quarter.

(5) If the person earning the quarter applied for a federal means-tested benefit during the fortieth quarter and the person earning the quarter earned enough money to qualify for benefits before applying for benefits, the quarter is credited.

(6) An immigrant can be provisionally credited with forty work quarters for up to six months while awaiting verification of work quarters only if:

- (a) SSA responded that the immigrant (and spouse and parents) has less than forty quarters, but SSA is making an investigation to see if more quarters can be credited; or
- (b) The immigrant has turned in a request to another federal agency for proof of the immigrant's eligible alien status and the agency has accepted the request.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0008, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0009 Citizenship and alien status—Social Security number (SSN) requirements. (1) A "qualified alien," as defined in WAC 388-424-0001, who has applied for a Social Security number (SSN) as part of their application for benefits cannot have benefits delayed, denied, or terminated pending the issuance of the SSN by the Social Security Administration (SSA).

(2) The following immigrants are not required to apply for an SSN:

- (a) An alien, regardless of immigration status, who is applying for a program listed in WAC 388-476-0005(7);
- (b) A PRUCOL alien as defined in WAC 388-424-0001; and
- (c) Members of a household who are not applying for benefits for themselves.

(3) "Qualified aliens," as defined in WAC 388-424-0001, who are applying for federal benefits but who are not authorized to work in the U.S., must still apply for a nonwork SSN. The department must assist them in this application without delay.

(4) An immigrant who is otherwise eligible for benefits may choose not to provide the department with an SSN without jeopardizing the eligibility of others in the household. See WAC 388-450-0140 for how the income of such individuals is treated.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0009, filed 7/7/04, effective 8/7/04.]

[Title 388 WAC—p. 809]

WAC 388-424-0010 Citizenship and alien status—Eligibility restrictions for the temporary assistance for needy families program and medical benefits, including nonemergency Medicaid and the state children's health insurance program (SCHIP). (1) To receive TANF or medical benefits you must meet all other eligibility requirements and be one of the following as defined in WAC 388-424-0001:

- (a) A U.S. citizen;
- (b) A U.S. national;
- (c) An American Indian born outside the U.S.;
- (d) A "qualified alien";
- (e) A victim of trafficking; or
- (f) A Hmong or Highland Lao.

(2) A "qualified alien" who first physically entered the U.S. before August 22, 1996 as described in WAC 388-424-0006(1) may receive TANF, nonemergency Medicaid, and SCHIP benefits.

(3) A "qualified alien" who first physically entered the U.S. on or after August 22, 1996 cannot receive TANF, non-emergency Medicaid, or SCHIP for five years after obtaining status as a qualified alien unless he or she is an alien as described under WAC 388-424-0006(4).

(4) An alien who is ineligible for TANF, nonemergency Medicaid, or SCHIP because of the five-year bar or because of their immigration status may be eligible for:

- (a) Emergency benefits as described in WAC 388-436-0015 (consolidated emergency assistance program) and WAC 388-438-0110 (alien emergency medical program); or
- (b) State-funded cash or chemical dependency benefits as described in WAC 388-424-0015 (SFA, GA and ADATSA) and medical benefits as described in WAC 388-424-0016; or
- (c) Pregnancy medical benefits as described in WAC 388-462-0015; or
- (d) Children's health program as described in WAC 388-505-0210.

[Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-424-0010, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0010, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-424-0010, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and Public Law 106-395. 02-03-008, § 388-424-0010, filed 1/4/02, effective 2/4/02. Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-424-0010, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520 and 388-518-1805.]

WAC 388-424-0015 Immigrant eligibility restrictions for the state family assistance, general assistance, and ADATSA programs. (1) To receive state family assistance (SFA) benefits, you must be:

- (a) A "qualified alien" as defined in WAC 388-424-0001 who is ineligible for TANF due to the five-year bar as described in WAC 388-424-0006(3); or
- (b) A PRUCOL alien as defined in WAC 388-424-0001, including a noncitizen American Indian who does not meet the criteria in WAC 388-424-0001.

(2) To receive general assistance (GA) benefits, you must be ineligible for the TANF, SFA, or SSI program for a reason other than failure to cooperate with program require-

ments, and belong to one of the following groups as defined in WAC 388-424-0001:

- (a) A U.S. citizen;
 - (b) A U.S. national;
 - (c) An American Indian born outside the U.S.;
 - (d) A "qualified alien" or similarly defined lawful immigrant such as Hmong or Highland Lao or victim of trafficking; or
 - (e) A PRUCOL alien.
- (3) To receive ADATSA benefits, you must belong to one of the following groups as defined in WAC 388-424-0001:
- (a) A U.S. citizen;
 - (b) A U.S. national;
 - (c) An American Indian born outside the U.S.;
 - (d) A "qualified alien" or similarly defined lawful immigrant such as Hmong or Highland Lao or victim of trafficking; or
 - (e) A PRUCOL alien.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0015, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.04.050, 74.08.090. 00-08-060, § 388-424-0015, filed 3/31/00, effective 4/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

WAC 388-424-0016 Citizenship and alien status—Immigrant eligibility restrictions for state medical benefits. (1) To receive general assistance medical (medical care services) you must meet the alien requirements of general assistance as described in WAC 388-424-0015(2) and be a recipient of general assistance cash.

(2) To receive medical benefits for pregnancy, you must be ineligible for other programs as described in WAC 388-462-0015, verify you are pregnant, and be:

- (a) A "qualified alien" who is ineligible for TANF due to the five-year bar as described in WAC 388-424-0006(3);
- (b) PRUCOL as defined in WAC 388-424-0001; or
- (c) An undocumented alien as defined in WAC 388-424-0001.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0016, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0020 How does my alien status impact my eligibility for the federally-funded Washington Basic Food program benefits? (1) If you are a U.S. citizen or U.S. national as defined in WAC 388-424-0001 and meet all other eligibility requirements, you may receive federal Basic Food benefits.

(2) If you are not a U.S. citizen or U.S. national, you must fall within (a) or (b) of this subsection, and meet all other eligibility requirements, in order to receive federal Basic Food benefits:

- (a) You are a member of one of the following groups of "qualified aliens" or similarly defined lawful immigrants as defined in WAC 388-424-0001:
 - (i) Amerasian;
 - (ii) Asylee;
 - (iii) Cuban or Haitian entrant;
 - (iv) Deportation or removal withheld;
 - (v) Refugee;

- (vi) Victim of trafficking;
- (vii) Noncitizen American Indian; or
- (viii) Hmong or Highland Lao tribal member.

(b)(i) You are a member of one of the following groups of qualified aliens as defined in WAC 388-424-0001:

- (A) Conditional entrant;
- (B) Lawful permanent resident (LPR);
- (C) Paroled for one year or more; or
- (D) Victim of domestic violence or parent or child of a victim.

(ii) And, one of the following also applies to you:

(A) You have worked or can get credit for forty Social Security Administration (SSA) work quarters - as described in WAC 388-424-0008;

(B) You are an active duty personnel or honorably discharged veteran of the U.S. military or you are the spouse, unmarried surviving spouse, or unmarried dependent child of someone who meets this requirement, as described in WAC 388-424-0007(1);

(C) You receive cash or medical benefits based on Supplemental Security Income (SSI) criteria for blindness or disability;

(D) You have lived in the U.S. as a "qualified alien" as described in WAC 388-424-0001 for at least five years;

(E) You are under age eighteen; or

(F) You were lawfully residing in the U.S. on August 22, 1996 and were born on or before August 22, 1931.

(3) If you are ineligible for federal Basic Food benefits due to your alien status, you may be eligible for state Basic Food benefits (see WAC 388-424-0025).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0020, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-029, § 388-424-0020, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and H.R. 2646 Farm Security and Rural Investment Act of 2002. 02-22-046, § 388-424-0020, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.04.510, S. 1150, the Agricultural Research, Extension, and Education Reform Act of 1998. 99-01-058, § 388-424-0020, filed 12/11/98, effective 1/11/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

WAC 388-424-0025 How does my alien status impact my eligibility for state-funded benefits under the Washington Basic Food program? To receive state-funded benefits under the Washington Basic Food program, you must be one of the following:

(1) A "qualified alien," as defined in WAC 388-424-0001, who does not meet the eligibility requirements under WAC 388-424-0020 to receive federally-funded Basic Food benefits; or

(2) An alien who does not meet the definition of a qualified alien as defined in WAC 388-424-0001 but who is Permanently Residing Under Color of Law (PRUCOL) in the United States as defined in WAC 388-424-0001.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0025, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-029, § 388-424-0025, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.08A.120. 00-13-036, § 388-424-0025, filed 6/13/00, effective 7/14/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

(2007 Ed.)

Chapter 388-426 WAC CLIENT COMPLAINTS

WAC

388-426-0005

How do I make a complaint to the department?

WAC 388-426-0005 How do I make a complaint to the department? If you do not agree with a decision we made or an action we took, you can make a complaint. We address your concerns based on the nature of your complaint.

Civil Rights:

(1) We will not discriminate based on your race, color, national origin, sex, age, disability, religion, or political beliefs. This agrees with:

(a) Federal law and policy of the United States Department of Agriculture (USDA) and the United States Department of Health and Human Services (HHS) that ban discrimination based on race, color, national origin, sex, age or disability; and

(b) The Food Stamp Act and USDA policy, which bans discrimination on religion or political beliefs.

(2) To file a complaint that we discriminated based on your race, color, national origin, sex, age, disability, religion, or political beliefs, contact USDA or HHS:

Write:	
USDA	HHS
Director, Office of Civil Rights	Director, Office for Civil Rights
1400 Independence Avenue, S.W.	Room 506-F
Washington, D.C. 20250-9410	200 Independence Avenue, S.W.
	Washington, D.C. 20201
Or call:	
USDA	HHS
(800) 795-3272 (voice); or	(202) 619-0403 (voice); or
(202) 720-6382 (TTY).	(202) 619-3257 (TTY).
USDA and HHS are equal opportunity providers and employers.	

Complaints about our decisions or actions:

(3) If you do not agree with a decision we made or an action we took, you may use our complaint process:

(a) **Supervisor review:** You may give a supervisor a written complaint. We will:

(i) Make a decision about your written complaint within ten days of the date we get it; and

(ii) Send you a letter telling you what we decided and that you may have another review by the local office administrator if you ask for it.

(b) **Administrator review:** If you do not accept the decision you get from a supervisor, you may give the local office administrator a written complaint. We will:

(i) Make a decision about your written complaint within ten days of the date we get it; and

(ii) Send you a letter telling you what we decided.

(4) When we send you a letter with the administrator's decision, this ends the complaint process.

(5) If you file a written complaint, you may still ask for a fair hearing under chapter 388-02 WAC.

(6) You may always speak with your worker's supervisor or have them review your worker's decision even if you do not file a formal complaint.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.04.515, 74.08.090. 06-10-057, § 388-426-0005, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-03-050, § 388-426-0005, filed 1/15/04, effective 2/15/04. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-426-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-426-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-428 WAC CONFIDENTIALITY

WAC

388-428-0010 Request for address disclosure by a parent when a child is living with a nonparental caretaker.

WAC 388-428-0010 Request for address disclosure by a parent when a child is living with a nonparental caretaker.

(1) When TANF or SFA has been approved for a child who is living with a nonparental caretaker, the address and location of the child may be released to the child's parent when:

(a) The parent has legal custody of the child or is allowed visitation rights or residential time with the child under a court order; and

(b) No court order restricts or limits the parent's right to contact or visit the child or the child's caretaker by imposing conditions to protect the child or the caretaker from harm;

(c) The department has not found that the caretaker has good cause for refusing to cooperate in child support enforcement activities related to the parent's support obligation; and

(d) There is no substantiated claim or pending investigation involving abuse or neglect of any child by the parent;

(e) There are no pending proceedings as listed in subsections (1)(b) through (d).

(2) A parent may request the child's address and location:

(a) In person, with satisfactory evidence of identity, at the community services office where the child's record is being maintained;

(b) Through an attorney; or

(c) If residing outside the state of Washington, by submitting a notarized request.

(3) If the request for the child's address and location is based on a court order granting the parent legal custody, visitation rights or residential time, the parent must also submit:

(a) A copy of the court order; and

(b) A sworn statement that the order has not been modified.

(4) Prior to release of the child's address and location, the child's caretaker will be notified that:

(a) The child's parent has requested the information; and

(b) The information will be released within thirty days from the date of the notice unless the caretaker:

(i) Provides proof of a current investigation or pending court case involving the abuse or neglect of any child by the parent;

(ii) Provides a copy of a court order which prevents disclosure of the address or restricts the parent's right to contact

or visit the caretaker or the child by imposing conditions to protect the caretaker or child from harm;

(iii) Requests a fair hearing which results in a decision that disclosure must be denied because of the existence of one or more of the conditions in subsection (1) of this section.

(5) A parent's request for disclosure of a child's address and location will be responded to within thirty-five days. The response will notify the parent:

(a) Of the child's address and location if the information may be disclosed;

(b) The reasons for denying the request if the information may not be disclosed; or

(c) That a decision has not been made because the child's caretaker:

(i) Has requested a hearing and a final hearing decision has not been entered; or

(ii) Is claiming good cause for refusing to cooperate in child support enforcement activities related to the parent's support obligation and a final decision has not been made on the caretaker's claim.

(d) When the decision has not been made because of a pending fair hearing decision or good cause claim determination, the parent will be notified of the decision within ten days of the hearing decision or good cause determination.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-428-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-432 WAC DIVERSION ASSISTANCE

WAC

388-432-0005 Can I get help from DSHS for a family emergency without receiving monthly cash assistance?

WAC 388-432-0005 Can I get help from DSHS for a family emergency without receiving monthly cash assistance? DSHS has a program called diversion cash assistance (DCA). If your family needs an emergency cash payment but does not need ongoing monthly cash assistance, you may be eligible for this program.

(1) To get DCA, you must:

(a) Meet all the eligibility rules for temporary assistance for needy families (TANF)/state family assistance (SFA) except:

(i) You do not have to participate in WorkFirst requirements as defined in chapter 388-310 WAC; and

(ii) You do not have to assign child support rights or cooperate with division of child support as defined in chapter 388-422 WAC.

(b) Have a current bona fide or approved need for living expenses;

(c) Provide proof that your need exists; and

(d) Have or expect to get enough income or resources to support yourselves for at least twelve months.

(2) You may get DCA to help pay for one or more of the following needs:

(a) Child care;

(b) Housing;

(c) Transportation;

(d) Expenses to get or keep a job;

(e) Food costs, but not if an adult member of your family has been disqualified for food stamps; or

(f) Medical costs, except when an adult member of your family is not eligible because of failure to provide third party liability (TPL) information as defined in WAC 388-505-0540.

(3) DCA payments are limited to:

(a) One thousand five hundred dollars once in a twelve-month period which starts with the month the DCA benefits begin; and

(b) The cost of your need.

(4) We do not budget your income or make you use your resources to lower the amount of DCA payments you can receive.

(5) DCA payments can be paid:

(a) All at once; or

(b) As separate payments over a thirty-day period. The thirty-day period starts with the date of your first DCA payment.

(6) When it is possible, we pay your DCA benefit directly to the service provider.

(7) You are not eligible for DCA if:

(a) Any adult member of your assistance unit got DCA within the last twelve months;

(b) Any adult member of your assistance unit gets TANF/SFA;

(c) Any adult member of your assistance unit is not eligible for cash assistance for any reason unless one parent in a two-parent-assistance unit is receiving SSI; or

(d) Your assistance unit does not have a needy adult (such as when you do not receive TANF/SFA payment for yourself but receive it for the children only).

(8) If you apply for DCA after your TANF/SFA grant has been terminated, we consider you an applicant for DCA.

(9) If you apply for TANF/SFA and you received DCA less than twelve months ago:

(a) We set up a DCA loan.

(i) The amount of the loan is one-twelfth of the total DCA benefit times the number of months that are left in the twelve-month period.

(ii) The first month begins with the month DCA benefits began.

(b) We collect the loan only by reducing your grant. We take five percent of your TANF/SFA grant each month.

(10) If you stop getting TANF/SFA before you have repaid the loan, we stop collecting the loan unless you get back on TANF/SFA.

[Statutory Authority: RCW 74.08.090, 74.04.050, 01-03-066, § 388-432-0005, filed 1/12/01, effective 3/1/01.]

Chapter 388-434 WAC

ELIGIBILITY REVIEWS AND RECERTIFICATIONS

WAC

388-434-0005	How often does the department review my eligibility for benefits?
388-434-0010	How do I get Basic Food benefits after my certification period has ended?

WAC 388-434-0005 How often does the department review my eligibility for benefits? (1) If you receive cash
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assistance, the department reviews your eligibility for assistance at least once every twelve months.

(2) When it is time for your eligibility review, the department requires you to complete a review. We use the information you provide to determine your eligibility for all assistance programs.

(3) If you complete an interview for assistance with a department representative and sign the printed application for benefits (AFB) form, you do not have to complete a separate review form.

(4) For cash assistance, an eligibility review form or the AFB must be dated and signed by both husband and wife, or both parents of a child in common when the parents live together.

(5) For medical assistance, a signature is not required to complete your review.

(6) We may review your eligibility at any time if we decide your circumstances need to be reviewed sooner.

(7) At your review, we look at:

(a) All eligibility requirements under WAC 388-400-0005 through 388-400-0035, 388-503-0505 through 388-503-0515, and 388-505-0210 through 388-505-0220;

(b) Changes since we last determined your eligibility; and

(c) Changes that are anticipated for the next review period.

(8) If you receive medical assistance, we set your certification period according to WAC 388-416-0010, 388-416-0015, 388-416-0020, and 388-416-0035.

(9) Clients You are responsible for attending an interview if one is required under WAC 388-452-0005.

(10) If you do not complete the eligibility review for cash assistance, we consider you to be withdrawing your request for continuing assistance:

(a) Your cash assistance benefits will end; and

(b) Your medical assistance will continue for twelve consecutive months from the month we received your most recent application or eligibility review.

(11) We will send you written notice as described under chapter 388-458 WAC before assistance is suspended, terminated, or a benefit error is established as a result of your eligibility review.

(12) If you currently receive Categorically Needy (CN) medical assistance, and you are found to no longer be eligible for benefits, we will determine if you are eligible for other medical programs. Until we decide if you are eligible for another program, your (CN) medical assistance will continue under WAC 388-418-0025.

(13) When you need a supplemental accommodation under WAC 388-472-0010, we will help you meet the requirements of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54, 04-19-134, § 388-434-0005, filed 9/21/04, effective 10/1/04. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 c 10, 04-03-019, § 388-434-0005, filed 1/12/04, effective 2/12/04. Statutory Authority: RCW 74.08.090 and 74.04.510, 99-23-083, § 388-434-0005, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-434-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2230.]

WAC 388-434-0010 How do I get Basic Food benefits after my certification period has ended? To keep getting

Basic Food benefits after your certification period in WAC 388-416-0005 has ended, we must determine if you are still eligible for benefits. This is called recertification.

(1) To be recertified for Basic Food, you must:

(a) Turn in and sign an application for benefits as required under WAC 388-406-0010. If you complete an electronic application, your signature is the password you use to complete the electronic application;

(b) Complete an interview if you are required to have an interview under WAC 388-452-0005; and

(c) Submit needed proof of your circumstances if we ask for it.

(2) If you reapply timely and get recertified before your certification period ends, we will keep depositing your benefits into your EBT (electronic benefit transfer) account on the same day of the month. To reapply timely, we must get your application by the fifteenth day of the last month of your certification period.

(3) When we decide if you are eligible for benefits, we will send you a letter to tell you that your benefits have been approved or denied as required under chapter 388-458 WAC.

(4) If you reapply timely and complete the steps required in subsection (1) by the fifteenth day of the last month of your certification period, you get the approval or denial letter by the end of your current certification period.

(5) If you do not turn in an application form by the end of your current certification period, you have not taken the action we require for you to get ongoing Basic Food benefits. Your Basic Food benefits stop at the end of your certification period.

(6) **If you turn in your application before your certification period ends**, we start your Basic Food from the first of the month of your new certification period after we determine if you are eligible.

(a) If you do not reapply timely, your benefits for the first month of your new certification period may be delayed.

(b) You have until the end of the month following your certification period end date to complete an interview if required and provide any proof of your circumstances we requested.

(c) If you do not meet all requirements for verification by the end of the month following your certification end date, your recertification will not be approved.

(7) **If you turn in your application after your certification period ends**, we treat the application as a new application for benefits. We start your Basic Food from the date you turned in the application after we determine if you are eligible.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-19-133, § 388-434-0010, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510, and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 02-18-083, § 388-434-0010, filed 8/30/02, effective 10/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.05.057, and 74.08.090. 01-15-011, § 388-434-0010, filed 7/6/01, effective 8/1/01; 98-16-044, § 388-434-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-436 WAC

EMERGENCY CASH ASSISTANCE

WAC

388-436-0002 If my family has an emergency, can I get help from DSHS to get or keep our housing or utilities?

[Title 388 WAC—p. 814]

388-436-0015
388-436-0020
388-436-0025
388-436-0030

388-436-0035
388-436-0040
388-436-0045
388-436-0050

Consolidated emergency assistance program (CEAP).
CEAP assistance unit composition.
Eligibility conditions for CEAP—Job refusal.
Eligibility for CEAP depends on other possible cash benefits.
Income and resources for CEAP.
Excluded income and resources for CEAP.
Income deductions for CEAP.
Determining financial need and benefit amount for CEAP.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-436-0001 Additional requirement for emergent needs (AREN). [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0001, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-046, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055 and 74.08.090.

388-436-0005 AREN good cause. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0005, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-046, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055 and 74.08.090.

388-436-0010 Winterization. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0010, filed 7/31/98, effective 9/1/98.] Repealed by 00-10-036, filed 4/24/00, effective 6/1/00. Statutory Authority: RCW 74.08.090.

WAC 388-436-0002 If my family has an emergency, can I get help from DSHS to get or keep our housing or utilities? DSHS has a program called additional requirements for emergent needs (AREN). If your family has an emergency and you need assistance to get or keep safe housing or utilities, you may be eligible. The special AREN payment is in addition to the regular monthly cash grant your family may already get.

(1) To get AREN, you must:

(a) Be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or refugee cash assistance (RCA);

(b) Have an emergency housing or utility need; and

(c) Have a good reason that you do not have enough money to pay your housing or utility costs.

(2) To get AREN, you must be eligible for TANF, SFA, or RCA. This means you must:

(a) Get benefits through TANF, SFA, or RCA. For RCA you must also be pregnant or have an eligible child; or

(b) Apply for TANF, SFA, and RCA, and meet all eligibility criteria including:

(i) The maximum earned income limit under WAC 388-478-0035;

(ii) The requirement that your unearned income not exceed the grant payment standard;

(iii) The requirement that your countable income as defined under WAC 388-450-0162 must be below the payment standard in WAC 388-478-0020 when you have both earned income and unearned income;

(iv) The resource limits under chapter 388-470 WAC;

(v) The program summary rules for either TANF (WAC 388-400-0005); SFA (WAC 388-400-0010); or RCA (WAC 388-400-0030); and

(vi) The requirement that you must be pregnant or have an eligible child.

(3) If you do not get or do not want to get TANF, SFA or RCA, you cannot get AREN to help with housing or utility

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costs. We will look to see if you are eligible for diversion cash assistance (DCA) under WAC 388-432-0005.

(4) To get AREN, you must have an emergency housing or utility need. You may get AREN to help pay to:

- (a) Prevent eviction or foreclosure;
- (b) Get housing if you are homeless or need to leave your home because of domestic violence;
- (c) Hook up or prevent a shut off of utilities related to your health and safety. We consider the following utilities to be needed for health and safety:

- (i) Electricity or fuel for heating, lighting, or cooking;
- (ii) Water;
- (iii) Sewer; and
- (iv) Basic local telephone service if it is necessary for your basic health and safety. If you receive TANF or SFA, the Washington telephone assistance program (WTAP) may be used to help you pay for basic local telephone service.

(d) Repair damage or defect to your home when it causes a risk to your health or safety:

(i) If you own the home, we may approve AREN for the least expensive method of ending the risk to your health or safety;

(ii) If you do not own the home, you must ask the landlord in writing to fix the damage according to the Residential Landlord-Tenant Act at chapter 59.18 RCW. If the landlord refuses to fix the damage or defect, we may pay for the repair or pay to move you to a different place whichever cost is lower.

(e) If you receive TANF or SFA, WorkFirst support services under WAC 388-310-0800 may be used to help you relocate to new housing to get a job, keep a job, or participate in WorkFirst activities. Nonhousing expenses that are not covered under AREN may be paid under WorkFirst support services. This includes expenses such as car repair, diapers, or clothing.

(5) To get AREN, you must have a good reason for not having enough money to pay for your housing or utility costs. You must prove that you:

(a) Did not have money available that you normally use to pay your rent and utilities due to an emergency situation that reduced your income (such as a long-term illness or injury);

(b) Had to use your money to pay for necessary or emergency expenses. Examples of necessary or emergency expenses include:

- (i) Basic health and safety needs for shelter, food and clothing;
- (ii) Medical care;
- (iii) Dental care needed to get a job or because of pain;
- (iv) Emergency child care;
- (v) Emergency expenses due to a natural disaster, accident, or injury; and
- (vi) Other reasonable and necessary expenses.

(c) Are currently homeless; or

(d) Had your family's cash grant reduced or suspended when we budgeted your expected income for the month, but the income will not be available to pay for the need when the payment is due. You must make attempts to negotiate later payments with your landlord or utility company before you can get AREN.

(6) In addition to having a good reason for not having enough money to pay for your costs, you must also explain how you will afford to pay for the on-going need in the future. We may deny AREN if your expenses exceed your income (if you are living beyond your means). We may approve AREN to help you get into housing you can afford.

(7) If you meet the above requirements, we decide the amount we will pay based on the following criteria.

(a) AREN payments may be made up to a maximum of seven hundred fifty dollars in a consecutive twelve-month period.

(b) The number of AREN payments you can receive in a twelve-month period is not limited, as long as the total amount does not exceed seven hundred fifty dollars.

(c) The department may approve an AREN payment above the seven hundred fifty dollar maximum for health and safety reasons.

(d) The amount of AREN is in addition to the amount of your monthly TANF, SFA, or RCA cash grant.

(e) We will decide the lowest amount we must pay to end your housing or utility emergency. We will contact your landlord, utility company, or other vendor for information to make this decision. We may take any of the following steps when deciding the lowest amount to pay:

(i) We may ask you to arrange a payment plan with your landlord or utility company. This could include us making a partial payment, and you setting up a plan for you to repay the remaining amount you owe over a period of time.

(ii) We may have you use some of the money you have available in cash, checking, or savings to help pay for the expense. We will look at the money you have available as well as your bills when we decide how much we will pay.

(iii) We may consider income that is excluded or disregarded for cash assistance benefit calculations, such as SSI, as available to meet your emergency housing need.

(iv) We may consider money other individuals such as family or friends voluntarily give you. We will not count loans of money that you must repay to friends or family members.

(v) We may consider money from a nonneedy caretaker relative that lives in the home.

(vi) We may look at what other community resources you currently have to help you with your need.

(f) The seven hundred fifty dollar limit every twelve months applies to the following people even if they leave the assistance unit:

- (i) Adults; and
- (ii) Minor parents that get AREN when no adults are in the assistance unit.

(8) We pay AREN:

(a) Directly to the landlord, mortgage company, utility, or other vendor whenever we can.

(b) If we cannot pay AREN directly to the landlord or other vendor, we will issue the AREN as a part of your TANF, SFA, or RCA cash grant. If we issue the AREN as a part of your grant, you must use it for your emergency need.

(9) We may assign you a protective payee for your monthly grant under WAC 388-460-0020.

[Statutory Authority: RCW 74.08.090, 74.04.050 and 74.08A.340. 04-07-023, § 388-436-0002, filed 3/8/04, effective 4/8/04. Statutory Authority: RCW 74.08.090, 74.04.050. 00-22-064, § 388-436-0002, filed 10/27/00,

effective 12/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, and 74.08.090. 99-14-046, § 388-436-0002, filed 6/30/99, effective 8/1/99.]

WAC 388-436-0015 Consolidated emergency assistance program (CEAP). (1) CEAP is available to the following persons:

- (a) A pregnant woman in any stage of pregnancy; or
- (b) Families with dependent children.
- (2) Applicants must be residents of Washington state as defined in WAC 388-468-0005.
- (3) Applicants must demonstrate a financial need for emergency funds for one or more of the following basic requirements:
 - (a) Food;
 - (b) Shelter;
 - (c) Clothing;
 - (d) Minor medical care;
 - (e) Utilities;
 - (f) Household maintenance supplies;
 - (g) Necessary clothing or transportation costs to accept or retain a job; or
 - (h) Transportation for a minor, not in foster care, to a home where care will be provided by family members or approved caretakers.
- (4) Payment under this program is limited to not more than thirty consecutive days within a period of twelve consecutive months.

[Statutory Authority: RCW 74.04.050, 74.04.055, and 74.04.057. 04-05-013, § 388-436-0015, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0020 CEAP assistance unit composition. (1) To be eligible for CEAP, a child must be living with:

- (a) A parent or a relative of specified degree as defined under WAC 388-454-0010; or
- (b) Has lived with such a relative within six months of the request for assistance.
- (2) The following persons living in the household must be included as members of the CEAP assistance unit:
 - (a) All full, half, or adopted siblings under eighteen years of age, including a minor parent; and
 - (b) The parent, adoptive parent, or stepparent living with the child or children.
- (3) The following persons living in the household do not have to be included but may be included as members at the option of the applicant:
 - (a) One caretaker relative of specified degree when the child's parent does not live in the home;
 - (b) Stepbrothers or stepsisters to all children in the assistance unit.
- (4) The following persons may make up a CEAP assistance unit without including others living in the home:
 - (a) The child of a parent who is a minor when the minor parent is not eligible due to the income and resources of his/her parents; or
 - (b) A pregnant woman when no other child is in the home.
- (5) The following persons living in the household are not included as members of the CEAP assistance unit:

- (a) A household member receiving Supplemental Security Income (SSI);

- (b) A household member ineligible due to reasons stated in WAC 388-436-0025 and 388-436-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0025 Eligibility conditions for CEAP—Job refusal. (1) Within thirty days of the date of application, applicants for CEAP cannot have refused without good cause:

- (a) A bona fide job offer; or
- (b) Training for employment.
- (2) Applicants have good cause for refusal when the applicant:
 - (a) Can not perform the work satisfactorily because of a physical, mental, or emotional inability;
 - (b) Is not able to get to and from the job without undue cost or hardship;
 - (c) Would be forced to perform hazardous work;
 - (d) Would be working for less than minimum wage or the wages are not customary for that type of work;
 - (e) Is offered the job only because of a labor dispute; or
 - (f) Is not able to obtain necessary child care.
- (3) An applicant who cannot demonstrate good cause for refusing a job offer makes the entire assistance unit ineligible for CEAP:

- (a) For thirty days from the date of refusal; or
- (b) Until the applicant accepts employment, whichever comes first.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0030 Eligibility for CEAP depends on other possible cash benefits. (1) Before the department approves CEAP benefits, we must determine that all household members are ineligible for benefits from any of the following programs:

- (a) Temporary assistance for needy families (TANF);
- (b) State family assistance (SFA);
- (c) Refugee cash assistance (RCA);
- (d) Diversion cash assistance (DCA).
- (2) To receive CEAP, the applicant must take any required action to receive benefits from the following programs:
 - (a) TANF, SFA, and RCA;
 - (b) Supplemental security income (SSI);
 - (c) Medical assistance for those applicants requesting help for a medical need;
 - (d) Food assistance for those applicants requesting help for a food need;
 - (e) Housing assistance from any available source for those applicants requesting help for a housing need;
 - (f) Unemployment compensation, veteran's benefits, industrial insurance benefits, Social Security benefits, pension benefits, or any other source of financial benefits the applicant is potentially eligible to receive.

(3) The department may not authorize CEAP benefits to any household containing a member who is under a grant penalty for failure to comply with program requirements of

TANF/SFA, RCA, or WorkFirst under chapter 388-310 WAC.

[Statutory Authority: RCW 74.04.660, 99-24-130, § 388-436-0030, filed 12/1/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-436-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0035 Income and resources for CEAP. (1) Estimated income, resources and circumstances of the following persons are used in determining need and payment for CEAP:

(a) All persons included as members of the CEAP assistance unit;

(b) If living in the home, the spouses and minor brothers and sisters of persons included as members of the CEAP assistance unit.

(2) Public assistance payments plus authorized additional requirements received in the calendar month of CEAP application are considered as income.

(3) The value of resources not listed as excluded in WAC 388-436-0040 is considered available to meet the emergent needs of the CEAP assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-436-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0040 Excluded income and resources for CEAP. Resources and income listed below will not be considered in determining need or payment for CEAP:

(1) A home as defined under WAC 388-470-0045;

(2) One vehicle, running and used regularly by the assistance unit, with an equity value not to exceed one thousand five hundred dollars);

(3) Household furnishings being used by the assistance unit;

(4) Personal items being used by members of the assistance unit;

(5) Tools and equipment being used in the applicant's occupation;

(6) The value of the coupon allotment under the Food Stamp Act of 1977, as amended;

(7) Benefits received under the women, infants and children program (WIC) of the child nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended;

(8) Energy assistance payments;

(9) Grants, loans, or work study to a student under Title IV of the Higher Education Amendments or Bureau of Indian Affairs for attendance costs as identified by the institution;

(10) Income and resources of an SSI recipient;

(11) Livestock when the products are consumed by members of the assistance unit;

(12) All resources and income excluded for the TANF program under WAC 388-470-0045 and by federal law.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-010, § 388-436-0040, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-436-0040, filed 7/31/98, effective 9/1/98.]

	1	2	3	4	5	6	7	8 or more
Food	\$211	\$268	\$332	\$391	\$450	\$511	\$583	\$645
Shelter	258	325	404	476	548	621	719	795
Clothing	30	38	47	56	64	73	83	94

WAC 388-436-0045 Income deductions for CEAP.

The following deductions are allowed when determining the CEAP assistance unit's net income:

(1) A ninety dollar work expense from each member's earned income;

(2) Actual payments made by a member with earned income for care of a member child up to the following maximums:

Hours Worked Per Month	Each Child Under Two Years	Each Child Two Years Or Older
0 - 40	\$ 50.00	\$ 43.75
41 - 80	100.00	87.50
81 - 120	150.00	131.25
121 or More	200.00	175.00

(3) Verified expenses for members of the assistance unit during the current month as follows:

(a) Medical bills;

(b) Child care paid in an emergency in order to avoid abuse;

(c) Dental care to relieve pain; or

(d) Costs incurred in obtaining employment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-436-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0050 Determining financial need and benefit amount for CEAP. (1) To be eligible for CEAP assistance, the assistance unit's nonexcluded income, minus allowable deductions, must be less than ninety percent of the TANF payment standard for households with shelter costs. The net income limit for CEAP assistance units is:

Assistance Unit Members	Net Income Limit
1	\$ 314
2	396
3	491
4	577
5	666
6	756
7	873
8 or more	967

(2) The assistance unit's allowable amount of need is the lesser of:

(a) The TANF payment standard, based on assistance unit size, for households with shelter costs as specified under WAC 388-478-0020; or

(b) The assistance unit's actual emergent need, not to exceed maximum allowable amounts, for the following items:

Need Item: Maximum allowable amount by assistance unit size:

	1	2	3	4	5	6	7	8 or more
Food	\$211	\$268	\$332	\$391	\$450	\$511	\$583	\$645
Shelter	258	325	404	476	548	621	719	795
Clothing	30	38	47	56	64	73	83	94

	1	2	3	4	5	6	7	8 or more
Minor Medical Care	179	228	282	332	382	432	501	554
Utilities	87	110	136	160	184	210	243	268
Household maintenance	64	81	100	118	136	155	178	197
Job related transportation	349	440	546	642	740	841	971	1075

(3) The assistance unit's CEAP payment is determined by computing the difference between the allowable amount of need, as determined under subsection (2) of this section, and the total of:

(a) The assistance unit's net income, as determined under subsection (1) of this section;

(b) Cash on hand, if not already counted as income; and

(c) The value of other nonexcluded resources available to the assistance unit.

(4) The assistance unit is not eligible for CEAP if the amount of income and resources, as determined in subsection (3) of this section, is equal to or exceeds its allowable amount of need.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0050, filed 7/31/98, effective 9/1/98.]

Chapter 388-437 WAC

EMERGENCY ASSISTANCE FOR FOOD STAMPS

WAC

388-437-0001 Disaster food stamp program.

WAC 388-437-0001 Disaster food stamp program.

(1) In the event of a disaster, the department works with the United States Department of Agriculture, Food and Nutrition Services (FNS) to change some requirements for the Washington Basic Food program and help ensure that people in a disaster area have access to food. This is known as the disaster food stamp program.

(2) If the President of the United States has declared a portion of the state as a federal disaster area, we ask FNS to allow use of the disaster food stamp program for the areas impacted by the disaster. Both of the following conditions must be met:

(a) People's normal access to buy food has been disrupted; and

(b) These commercial channels have since been restored with reasonable access and sufficient food supplies as determined by FNS.

(3) The department will implement any disaster food stamp program as approved by FNS.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-23-028, § 388-437-0001, filed 11/8/05, effective 12/9/05; 98-16-044, § 388-437-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-438 WAC

EMERGENCY ASSISTANCE FOR MEDICAL NEEDS

WAC

388-438-0110 The alien emergency medical (AEM) program.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-438-0100 Medically indigent (MI) program. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0100, filed 7/31/98, effective 9/1/98.]

9/1/98. Formerly 388-503-0370, 388-518-1805, 388-518-1810 and 388-518-1850.] Repealed by 04-07-141, filed 3/22/04, effective 4/22/04. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 1st sp.s. c 25.

Notice of Objection (1): It is the opinion of the Joint Administrative Rules Review Committee that the Department of Social and Health Services has not modified, amended, withdrawn or repealed WAC 388-100-005 to conform with the intent of the legislature, as expressed in both chapters 70.48 and 74.09 RCW.

Although the department has statutory authority in chapter 74.09 RCW, to determine who is eligible to receive assistance under the limited casualty medical program, that authority is not without limitation. The City and County Jail Act of 1977 requires the Department of Social and Health Services to reimburse the local government for inmate medical costs, provided that inmate is otherwise eligible for such care. Inmates have not been denied coverage based on their status as inmates since the enactment of the City and County Jail Act.

In determining legislative intent, a portion of a statute cannot be examined in a vacuum. Rather, all statutes relating to the same subject should be read together and given a harmonious interpretation. The legislature is presumed to enact law with knowledge of existing law. RCW 70.48.130 is made moot by the department's administrative denial of inmate medical coverage, and the legislature does not intend to enact "moot" legislation.

The Joint Administrative Rules Review Committee objects to WAC 388-100-005 and herewith directs the code reviser to publish this Notice of Objection...pursuant to RCW 34.04.240.

[Joint Administrative Rules Review Committee, Memorandum, July 10, 1987—Filed July 27, 1987, WSR 87-16-031]

Notice of Objection (2): The Joint Administrative Rules Review Committee (JARRC) held on July 27, 1987, that WAC 388-100-005 did not conform with the intent of the Legislature. This rule, adopted by the Department of Social and Health Services (DSHS), excluded inmates of federal or state prisons from eligibility for the limited casualty-medically indigent program of medical assistance.

As authority for its opinion, the committee cited RCW 70.48.130 of the City and County Jail Act of 1977 which requires DSHS to reimburse local governments for inmate medical costs provided to otherwise eligible inmates.

There has been no amendment to RCW 70.48.130 changing its meaning since 1986. Effective May 15, 1993, an amendment resulted in even further emphasis of the intent of the Legislature that all jail inmates receive cost-effective medical care. (1993 C 409 § 2)

On May 31, 1994, DSHS refiled a permanent rule, WSR 94-10-065, WAC 388-503-0370 which recodified WAC 388-100-005. The eligibility requirement that an applicant for the medically indigent program not be an inmate of a federal or state prison is retained in the new rule.

Since neither the statutory authority nor the substance of the rule has changed since the JARRC decision of July 27, 1987, the committee is of the opinion that DSHS has not modified, amended, withdrawn or repealed WAC 388-100-005 to conform with the intent of the Legislature. This being the case, pursuant to RCW 34.05.640 (5) and (6), the committee respectfully requests that the notice of objection published along with WAC 388-100-005 continue to be published along with WAC 388-503-0370.

[Joint Administrative Rules Review Committee, Memorandum February 21, 1995—Filed February 27, 1995, WSR 95-06-053.]

Reviser's note: The substance of WAC 388-503-0370 was moved into WAC 388-438-0100 filed as WSR 98-16-044 on July 31, 1998.

WAC 388-438-0110 The alien emergency medical (AEM) program. (1) The alien emergency medical (AEM) program is a required federally funded program. It is for aliens who are ineligible for other Medicaid programs, due to the citizenship or alien status requirements described in WAC 388-424-0010.

(2) Except for the social security number, citizenship, or alien status requirements, an alien must meet categorical Medicaid eligibility requirements as described in:

- (a) WAC 388-505-0110, for an SSI-related person;
- (b) WAC 388-505-0220, for family medical programs;
- (c) WAC 388-505-0210, for a child under the age of nineteen; or

(d) WAC 388-523-0100, for medical extensions.

(3) When an alien has monthly income that exceeds the CN medical standards, the department will consider AEM medically needy coverage for children or for adults who are age sixty-five or over or who meet SSI disability criteria. See WAC 388-519-0100.

(4) To qualify for the AEM program, the alien must meet one of the criteria described in subsection (2) of this section and have a qualifying emergency medical condition as described in WAC 388-500-0005.

(5) The alien's date of arrival in the United States is not used when determining eligibility for the AEM program.

(6) The department does not deem a sponsor's income and resources as available to the client when determining eligibility for the AEM program. The department counts only the income and resources a sponsor makes available to the client.

(7) Under the AEM program, a person receives CN scope of care, as described in WAC 388-529-0100. Covered services are limited to those medical services necessary for treatment of the person's emergency medical condition. The following services are not covered:

- (a) Organ transplants and related services;
- (b) Prenatal care, except labor and delivery;
- (c) School-based services;
- (d) Personal care services;
- (e) Waiver services; and
- (f) Nursing facility services, unless they are approved by the department's medical consultant.

(8) When a person's income exceeds the CN income standard as described in subsection (3) of this section, the person has spend down liability and MN scope of care. MN scope of care is described in WAC 388-529-0100. The medical service limitations and exclusions described in subsection (7) also apply under the MN program.

(9) A person determined eligible for the AEM program is certified for three months. The number of three-month certification periods is not limited, but, the person must continue to meet eligibility criteria in subsection (2) and (4) of this section.

(10) A person is not eligible for the AEM program if they entered the state specifically to obtain medical care.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530. 06-04-047, § 388-438-0110, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-438-0110, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 1903 (v)(2)(c) of the Social Security Act. 03-24-058, § 388-438-0110, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-438-0110, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and C.F.R. 436.128, 436.406(c) and 440.255. 01-05-041, § 388-438-0110, filed 2/14/01, effective 3/17/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, 42 C.F.R. 435.139 and 42 C.F.R. 440.255. 99-23-082, § 388-438-0110, filed 11/16/99, effective 12/17/99. Statutory Authority: RCW

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74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0110, filed 7/31/98, effective 9/1/98.]

Chapter 388-440 WAC EXCEPTION TO RULE

WAC

- 388-440-0001 Exceptions to rule.
- 388-440-0005 Exception to rule—Notification requirement.

WAC 388-440-0001 Exceptions to rule. (1) The secretary of the department, or designee, authorizes department staff to request an exception to a rule in the Washington Administrative Code (WAC) for individual cases, except as noted in subsection (5) of this section, when:

- (a) The exception would not contradict a specific provision of federal law or state statute; and
- (b) The client's situation differs from the majority; and
- (c) It is in the interest of overall economy and the client's welfare; and
- (d) It increases opportunities for the client to function effectively; or
- (e) A client has an impairment or limitation that significantly interferes with the usual procedures required to determine eligibility and payment.

(2) The secretary or the secretary's designee makes the final decision on all requests for exceptions to a rule.

(3) Clients have no fair hearing rights as defined under chapter 388-02 WAC regarding exception to rule decisions by department staff.

(4) Clients who do not agree with a decision on an exception to rule may file a complaint according to chapter 388-426 WAC.

(5) This section does not apply to requests for noncovered medical or dental services or related equipment. See WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-05-010, § 388-440-0001, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 00-03-034, § 388-440-0001, filed 1/12/00, effective 2/12/00; 98-16-044, § 388-440-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-440-0005 Exception to rule—Notification requirement. (1) Clients are notified in writing within ten days of:

- (a) The department staff's decision to file an exception to rule request; and
- (b) The department's decision to approve or deny an exception to rule request.

(2) The notice will include the complaint procedures as specified in chapter 388-426 WAC.

(3) This section does not apply to notification requirements for exceptions to rules concerning noncovered medical or dental services or related equipment. See WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 00-03-034, § 388-440-0005, filed 1/12/00, effective 2/12/00; 98-16-044, § 388-440-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-442 WAC FELONS

WAC

388-442-0010 How does being a fleeing felon impact my eligibility for benefits?

WAC 388-442-0010 How does being a fleeing felon impact my eligibility for benefits? (1) You are a **fleeing felon** if you are fleeing to avoid prosecution, custody, or confinement for a crime or an attempt to commit a crime that is considered a felony in the place from which you are fleeing.

(2) If you are a fleeing felon, or violating a condition of probation or parole as determined by an administrative body or court that has the authority to make this decision, you are not eligible for TANF/SFA, GA, or Basic Food benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.025, 74.08.090 and 21 U.S.C. 862a (d)(1)(A). 05-21-100, § 388-442-0010, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-18-002, § 388-442-0010, filed 8/19/04, effective 9/19/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.510. 00-05-007, § 388-442-0010, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-442-0010, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-442-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-444 WAC

FOOD STAMP EMPLOYMENT AND TRAINING

WAC

388-444-0005 Food stamp employment and training (FS E&T) program—General requirements.

388-444-0010 Clients who are required to register for work and must participate in FS E&T.

388-444-0015 Who is not required to register for work or participate in FS E&T?

388-444-0020 When must clients register for work but are not required to participate in the food stamp employment and training program (FS E&T)?

388-444-0025 Payments for FS E&T related expenses.

388-444-0030 Work requirements for persons who are able-bodied adults without dependents (ABAWDS).

388-444-0035 When am I (able-bodied adult with no dependents) exempt from ABAWD provisions?

388-444-0040 Work programs for ABAWDs in the food stamp employment and training program.

388-444-0045 Regaining eligibility for food assistance.

388-444-0050 Good cause for failure to register for work or for not participating in the FS E&T program.

388-444-0055 What are the penalties for refusing or failing to comply?

388-444-0060 FS E&T—Unsuitable employment.

388-444-0065 What happens if I quit my job?

388-444-0070 Good cause for quitting a job.

388-444-0075 What are the disqualification periods for quitting a job without good cause?

WAC 388-444-0005 Food stamp employment and training (FS E&T) program—General requirements. (1) To receive Basic Food some people must register for work and participate in the food stamp employment and training (FS E&T) program.

(2) We determine if you must register for work and participate in FS E&T under WAC 388-444-0010:

(a) If we require you to register for work and participate in FS E&T you are nonexempt from FS E&T.

(b) If you meet one of the conditions under WAC 388-444-0015, you are exempt from FS E&T. If you are exempt, you may choose to receive services through the FS E&T program.

[Title 388 WAC—p. 820]

(3) If you are nonexempt from FS E&T requirements, we register you for work:

(a) When you apply for Basic Food benefits or are added to someone's assistance unit; and

(b) Every twelve months thereafter.

(4) If you are nonexempt, you must meet all the FS E&T program requirements in subsections (5) through (7) of this section. If you fail to meet the requirements without good cause, we disqualify you from receiving Basic Food benefits:

(a) We define good cause for not meeting FS E&T requirements under WAC 388-444-0050; and

(b) We disqualify nonexempt persons who fail to meet E&T requirements as described under WAC 388-444-0055.

(5) If you are nonexempt, you must:

(a) Report to us or your FS E&T service provider and participate as required;

(b) Provide information regarding your employment status and availability for work when we ask for it;

(c) Report to an employer when we refer you; and

(d) Accept a bona fide offer of suitable employment. We define unsuitable employment under WAC 388-444-0060.

(6) If you are nonexempt, you must participate in one or more of the following FS E&T activities:

(a) Job search;

(b) Paid or unpaid work;

(c) Training or work experience;

(d) General education development (GED) classes; or

(e) English as a second language (ESL) classes.

(7) If you must participate in WorkFirst under WAC 388-310-0200, you have certain requirements for the Food Stamp Employment and Training Program:

(a) Your FS E&T requirement is to fully participate in the WorkFirst activities approved in your Individual Responsibility Plan (IRP) under WAC 388-310-0500; and

(b) If everyone who receives Basic Food with you receives TANF benefits **and** your IRP includes unpaid community service or work experience, we use your TANF grant and Basic Food allotment to determine the maximum hours of unpaid work we include in your plan.

(8) Your FS E&T activities including paid or unpaid work **will not** exceed one hundred twenty hours a month whether you are exempt or nonexempt.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 7 C.F.R. 273.7 and 273.25. 06-24-026, § 388-444-0005, filed 11/29/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0010 Clients who are required to register for work and must participate in FS E&T. The following clients are nonexempt, must register for work and are required to participate in FS E&T:

(1) Age sixteen through fifty-nine with dependents;

(2) Age sixteen or seventeen, not attending secondary school and not the head-of-household;

(3) Age fifty through fifty-nine with no dependents.

(4) Age eighteen to fifty, able-bodied and with no dependents as provided in WAC 388-444-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0010, filed 7/31/98, effective 9/1/98.]

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WAC 388-444-0015 Who is not required to register for work or participate in FS E&T? Some people do not have to register for work or participate in the Food Stamp Employment and Training Program (FS E&T). These people are exempt from FS E&T.

(1) You are exempt from FS E&T requirements in chapter 388-444 WAC if you meet any of the following conditions:

(a) You are age sixteen or seventeen, not the head-of-household, and:

(i) Attend school such as high school or GED programs; or

(ii) Are enrolled at least half time (using the institutions definition) in an employment and training program under:

(A) The Workforce Investment Act (WIA);

(B) Section 236 of the Trade Act of 1974; or

(C) Another state or local employment and training program.

(b) You are a student age eighteen or older enrolled at least half time as defined by the institution in:

(i) Any accredited school;

(ii) A training program; or

(iii) An institution of higher education. If you are enrolled in higher education, you meet the requirements under WAC 388-482-0005 to be eligible for Basic Food benefits.

(c) you are an employed or self-employed person working thirty hours or more per week, or receiving weekly earnings equal to the federal minimum wage multiplied by thirty.

(d) You receive unemployment compensation (UC) benefits or have an application pending for UC benefits;

(e) You are responsible to care for:

(i) A dependent child under age six; or

(ii) Someone who is incapacitated.

(f) We determine that you are physically or mentally unable to work; or

(g) You regularly participate in a drug addiction or alcoholic treatment and rehabilitation program.

(2) If you are exempt, you may choose to receive services through the FS E&T program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 7 C.F.R. 273.7 and 273.25. 06-24-026, § 388-444-0015, filed 11/29/06, effective 1/1/07. Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0015, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0020 When must clients register for work but are not required to participate in the food stamp employment and training program (FS E&T)? You, as a client must register for work, as provided in WAC 388-444-0005, even though you are exempt from participation in the FS E&T program if you are:

(1) Participating in a refugee assistance program;

(2) Living in an area where the FS E&T program is not provided (exempt area), see Food Stamp E&T Appendix 1 for exempt areas;

(3) Living one hour or more travel distance from available FS E&T services;

(4) Without a mailing address or message telephone;

(5) Temporarily unable to work and it is expected to last longer than sixty days; or

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(6) A client who has dependent care needs that exceed the maximum amount payable by the department. The exemption continues until:

(a) A different work activity is available; or

(b) Circumstances change and monthly dependent care costs no longer exceed the reimbursement limit set by the department.

[Statutory Authority: RCW 74.04.510 and 74.04.050. 00-21-111, § 388-444-0020, filed 10/18/00, effective 11/18/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0025 Payments for FS E&T related expenses. (1) Some of a client's actual expenses needed to participate in the FS E&T program may be paid by the department. Allowable expenses are:

(a) Transportation related costs; and

(b) Dependent care costs for each dependent six through twelve years of age.

(2) Dependent care payments are not paid if:

(a) The child is thirteen years of age or older unless the child is:

(i) Physically and/or mentally incapable of self-care; or

(ii) Under court order requiring adult supervision; or

(b) Any member in the food assistance unit provides the dependent care.

(3) Dependent care payments paid by the department cannot be claimed as an expense and used in calculating the dependent care deduction as provided in WAC 388-450-0185.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0030 Work requirements for persons who are able-bodied adults without dependents (ABAWDS). (1) Clients who are age eighteen to fifty and have no dependents must, unless exempt, participate in specific employment and training activities to receive food assistance.

(2) Nonexempt clients who fail to participate are eligible for no more than three months of food assistance in a thirty-six month period.

(3) Except as provided in WAC 388-444-0035, a person is not eligible to receive food assistance for more than three full months in the thirty-six month period beginning January 1, 1997 unless that person:

(a) Works at least twenty hours a week averaged monthly; or

(b) Participates in and complies with the requirements of a work program for twenty hours or more per week; or

(c) Participates in a workfare program as provided in WAC 388-444-0040.

(4) A work program is defined as a program under:

(a) The Job Training Partnership Act (JTPA);

(b) Section 236 of the Trade Act of 1974; or

(c) A state-approved employment and training program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0035 When am I (able-bodied adult with no dependents) exempt from ABAWD provisions? Some food assistance household members are exempt from ABAWD provisions. You are exempt from the ABAWD rules provided in WAC 388-444-0030 if you are:

- (1) Under eighteen or fifty years of age or older;
- (2) Determined to be physically or mentally unable to work;
- (3) A member of a household with responsibility for a person determined to be incapacitated;
- (4) An adult in a household that has a member who is under the age of eighteen, even when the child is an ineligible household member;
- (5) Pregnant;
- (6) Living in an area approved as exempt by U.S. Department of Agriculture;
- (7) Complying with the work requirements of an employment and training program under temporary assistance for needy families (TANF);
- (8) Applying for or receiving unemployment compensation;
- (9) Students enrolled at least half time as defined by the institution in:
 - (a) Any accredited school;
 - (b) Training program; or
 - (c) Institution of higher education. A student enrolled in higher education must follow the student criteria defined in chapter 388-482 WAC.
- (10) Participating in a chemical dependency treatment program;
- (11) Employed a minimum of thirty hours per week or receiving weekly earnings which equal the minimum hourly rate multiplied by thirty hours;
- (12) Eligible for one of the annual federal-approved exemption slots under what is called the fifteen percent exemption rule.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 03-05-031, § 388-444-0035, filed 2/10/03, effective 4/1/03; 00-04-006, § 388-444-0035, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0035, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0040 Work programs for ABAWDs in the food stamp employment and training program. Work programs are available to clients eighteen to fifty years of age who are able to work and have no dependents.

- (1) The following are considered work programs:
 - (a) Workfare consists of:
 - (i) Thirty days of job search activities in the first month beginning with the first day of application, or sixteen hours of volunteer work with a public or private nonprofit agency; and
 - (ii) In subsequent months, sixteen hours per month of volunteer work with a public or private nonprofit agency allows the client to remain eligible for food stamps. Workfare is not enforced community service or for paying fines or debts due to legal problems.
 - (b) Work experience (WEX) is supervised, unpaid work for at least twenty hours a week. The work must be for a non-profit agency or governmental or tribal entity. This work is to improve the work skills of the client.

(c) On-the-job training (OJT) is paid employment for at least twenty hours a week. It is job training provided by an employer at the employer's place of business and may include some classroom training time.

(2) The department may not require more than thirty hours a week of Workfare and paid work combined.

(3) The department may pay for some of a client's actual expenses needed for the client to participate in work programs. Standards for paying expenses are set by the department.

[Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0040, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0045 Regaining eligibility for food assistance. (1) A client who is ineligible for food assistance because that client has exhausted the three-month limit in WAC 388-444-0030, can regain eligibility by:

- (a) Working eighty hours or more during a thirty-day period;
- (b) Participating in and complying with a work program for eighty hours or more during a thirty-day period;
- (c) Participating in and complying with the community service part of a Workfare program; or
- (d) Meeting any of the work requirements in (a) through (c) of this subsection in the thirty days after an application for benefits has been filed.

(2) A client who regains eligibility for food assistance under subsection (1) of this section is eligible from the date of application and as long as the requirements of WAC 388-444-0030 are met.

(3) If otherwise eligible, a client who regains eligibility under the provision of subsection (1) of this section, may receive an additional three consecutive months of food assistance when the client:

- (a) Loses employment; or
 - (b) Loses the opportunity to participate in a work program.
- (4) The provisions in subsection (3) of this section are allowed only once in the thirty-six month period.

[Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0045, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0050 Good cause for failure to register for work or for not participating in the FS E&T program. (1) A nonexempt client may have good cause for refusing or failing to register for work or to participate in the FS E&T program.

- (2) Good cause reasons include, but are not limited to:
 - (a) Illness of the client;
 - (b) Illness of another household member requiring the help of the client;
 - (c) A household emergency;
 - (d) The unavailability of transportation; or
 - (e) Lack of adequate dependent care for children six through twelve years of age.

(3) A client who is determined by the department to lack good cause for failing or refusing to participate in FS E&T is disqualified and is not eligible to receive food assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0055 What are the penalties for refusing or failing to comply? (1) If you are nonexempt you must follow the food assistance work requirements as defined in WAC 388-444-0005 or 388-444-0030 unless you have good cause as defined in WAC 388-444-0050. If you do not follow these rules, you will become an ineligible assistance unit member as provided in WAC 388-450-0140. The remaining members of the assistance unit continue to be eligible for food assistance.

(2) If you do not follow these rules unless you have good cause, you cannot receive food assistance for the following periods of time and until you comply with program requirements:

- (a) For the first failure to comply, one month;
- (b) For the second failure to comply, three months; and
- (c) For the third or subsequent failure to comply, six months.

(3) If you become exempt under WAC 388-444-0015 and are otherwise eligible, you may begin to receive food assistance.

(4) If you are nonexempt and you do not comply with the work requirements of the following programs, you cannot receive food assistance:

- (a) WorkFirst;
- (b) Unemployment compensation;
- (c) The refugee cash assistance program.

(5) Within ten days after learning of your refusal to participate in your program, the financial worker will send you a notice that your food assistance will end unless you comply with your program requirements.

(6) If you do not comply within ten days, you will be issued a notice disqualifying you from receiving food assistance until you comply with your program, or until you meet the FS E&T disqualification requirements in subsection (2) of this section.

(7) After the penalty period in subsection (2) of this section is over, and you have complied with your program requirements, and you are otherwise eligible, you may receive food assistance:

- (a) If you are alone in the assistance unit and apply to reestablish eligibility; or
- (b) If you are a member of an assistance unit, you may resume receiving food assistance.

(8) During the penalty period, if you begin to participate in one of the programs listed in subsection (4)(a) through (c) and that penalty is removed, the FS E&T disqualification also ends. If you are otherwise eligible, you may begin to receive food assistance.

(9) You have a right to a fair hearing as provided in chapter 388-02 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-010, § 388-444-0055, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0055, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0055, filed 7/31/98, effective 9/1/98.]

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WAC 388-444-0060 FS E&T—Unsuitable employment. Nonexempt clients participating in FS E&T must accept a bona fide offer of suitable employment. Employment is considered unsuitable when:

(1) The wage offered is less than the federal or state minimum wage, whichever is highest;

(2) The job offered is on a piece-rate basis and the average hourly yield expected is less than the federal or state minimum wage, whichever is highest;

(3) The employee, as a condition of employment, is required to join, resign from or is barred from joining any legitimate labor union;

(4) The work offered is at a site subject to strike or lock-out at the time of offer unless:

- (a) The strike is enjoined under the Taft-Hartley Act; or
- (b) An injunction is issued under section 10 of the Railway Labor Act.

(5) The degree of risk to health and safety is unreasonable;

(6) The client is physically or mentally unable to perform the job as documented by medical evidence or reliable information from other sources;

(7) The employment offered within the first thirty days of registration for FS E&T is not in the client's major field of experience;

(8) The distance from the client's home to the job is unreasonable considering the wage, time and cost of commute:

(a) The job is not suitable when daily commuting time exceeds two hours per day, not including transporting a child to and from child care; and

(b) The job is not suitable when the distance to the job prohibits walking and public or private transportation is not available.

(9) The working hours or nature of the job interferes with the client's religious observances, convictions, or beliefs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0060, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0065 What happens if I quit my job?

(1) You are not eligible for food assistance if you quit your current job without good cause as defined in WAC 388-444-0070, and you are in one of the following categories:

(a) You were working twenty hours or more per week or the job provided weekly earnings equal to the federal minimum wage multiplied by twenty hours;

(b) The quit was within sixty days before you applied for food assistance or any time after;

(c) At the time of quit you were an applicant and would have been required to register for work as defined in WAC 388-444-0010;

(d) If you worked or you were self-employed and working thirty hours a week or you had weekly earnings at least equal to the federal minimum wage multiplied by thirty hours.

(2) You are not eligible to receive food assistance if you have participated in a strike against a federal, state or local government and have lost your employment because of such participation.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 00-04-006, § 388-444-0065, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.-

050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0070 Good cause for quitting a job.

Unless otherwise specified the following rules apply to all food assistance clients.

- (1) Good cause for quitting a job includes the following:
 - (a) For all food assistance clients, the employment is unsuitable as defined under WAC 388-444-0060;
 - (b) The client is discriminated against by an employer based on age, race, sex, color, religious belief, national origin, political belief, marital status, or the presence of any sensory, mental, or physical disability or other reasons in RCW 49.60.180;
 - (c) Work demands or conditions make continued employment unreasonable, such as working without being paid on schedule;
 - (d) The client accepts other employment or is enrolled at least half time in any recognized school, training program, or institution of higher education;
 - (e) The client must leave a job because another assistance unit member accepts a job or is enrolled at least half time in any recognized school, training program, or institution of higher education in another county or similar political subdivision and the assistance unit must move;
 - (f) The client who is under age sixty and retires as recognized by the employer;
 - (g) The client accepts a bona fide offer of employment of twenty or more a week or where the weekly earnings are equivalent to the federal minimum wage multiplied by twenty hours. However, because of circumstances beyond the control of the client, the job either does not materialize or results in employment of twenty hours or less a week or weekly earnings of less than the federal minimum wage multiplied by twenty hours;
 - (h) The client leaves a job in connection with patterns of employment where workers frequently move from one employer to another, such as migrant farm labor or construction work; and.
 - (i) For FS E&T participants, circumstances included under WAC 388-444-0050;

(2) A client who quits the most recent job is eligible for food assistance if the circumstances of the job involve:

- (a) Changes in job status resulting from reduced hours of employment while working for the same employer;
 - (b) Termination of a self-employment enterprise; or
 - (c) Resignation from a job at the demand of an employer.
- (3) The client must verify good cause for quitting. Food assistance is not denied if the client and the department are unable to obtain verification.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0070, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0075 What are the disqualification periods for quitting a job without good cause? (1) If you are an applicant who quits a job without good cause sixty days before applying for food assistance, the department will deny your application. The penalty period in subsection (3) of this section begins from the date of application.

(2) If you are already receiving food assistance and you quit your job without good cause, the department must send

you a letter notifying you that you are going to be disqualified from food assistance. The disqualification in subsection (3) of this section begins the first of the month following the notice of adverse action.

(3) You are disqualified for the following minimum periods of time and until the conditions in subsection (4) of this section are met:

- (a) For the first quit, one month;
 - (b) For the second quit, three months; and
 - (c) For the third or subsequent quit, six months.
- (4) You may reestablish eligibility after the disqualification, if otherwise eligible by:
- (a) Getting a new job;
 - (b) In nonexempt areas, participating in the FS E&T program;
 - (c) Participating in Workfare as provided in WAC 388-444-0040;
 - (d) In an exempt area, serving the penalty period.

(5) The department can end the disqualification period if you become exempt from the work registration requirements as provided in WAC 388-444-0015 unless you are applying for or receiving unemployment compensation (UC), or participating in an employment and training program under TANF.

(6) If you are disqualified and move from the assistance unit and join another assistance unit, you continue to be treated as an ineligible member of the new assistance unit for the remainder of the disqualification period.

(7) If you are disqualified and move to a FS E&T exempt area, you must serve the remainder of the disqualification period.

[Statutory Authority: RCW 74.04.050 and 74.04.510. 01-05-006, § 388-444-0075, filed 2/7/01, effective 3/1/01; 00-04-006, § 388-444-0075, filed 1/20/00, effective 3/1/00. Statutory Authority: RCW 74.04.510. 99-07-024, § 388-444-0075, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0075, filed 7/31/98, effective 9/1/98.]

Chapter 388-446 WAC

FRAUD

WAC

388-446-0001	Cash and medical assistance fraud.
388-446-0005	Disqualification period for cash assistance.
388-446-0010	TANF disqualification period for fraud convictions of misrepresenting interstate residence.
388-446-0015	Intentional program violation (IPV) and disqualification hearings for Basic Food.
388-446-0020	Food assistance disqualification penalties.

WAC 388-446-0001 Cash and medical assistance fraud. (1) All cash or medical assistance cases in which substantial evidence is found supporting a finding of fraud are referred to the county prosecuting attorney. The prosecuting attorney's office determines which cases are subject to criminal prosecution.

(2) An applicant or recipient is suspected of committing fraud if intentional misstatement or failure to reveal information affecting eligibility results in an overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0001, filed 7/31/98, effective 9/1/98. Formerly WAC 388-501-0140.]

WAC 388-446-0005 Disqualification period for cash assistance. (1) An applicant or recipient who has been convicted of unlawful practices in obtaining cash assistance is disqualified from receiving further cash benefits if:

(a) For TANF/SFA, the conviction was based on actions which occurred on or after May 1, 1997; or

(b) For general assistance, the conviction was based on actions which occurred on or after July 23, 1995.

(2) The disqualification period must be determined by the court and will be:

(a) For a first conviction, no less than six months; and

(b) For a second or subsequent conviction, no less than twelve months.

(3) The disqualification applies only to the person convicted and begins on the date of conviction.

(4) A recipient's cash benefits are terminated following advance or adequate notice requirements as specified in WAC 388-458-0030.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.057, 04-13-097, § 388-446-0005, filed 6/21/04, effective 7/22/04; 98-16-044, § 388-446-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-446-0010 TANF disqualification period for fraud convictions of misrepresenting interstate residence. (1) An applicant or recipient is disqualified from receiving cash benefits under TANF if convicted of fraud by misrepresentation of residence in order to receive assistance from two or more states at the same time from any assistance program funded by the following:

(a) TANF and any other benefit authorized by Title IV-A of the Social Security Act; or

(b) Any benefit authorized by The Food Stamp Act of 1997; or

(c) Any benefit authorized by Title XIX, Medicaid; or

(d) SSI benefits authorized by Title XVI.

(2) The disqualification penalty is applied as follows:

(a) Only to convictions based on actions which occurred on or after May 1, 1997; and

(b) Only to the person convicted of fraud in federal or state court; and

(c) For a disqualification period of ten years or a period determined by the court, whichever is longer.

(3) The disqualification period begins the date the person is convicted of fraud by misrepresentation of residence in order to receive assistance from two or more states at the same time.

(4) The provisions of subsections (1) through (3) of this section do not apply when the President of the United States has granted a pardon for the conduct resulting in the conviction of fraud by misrepresentation of residence. The disregard of the provisions because of a pardon is effective the date the pardon is granted and continues for each month thereafter.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-446-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-446-0015 Intentional program violation (IPV) and disqualification hearings for Basic Food. (1) An intentional program violation (IPV) is defined as an act in which a person intentionally:

(a) Makes a false or misleading statement;

(b) Misrepresents, conceals or withholds facts; or

(c) Acts in violation of the Food Stamp Act, the Food Stamp Program regulations, or any state statute relating to the use, presentation, transfer, acquisition, receipt, trafficking, or possession of food benefits.

(2) Basic Food clients suspected of committing an IPV are subject to referral for an administrative disqualification hearing, if:

(a) The suspected IPV causes an over issuance of four hundred fifty dollars or more; or

(b) The suspected IPV is due to the trafficking of food benefits; and

(c) The person has not been referred for criminal proceedings; and

(d) The person resides in Washington state, at the time of the referral; or

(e) The person resides outside Washington state, but is within one hour's reasonable drive to a CSO.

(3) An administrative disqualification hearing (ADH) is a formal hearing to determine if a person committed an IPV. ADHs are governed by the rules found in chapter 388-02 WAC. However, rules in this section are the overriding authority if there is a conflict.

(4) A client who commits one or more IPV's and is suspected of committing another, is referred for an ADH when the act of suspected violation occurred:

(a) After the department mailed the disqualification notice to the client for the most recent IPV; or

(b) After criminal proceedings for the most recent IPV are concluded.

(5) A person suspected of IPV is entitled to receive notice of an ADH at least thirty days in advance of the hearing date. The notice is sent by certified mail, or provided to the client by personal service and will contain the following:

(a) The date, time, and place of the hearing;

(b) The charges against the individual;

(c) A summary of the evidence, and how and where the evidence can be examined;

(d) A warning that a decision will be based solely on evidence provided by the department, if the individual fails to appear at the hearing;

(e) A statement that the individual has ten days from the date of the scheduled hearing to show good cause for failure to appear at the hearing and to request rescheduling;

(f) A warning that a determination of IPV will result in a disqualification period; and

(g) A statement that if a telephone hearing is scheduled, the individual can request an in-person hearing by filing a request with the administrative law judge one week or more prior to the date of the hearing.

(6) The person or a representative shall have the right to one continuance of up to thirty days if a request is filed ten days or more prior to the hearing date.

(7) The hearing will be conducted and a decision rendered even if the person or representative fail to appear, unless within ten days from the date of the scheduled hearing:

(a) The person can show good cause for failing to appear; and

(b) The person or representative requests the hearing be re-instated.

(8) A scheduled telephone hearing may be changed to an in-person hearing if requested one week or more in advance. If requested less than one week in advance the person must show good cause for the requested change.

(9) The ALJ issues a final decision as specified in WAC 388-02-0215(5) and WAC 388-02-0527. The decision determines whether the department establishes with clear and convincing evidence that the person committed and intended to commit an IPV.

(10) The department and the client each have the right to request a reconsideration of the decision as specified in WAC 388-02-0610 through 388-02-0635. The final order or the reconsideration decision is the final agency decision.

(11) A client's disqualification is not implemented and benefits continue at the current amount when:

(a) The client can show good cause for not attending the hearing within thirty days from the date the disqualification notice was mailed; and

(b) An administrative law judge determines the client had good cause; or

(c) The client requests reconsideration or files a petition for judicial review to appeal the disqualification as specified in WAC 388-02-0530 (1) or (4).

(12) An administrative disqualification hearing and a regular hearing can be combined when the cause for both hearings is related.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 9.91.142. 05-23-082, § 388-446-0015, filed 11/15/05, effective 1/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-446-0020 Food assistance disqualification penalties. (1) Disqualification penalties apply only to the person or persons found to have committed an intentional program violation (IPV) as follows:

(a) If the intentional program violation occurred in whole or in part after the household was notified of the following penalties:

- (i) Twelve months for the first violation;
- (ii) Twenty-four months for the second violation;
- (iii) Permanently for the third violation.

(b) If the violation ended before the household was notified of the penalties in subsection (1)(a) of this section:

- (i) Six months for the first violation;
- (ii) Twelve months for the second violation;
- (iii) Permanently for the third violation.

(2) The disqualification and penalty period for a person convicted in another state stays in effect until satisfied regardless of where a person moves.

(3) Multiple program violations are considered as one violation when determining the penalty for disqualification when the violations occurred before the department notified the household of the penalties, as described in subsection (1), (4) and (5) of this section.

(4) Disqualification penalties for persons convicted by a federal, state, or local court of trading or receiving food coupons for a controlled substance are:

- (a) Two years for a first conviction; and
- (b) Permanently for a second conviction.

(5) A first conviction by federal, state, or local court permanently disqualifies persons who:

(a) Trade or receive food coupons for firearms, ammunition, or explosives; or

(b) Knowingly buy, sell, trade, or present for redemption food coupons totalling five hundred dollars or more in violation of section 15 (b) and (c) of the Food Stamp Act of 1977, as amended.

(6) Persons convicted of providing false identification or residency information to receive multiple coupon benefits are disqualified for ten years.

(7) When a court convicts a person of an IPV, the disqualification penalties specified in subsection (1) through (5) apply as follows;

(a) In addition to any civil or criminal penalties; and

(b) Within forty-five days of the date of conviction; unless

(c) Contrary to the court order.

(8) Disqualification penalties are applied after notifying the household of the disqualification, the effective date, the amount of benefits the household will receive during the disqualification period and the need to reapply when the certification period expires.

(9) Even though only the individual is disqualified, the food assistance household is responsible for making restitution for the amount of any overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0020, filed 7/31/98, effective 9/1/98.]

Chapter 388-448 WAC INCAPACITY

WAC

388-448-0001	What are the incapacity requirements for general assistance?
388-448-0010	How do we decide if you are incapacitated?
388-448-0020	Which health professionals can I go to for medical evidence?
388-448-0030	What medical evidence do I need to provide?
388-448-0035	How we assign severity ratings to your impairment.
388-448-0040	PEP step I—Review of medical evidence required for eligibility determination.
388-448-0050	PEP step II—How we determine the severity of mental impairments.
388-448-0060	PEP step III—How we determine the severity of physical impairments.
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388-448-0080	PEP step V—How we determine your ability to function in a work environment if you have a mental impairment.
388-448-0090	PEP step V—How we determine your ability to function in a work environment if you have a physical impairment.
388-448-0100	PEP step VI—How we evaluate capacity to perform relevant past work.
388-448-0110	PEP step VII—How we evaluate your capacity to perform other work.
388-448-0120	How we decide how long you are incapacitated.
388-448-0130	Treatment and referral requirements.
388-448-0140	Good cause for refusing medical treatment or other agency referrals.
388-448-0150	Penalty for refusing medical treatment or other agency referrals.
388-448-0160	When do my general assistance benefits end?
388-448-0180	How do we redetermine your eligibility when we decide you are eligible for general assistance expedited Medicaid (GAX)?
388-448-0200	Can I get general assistance while waiting for Supplemental Security Income (SSI)?
388-448-0210	What is interim assistance and how do I assign it to you?

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

- 388-448-0005 The following criteria is used to determine if a child is deprived of parental support due to incapacity. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0005, filed 7/31/98, effective 9/1/98.] Repealed by 00-15-051, filed 7/17/00, effective 9/1/00. Statutory Authority: RCW 74.04.057, 74.08.090.
- 388-448-0170 Termination requirement—How we determine you are no longer incapacitated. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0170, filed 8/2/00, effective 9/1/00.] Repealed by 04-07-140, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10.
- 388-448-0190 Reinstating your eligibility after termination due to lack of medical evidence. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0190, filed 8/2/00, effective 9/1/00.] Repealed by 04-07-140, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10.

WAC 388-448-0001 What are the incapacity requirements for general assistance? For the purposes of this chapter, "we" and "us" refer to the department of social and health services. "You" means the applicant or recipient. "GA" means the general assistance program. For you to receive general assistance (GA) program benefits, we must determine you are incapacitated.

"Incapacitated" means that you cannot be gainfully employed as a result of a physical or mental impairment that is expected to continue for at least ninety days from the date you apply.

"Physical impairment" means a diagnosable physical illness. "Mental impairment" means a diagnosable mental disorder. We exclude any diagnosis of or related to alcohol or drug abuse or addiction.

(1) We determine you are incapacitated if you are:

- (a) Eligible for payments based on Social Security Administration (SSA) disability criteria;
- (b) Eligible for services from the division of developmental disabilities (DDD);
- (c) Diagnosed as having mental retardation based on a full scale score of seventy or lower on the Wechsler adult intelligence scale (WAIS);
- (d) At least sixty-four years old and seven months;
- (e) Eligible for long-term care services from aging and disability services administration; or
- (f) Approved through the progressive evaluation process (PEP).

(2) We consider you to be incapacitated for ninety days after:

- (a) You are released from inpatient treatment for a mental impairment if:
 - (i) The release from inpatient treatment was not against medical advice; and
 - (ii) There is no break in your participation between inpatient and outpatient treatment of your mental impairment.
- (b) You are released from a medical institution where you received long-term care services from the aging and disability services administration.

(c) The Social Security Administration stops your Supplemental Security Income payments because you are not a citizen.

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[Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0001, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.057, 74.08.090. 00-15-018, § 388-448-0001, filed 7/10/00, effective 9/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-448-0010 How do we decide if you are incapacitated? When you apply for GA program benefits, you must provide medical evidence to us to show that you are unable to work.

If you are gainfully employed at the time of your application for GA, we deny incapacity. **"Gainful employment"** means you are performing, in a regular and predictable manner, an activity usually done for pay or profit.

(1) We do not consider work to be gainful employment when you are working:

(a) Under special conditions that go beyond the employer providing reasonable accommodation, such as in a sheltered workshop we have approved; or

(b) Occasionally or part-time because your impairment limits the hours you are able to work compared to unimpaired workers in the same job as verified by your employer.

(2) We decide if you are incapacitated when:

(a) You apply for GA benefits. We may waive this decision if we use the criteria in WAC 388-448-0001 except the PEP to determine you are incapacitated;

(b) You become employed;

(c) You obtain work skills by completing a training program; or

(d) We get new information that indicates you may be employable.

(3) Unless you meet the other incapacity criteria in WAC 388-448-0001, we decide incapacity by applying the progressive evaluation process (PEP) to the medical evidence that you provide that meets WAC 388-448-0030. The PEP is the sequence of seven steps described in WAC 388-448-0035 through 388-448-0110.

(4) You are not eligible for GA benefits if you are incapacitated only because of alcoholism or drug addiction. If you have a physical or mental impairment and you are impaired by alcohol or drug addiction, we decide if you are eligible for general assistance. If you qualify for both GA and the ADATSA Shelter program, you may choose either program.

(5) In determining incapacity, we consider only your ability to perform basic work-related activities. "Basic work-related activities" are activities that anyone would be required to perform in a work setting. They consist of: Sitting, standing, walking, lifting, carrying, handling, seeing, hearing, communicating, and understanding and following instructions.

[Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0010, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0010, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0020 Which health professionals can I go to for medical evidence? We accept medical evidence from these sources:

(1) For a physical impairment, a health professional licensed in Washington state or where the examination was performed:

(a) A physician, which for GA program purposes, includes:

- (i) Medical doctor (M.D.);
- (ii) Doctor of osteopathy (D.O.);
- (iii) Doctor of optometry (O.D.) to evaluate visual acuity impairments;
- (iv) Doctor of podiatry (D.P.) for foot disorders; and
- (v) Doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) for tooth abscesses or temporomandibular joint (TMJ) disorders.

(b) An advanced registered nurse practitioner (ARNP) for physical impairments that are within the ARNP's area of certification to treat;

(c) The chief of medical administration of the Veterans' Administration, or their designee, as authorized in federal law; or

(d) A physician assistant when the report is cosigned by the supervising physician.

(2) For a mental impairment, professionals licensed in Washington state or where the examination was performed:

- (a) A psychiatrist;
- (b) A psychologist;
- (c) An advanced registered nurse practitioner certified in psychiatric nursing; or
- (d) At our discretion:

(i) A person identified as a mental health professional within the regional support network mental health treatment system provided the person's training and qualifications at a minimum include having a Master's degree and two years of mental health treatment experience; or

(ii) The physician who is currently treating you for a mental impairment.

(3) **"Supplemental medical evidence"** means information from a health professional not listed in subsection (1) or (2) of this section and who can provide supporting medical evidence for impairments identified by any of the professionals listed in subsections (1) or (2) of this section. We include as supplemental medical evidence sources:

(a) A health professional who has conducted tests on or provides on-going treatment to you, such as a physical therapist, chiropractor, nurse, physician assistant;

(b) Workers at state institutions and agencies who are not health professionals and are providing or have provided medical or health-related services to you; or

(c) Chemical dependency professionals (CDPs) when requesting information on the effects of alcohol or drug abuse.

[Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0020, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0020, filed 6/29/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0020, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0030 What medical evidence do I need to provide? You must provide medical evidence that clearly explains if you have an impairment and how that impairment prevents you from being capable of gainful employment.

[Title 388 WAC—p. 828]

Medical evidence must be in writing and be clear, objective and complete.

(1) Objective evidence means:

(a) For physical impairment:

- (i) Laboratory test results;
- (ii) Pathology reports;
- (iii) Radiology findings including results of X rays and computer imaging scans;

(iv) Clinical finding, including but not limited to ranges of joint motion, blood pressure, temperature or pulse; and observations from physical examination; or

(v) Hospital history and physical reports and admission and discharge summaries; or

(vi) Other medical history and physical reports.

(b) For mental impairment:

(i) Examination results including:

(A) Clinical interview observations, including mental status exam results and interpretation; and

(B) Explanation of how examination findings meet the clinical and diagnostic criteria of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(ii) Testing results, if any, including:

(A) Description and interpretation of tests of memory, concentration, cognition or intelligence; or

(B) Interpretation of medical tests to identify or exclude a connection between the mental impairment and physical illness.

(2) To be complete, medical evidence must include:

(a) Diagnosis for the impairment;

(b) A clear description of how the impairment relates to your ability to perform the work-related activities listed in WAC 388-448-0010(5) including signs and observations of drug or alcohol abuse and whether any limitations on ability to perform work-related activities would continue after sixty days of abstinence from use of drugs or alcohol;

(c) Facts in addition to objective evidence to support the medical provider's opinion that you are unable to be gainfully employed, such as proof of hospitalization; and

(d) Based on an examination done within the ninety days of the date of application or the forty-five days prior to the month of incapacity review.

(3) When making an incapacity decision, we do not use your report of symptoms as evidence unless objective evidence shows there is an impairment that could reasonably be expected to produce those symptoms.

(4) If you cannot get medical evidence without cost to you and you meet the eligibility conditions other than incapacity in WAC 388-400-0025, we pay the costs to obtain objective evidence based on our published payment limits and designated fee schedules.

(5) We decide incapacity based solely on the objective information we receive. We are not obligated to accept a decision that you are incapacitated or unemployable made by another agency or person.

[Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0030, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0030, filed 8/2/00, effective 9/1/00.]

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WAC 388-448-0035 How we assign severity ratings to your impairment. (1) "Severity rating" means a rating of the extent of your incapacity, and how severely it impacts your ability to perform the basic work activities. Severity ratings are assigned in Steps II through IV of the PEP. The following chart provides a description of levels of limitations on work activities and the severity ratings that would be assigned to each.

Effect on work activities	Severity rating
(a) There is no effect on your performance of basic work-related activities.	1
(b) There is no significant effect on your performance of basic work-related activities.	2
(c) There are significant limits on your performance of at least one basic work-related activity.	3
(d) There are very significant limits on your performance of at least one basic work-related activity.	4
(e) You are unable to perform at least one basic work-related activity.	5

(2) We use the severity rating given by the medical evidence provider:

- (a) If the rating is supported by and consistent with the medical evidence;
- (b) If the provider's assessment of your limitations is consistent with our definition of the rating; and
- (c) If the rating is consistent with other medical evidence provided to us.

(3) If the medical evidence provider assigns a severity rating that is not consistent with the objective evidence and your symptoms from your impairment as described in the medical evidence, we take the following action:

- (a) If your limitations are more severe than the rating given, we raise your severity rating; or
- (b) If your limitations are less severe than the rating given, we lower your severity rating; and
- (c) We give clear and convincing reasons for adjusting the rating.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0035, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0040 PEP step I—Review of medical evidence required for eligibility determination. When we receive your medical evidence, we review it to see if it is complete and to decide whether your circumstances match GAU program requirements.

(1) We require a written medical report to determine incapacity. The report must:

- (a) Contain sufficient information as described under WAC 388-448-0030;
- (b) Be written by an authorized medical professional;
- (c) Document the existence of a potentially incapacitating condition; and
- (d) Indicate an impairment is expected to last ninety days or more from the application date.

(2) If the information received is not clear, we may require more information before we decide your ability to be

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gainfully employed. As examples, we may require you to get more medical tests or be examined by a medical specialist.

(3) We deny incapacity when:

- (a) There is only one impairment with a severity rating less than three;
- (b) A reported impairment is not expected to last ninety days (twelve weeks) or more from the date of application;
- (c) The practitioner is not able to determine that the physical or mental impairment would remain incapacitating after at least sixty days of abstinence from alcohol and drugs; or
- (d) We do not have clear and objective medical evidence to approve incapacity.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0040, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0050 PEP step II—How we determine the severity of mental impairments. If you are diagnosed with a mental impairment, we use information from the provider to determine if your impairment prevents you from being gainfully employed. We review the psychological evidence to determine the severity of your mental impairment.

(1) The severity of your mental impairment is based on:

- (a) Psychosocial and treatment history;
- (b) Clinical findings;
- (c) Results of psychological tests; and
- (d) Symptoms observed by the examining practitioner that show impairment of your ability to perform basic work-related activities.

(2) If you are diagnosed with mental retardation, the diagnosis must be based on the Wechsler Adult Intelligence Scale (WAIS). The following test results determine the severity rating:

Intelligence Quotient (IQ) Score	Severity Rating
85 or above	1
71 to 84	3
70 or lower	5

(3) If you are diagnosed with a mental impairment with physical causes, we assign a severity rating based on the most severe of the following three areas of impairment:

- (a) Memory defect for recent events;
- (b) Impoverished, slowed, perseverative thinking, with confusion or disorientation; or
- (c) Labile, shallow, or coarse affect.

(4) We base the severity of the functional psychotic or nonpsychotic disorder, excluding alcoholism or drug addiction, on:

- (a) Clinical assessment of these twelve symptoms: Depressed mood, suicidal trends, verbal expression of anxiety or fear, expression of anger, social withdrawal, motor agitation, motor retardation, paranoid behavior, hallucinations, thought disorder, hyperactivity, preoccupation with physical complaints; and
- (b) Clinical assessment of the intensity and pervasiveness of your symptoms and their effect on work activities.

(5) We base the severity rating for a functional mental impairment on accumulated severity ratings for the twelve symptoms in subsection (4)(a) of this section as follows:

Symptom Ratings or Condition	Severity Rating
(a) The functional mental impairment is diagnosed with psychotic features; (b) You have had two or more hospitalizations for psychiatric reasons in the past two years; (c) You have had more than six months of continuous psychiatric hospital or residential treatment in the past two years; (d) The overall assessment of symptoms is rated three; or (e) At least three symptoms are rated three or higher.	3
(f) The overall assessment of symptoms is rated four; or (g) At least three symptoms are rated four or five.	4
(h) The overall assessment of symptoms is rated five; or (i) At least three symptoms are rated five.	5

(6) If you have more than one type of mental impairment, we assign a severity rating as follows:

Condition	Severity Rating
(a) Two or more disorders with ratings of three; or (b) One or more disorders rated three; and one rated four.	4
(c) Two or more disorders rated four.	5

(7) We deny incapacity when you do not have a significant physical impairment and your overall mental severity rating is one or two;

(8) We approve incapacity when you have an overall mental severity rating of five, regardless of whether you have a physical impairment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0050, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0060 PEP step III—How we determine the severity of physical impairments. We must decide if your physical impairment is serious enough to limit your ability to be gainfully employed. "Severity of a physical impairment" means the degree that an impairment restricts you from performing basic work-related activities (see WAC 388-448-0010). Severity ratings range from one to five, with five being the most severe. We will assign severity ratings according to the table in WAC 388-448-0035.

(1) We assign to each physical impairment a severity rating that is supported by medical evidence.

(2) If your physical impairment is rated two, and there is no mental impairment or a mental impairment that is rated one, we deny incapacity.

(3) If your physical impairment is consistent with a severity rating of five, we approve incapacity.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0060, filed 8/2/00, effective 9/1/00.]

[Title 388 WAC—p. 830]

WAC 388-448-0070 PEP step IV—How we determine the severity of multiple impairments. (1) If you have more than one impairment we decide the overall severity rating by deciding if your impairments have a combined effect on your ability to be gainfully employed. Each diagnosis is grouped by affected organ or function into one of thirteen "body systems." The thirteen body systems consist of:

- (a) Musculo-skeletal,
- (b) Special senses and speech,
- (c) Respiratory,
- (d) Cardiovascular,
- (e) Digestive,
- (f) Genito-urinary,
- (g) Hemic and lymphatic,
- (h) Skin,
- (i) Endocrine and obesity,
- (j) Neurological,
- (k) Mental disorders,
- (l) Neoplastic, and
- (m) Immune systems.

(2) We follow these rules when there are multiple impairments:

(a) We group each diagnosis by body system.

(b) When you have two or more diagnosed impairments that limit work activities, we assign an overall severity rating as follows:

Your Condition	Severity Rating
(i) All impairments are in the same body system, are rated two and there is no cumulative effect on basic work activities.	2
(ii) All impairments are in the same body system, are rated two and there is a cumulative effect on basic work activities. (iii) All impairments are in different body systems, are rated two and there is a cumulative effect on basic work activities.	3
(iv) Two or more impairments are in different body systems and are rated three. (v) Two or more impairments are in different body systems; one is rated three and one is rated four.	4
(vi) Two or more impairments in different body systems are rated four.	5

(c) We deny incapacity when the overall severity rating is two.

(d) We approve incapacity when the overall severity rating is five.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0070, filed 6/29/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0070, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0080 PEP step V—How we determine your ability to function in a work environment if you have a mental impairment. If you have a mental impairment we evaluate your cognitive and social functioning in a work set-

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ting. Functioning means your ability to perform the tasks that would be required of you on the job and your ability to get along with your coworkers, supervisors and other people you would be in contact with while on the job.

(1) We evaluate cognitive factors by assessing your ability to:

- (a) Understand, remember, and follow simple, one- or two-step instructions;
- (b) Understand, remember, and follow complex instructions, with three or more steps;
- (c) Learn new tasks;
- (d) Exercise judgment and make decisions; and
- (e) Perform routine tasks without undue supervision.

(2) We approve incapacity when the practitioner's evaluation shows you are:

(a) At least moderately impaired in your ability to understand, remember, and follow simple instructions and at least moderately limited in your ability to:

- (i) Learn new tasks, exercise judgment, and make decisions; and
- (ii) Perform routine tasks without undue supervision; or
- (b) Able to understand, remember, and follow simple instructions, but are:

(i) At least moderately impaired in the ability to understand, remember, and follow instructions with three or more steps; and

(ii) Markedly impaired in the ability to learn new tasks, exercise judgment and make decisions, and perform routine tasks without undue supervision.

(3) The practitioner's evaluation reports your social factors after assessing your ability to:

- (a) Relate appropriately to coworkers and supervisors;
- (b) Relate appropriately in contacts with the public;
- (c) Tolerate the pressures of a work setting;
- (d) Perform self-care activities, including personal hygiene; and
- (e) Maintain appropriate behavior in a work setting.

(4) We approve incapacity if you are rated at least two in one area of social functioning and at least three in all other areas of social functioning.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0080, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0090 PEP step V—How we determine your ability to function in a work environment if you have a physical impairment. In Step V of the PEP we review the medical evidence you provide and make a determination of how your physical impairment prevents you from working. This determination is then used in Steps VI and VII of the PEP to determine your ability to perform either work you have done in the past or other work.

(1) **"Exertion level"** means the ability to lift, carry, stand and walk with the strength needed to fulfill job duties in the following work categories. For this section, "occasionally" means less than one-third of the time and "frequently" means one-third to two-thirds of the time. We only consider your strength, mobility, and flexibility. We review any work limits you have in the following areas, and then assign an exertion level and determine exertional limitations.

The following table is used to determine your exertion level. Included in this table is a strength factor, which is your

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ability to perform physical activities, as defined in Appendix C of the Dictionary of Occupational Titles (DOT), Revised Edition, published by the U.S. Department of Labor.

If you	Then we assign this exertion level
(a) Can not lift at least two pounds or stand and/or walk.	Severely limited
(b) Can lift ten pounds maximum and frequently lift and/or carry lightweight articles. Walking and standing are only required for brief periods.	Sedentary
(c) Can lift twenty pounds maximum and frequently lift and/or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the workday, with sitting and pushing/ pulling arm or leg movements most of the day.	Light
(d) Can lift fifty pounds maximum and frequently lift and/or carry up to twenty-five pounds.	Medium
(e) Can lift one hundred pounds maximum and frequently lift and/or carry up to fifty pounds.	Heavy

(2) **"Exertionally-related limitation"** means a restriction in mobility, agility or flexibility in the following twelve activities: Balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. If you have exertionally-related limitations, we consider them in determining your ability to work.

(3) **"Functional physical capacity"** means the degree of strength, agility, flexibility, and mobility you can apply to work-related activities. We consider the effect of the physical impairment on the ability to perform work-related activities when the physical impairment is assigned an overall severity rating of three or four. We determine functional physical capacity based on your exertional, exertionally related and nonexertional limitations. All limitations must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

(4) **"Nonexertional physical limitation"** means a restriction on work activities that does not affect strength, mobility, agility, or flexibility. Examples are:

(a) Environmental restrictions which could include, among other things, your inability to work in an area where you would be exposed to chemicals; and

(b) Workplace restrictions, such as impaired hearing or speech, which would limit the types of work environments you could work in.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0090, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0100 PEP step VI—How we evaluate capacity to perform relevant past work. If your overall severity rating is three or four and we have reached this stage of the PEP and have not approved or denied your application, we decide if you can do the same or similar work as you have done in the past. We look at your current physical and/or mental limitations and vocational factors to make this deci-

sion. Vocational factors are education, relevant work history, and age.

(1) We evaluate education in terms of formal schooling or other training that enables you to meet job requirements. We classify education as:

If you	Then your education level is
(a) Can not read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b) Have no formal schooling beyond the eleventh grade; or (c) Have participated in special education.	Limited education
(d) Have received a high school diploma or general equivalency degree (GED); or (e) Have received skills training and were awarded a certificate, degree or license.	High school and above level of education

(2) We evaluate your work experience to determine if you have relevant past work. "Relevant past work" means work that:

(a) Is normally done for pay or profit. We exclude work done in a sheltered workshop, a job where you were given special consideration, or activities you may have performed as a student or homemaker;

(b) Has been performed in the past five years; and

(c) You have done long enough for you to have acquired the knowledge and skills to continue performing the job. You must meet the specific vocational preparation level as defined in Appendix C of the Dictionary of Occupational Titles.

(3) For each relevant past work situation you have had, we determine:

Highest work level assigned by the practitioner	Your age	Your education level	Other vocational factors
Sedentary	Any age	Any level	Does not apply
Light	Fifty and older	Any level	Does not apply
Light	Thirty-five and older	Illiterate or LEP	Does not apply
Light	Eighteen and older	Limited education	Does not have any past work
Medium	Fifty and older	Limited education	Does not have any past work
Medium	Fifty-five and older	Any level	Does not apply
Heavy	Fifty-five and older	Any level	Environmental restrictions apply

(2) We approve incapacity when you have a mental impairment only and meet the age and social functioning limitations below:

Social limitation	Age
(a) Can not appropriately relate to coworkers and supervisors (rated three); and (b) Can not tolerate the pressures of a work setting (rated four).	Fifty years and older
(c) Can not tolerate the pressures for a work setting (rated five).	Eighteen to fifty-four
(d) A mental disorder severity rated four; (e) One or more symptoms from WAC 388-448-0050(4) (rated five); (f) Can not appropriately relate to coworkers and supervisors (rated three); and (g) Can not tolerate the pressures of a work setting (rated four).	Eighteen to forty-nine

(3) We approve incapacity when you have both mental and physical impairments and vocational factors interfere with working as follows:

(a) The exertional or skill requirements of the job; and
(b) Current cognitive, social, or nonexertional factors that significantly limit your ability to perform past work.

(4) After considering vocational factors, we approve or deny incapacity based on the following:

If you	Then we take this action on incapacity
(a) Have the physical or mental ability to perform past work and there is no significant cognitive, social or nonexertional limitation.	Deny
(b) Have recently acquired specific work skills through completion of vocational training, enabling you to work within your current physical or mental capacities.	Deny
(c) Are fifty-five years of age or older and have an impairment that is assigned an overall severity rating of at least three and do not have the physical or mental ability to perform past work or do not have work experience.	Approve

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0100, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0110 PEP step VII—How we evaluate your capacity to perform other work. If we decide you cannot do work that you've done before, we then decide if you can do any other work. In making this decision, we again consider vocational factors of age, education and limited English proficiency (LEP).

(1) We approve incapacity if you have a physical impairment only and meet the vocational factors below:

Your age	Your education	Your other restrictions
Any age	Any level	(a) Can not appropriately relate to coworkers and supervisors (rated three; and (b) Can not tolerate pressures of a work setting (rated four).
Fifty or older	Limited education	(c) Restricted to medium work level or less.
Eighteen to forty-nine	Limited education	(d) Restricted to light work level.

(4) If we do not find that you are incapacitated by the end of Step VII of the PEP, an administrative review team (ART) makes the incapacity decision. The review team consists of two or more persons within the community service office (CSO) who are not in the position of providing direct eligibility or incapacity services to you. The ART reviews the medical evidence and your vocational factors.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0110, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0120 How we decide how long you are incapacitated. We decide how long you are incapacitated, up to the maximum period set by WAC 388-448-0160, using medical evidence on the expected length of time needed to heal or recover from the incapacitating disorder(s).

[Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0120, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0120, filed 6/29/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0120, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0130 Treatment and referral requirements. We refer you to medical providers for available medical treatment or other agencies for treatment, rehabilitation or work activities when we decide it will improve your ability to be gainfully employed or reduce your need for GAU. "Available medical treatment" means medical, surgical, chemical dependency, or mental health services, or a combination of them.

(1) When you are first approved and at each review determination, we give you written information regarding your treatment requirements.

(2) You must accept and follow through on required medical treatment and referrals to other agencies and services, including applying for SSI, unless you have good cause for not doing so. Examples of good cause are found in WAC 388-448-0140.

(3) We may require you to undergo alcohol or drug treatment before reviewing your eligibility for GAU.

(4) You may request a fair hearing if you disagree with the treatment or referral requirements we set for you (see WAC 388-458-0040).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0130, filed 6/29/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0130, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0140 Good cause for refusing medical treatment or other agency referrals. We may determine that you have good cause for refusing required treatment or referrals to other agencies. We may require you to provide

proof to support your good cause claim. Valid reasons for refusing treatment and other agency referrals include, but are not limited to, the following:

(1) Valid reasons for refusing treatment referrals:

(a) You are so fearful of the treatment that your fear could interfere with the treatment or reduce its benefits;

(b) Treatment could cause further limitations or loss of a function or an organ and you are not willing to take that risk;

(c) You practice an organized religion that prohibits treatment; or

(d) Treatment is not available without cost to you.

(2) Valid reasons for refusing treatment or other agency referrals:

(a) We did not give you enough information about the requirement;

(b) You did not receive written notice of the requirement;

(c) The requirement was made in error;

(d) You are temporarily unable to participate because of documented interference, or

(e) Your medical condition or limitations are consistent with the definition of necessary supplemental accommodation (NSA), WAC 388-472-0020 and your condition or limitations contributed to your refusal, per WAC 388-472-0050.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0140, filed 6/29/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0140, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0150 Penalty for refusing medical treatment or other agency referrals. (1) If you refuse required treatment or agency referral without having good cause, we will stop your GAU benefits.

(2) We stop your GAU benefits until you agree to accept and pursue the required treatment service or referral.

(3) If you reapply, you must wait for a penalty period to pass before you begin getting benefits. The penalty is based on how often you have refused:

Refusal	Penalty
First	One week
Second within six months	One month
Third and subsequent within one year	Two months

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0150, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0160 When do my general assistance benefits end? (1) The maximum period of eligibility for general assistance is twelve months before we must review additional medical evidence. We use medical evidence and the

expected length of time before you are capable of gainful employment to decide when your benefits will end.

(2) Your benefits stop at the end of your incapacity period unless you provide additional medical evidence that demonstrates during your current incapacity period that there was no material improvement in your impairment. No material improvement means that your impairment continues to meet the progressive evaluation process criteria in WAC 388-448-0010 through 388-448-0110, excluding the requirement that your impairment(s) prevent employment for ninety days.

(3) Additional medical evidence must meet all of the criteria defined in WAC 388-448-0030.

(4) We use additional medical evidence received after your incapacity period had ended when:

(a) The delay was not due to your failure to cooperate; and

(b) We receive the evidence within thirty days of the end of your incapacity period; and

(c) The evidence meets the progressive evaluation process criteria in WAC 388-448-0010 through 388-448-0110.

(5) You must provide information about your cooperation and progress with treatment or agency referrals we required according to WAC 388-448-0130.

(6) Even if your condition has not improved, you are not eligible for general assistance when:

(a) We get current medical evidence that does not meet the progressive evaluation process criteria in WAC 388-448-0035 through 388-448-0110; and

(b) Our prior decision that your incapacity met the requirements was incorrect because:

(i) The information we had was incorrect or not enough to show incapacity; or

(ii) We did not apply the rules correctly to the information we had at that time.

[Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0160, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0160, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0180 How do we redetermine your eligibility when we decide you are eligible for general assistance expedited Medicaid (GAX)? (1) The maximum period of eligibility for GAX is twelve months before we must review additional medical evidence. If you remain on GAX at the end of the twelve-month period, we determine your eligibility using current medical evidence.

(2) If your application for SSI is denied, and the denial is upheld by an SSI/SSA administrative hearing before the end of the twelve-month incapacity period, we change your program eligibility from GAX to GA and adjust the incapacity review date to be sixty days after the administrative hearing date.

[Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0180, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0180, filed 6/29/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0180, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0200 Can I get general assistance while waiting for Supplemental Security Income (SSI)?

(1) You may receive general assistance benefits while you are

waiting to receive Social Security Supplemental Security Income (SSI) benefits only when you:

(a) Have filed your SSI application with the Social Security Administration (SSA), follow through with SSA directions and requirements to process your application including keeping all interview and consultative examination appointments, and do not withdraw your application;

(b) Agree to assign the initial or reinstated SSI payment to us provided under WAC 388-448-0210;

(c) Are otherwise eligible according to WAC 388-400-0025; and

(d) Meet incapacity criteria listed in WAC 388-448-0001.

(2) When we obtain certification that you are likely to qualify for SSI, we also approve categorical needy medical coverage under WAC 388-505-0110.

[Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0200, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-14-059, § 388-448-0200, filed 6/29/01, effective 8/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0200, filed 8/2/00, effective 9/1/00.]

WAC 388-448-0210 What is interim assistance and how do I assign it to you? The general assistance and SSI programs both provide cash assistance to meet your basic needs. You cannot receive this assistance for the same time period from both programs. When you are approved for or reinstated on SSI, you may receive a back payment. When we made GA payments to you or on your behalf for the same time period, you must assign your interim assistance to repay us.

(1) **"Assign"** means that you sign a written authorization for the Social Security Administration (SSA) to send the SSI back payment to us. We will deduct the interim assistance we provided to you.

(2) **"Interim assistance"** means the GA funds we paid to you or on your behalf during:

(a) The time between your SSI application date and the month recurring SSI payments begin; or

(b) The period your SSI payments were suspended or terminated, and later reinstated.

(3) We pay up to twenty-five percent of the interim assistance reimbursement that we receive from the SSA to the attorney who successfully represented you in your effort to receive SSI.

[Statutory Authority: RCW 74.08.090, 74.04.005, and 2003 1st sp.s. c 10. 04-07-140, § 388-448-0210, filed 3/22/04, effective 5/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-16-113, § 388-448-0210, filed 8/2/00, effective 9/1/00.]

Chapter 388-450 WAC INCOME

WAC

388-450-0005	How does the department decide if I own a type of income and if this income is available to meet my needs?
388-450-0010	The department takes some or all of your time-loss benefits if you get cash assistance while waiting for your claim to be processed.
388-450-0015	What types of income does the department not use to figure out my benefits?
388-450-0025	What is unearned income?

388-450-0030	What is earned income?		RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-450-0035	Educational benefits.		98-16-044, § 388-450-0060, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0040	Native American benefits and payments.		
388-450-0045	How do we count income from employment and training programs?		
388-450-0050	How does your participation in the community jobs (CJ) program affect your cash assistance and Basic Food benefits?	388-450-0075	Income from time-loss compensation. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0075, filed 7/31/98, effective 9/1/98.] Repealed by 02-20-069, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0055	How does needs-based assistance from other agencies or organizations count against my benefits?		
388-450-0065	Gifts—Cash and noncash.		
388-450-0070	How do we count the earned income of a child?	388-450-0090	Self-employment expenses that are not allowed as income deductions. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0090, filed 7/31/98, effective 9/1/98.] Repealed by 01-19-020, filed 9/11/01, effective 10/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0080	What is self-employment income?		
388-450-0085	Does the department count all of my self-employment income to determine if I am eligible for benefits?		
388-450-0095	Allocating income—General.		
388-450-0100	Allocating income—Definitions.		
388-450-0105	Allocating the income of a financially responsible person included in the assistance unit.	388-450-0125	Allocating the income of the father of the unborn child to a pregnant woman. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0125, filed 7/31/98, effective 9/1/98.] Repealed by 01-11-108, filed 5/21/01, effective 7/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.200.
388-450-0106	How does the department count my income if someone in my family cannot get assistance because of their alien status?		
388-450-0110	Allocating the income of a GA-U client to legal dependents.		
388-450-0115	Allocating the income of a financially responsible person excluded from the assistance unit.	388-450-0150	SSI-related medical income allocation. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0150, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0630 and 388-519-1910.] Repealed by 04-09-005, filed 4/7/04, effective 6/1/04. Statutory Authority: RCW 74.04.050, 74.08.090. Later promulgation, see chapter 388-475 WAC.
388-450-0116	How does the department count my income if I cannot get assistance because I am an alien?		
388-450-0120	Allocating the income of financially responsible parents to a pregnant or parenting minor.		
388-450-0130	Allocating the income of a nonapplying spouse to a caretaker relative.		
388-450-0135	Allocating income of an ineligible spouse to a GA-U client.	388-450-0180	Effect of countable income on eligibility and benefit level for cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0180, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0140	How does the income of an ineligible assistance unit member affect my eligibility and benefits for Basic Food?		
388-450-0145	Income of a person who is not a member of a food assistance unit.		
388-450-0155	How does being a sponsored immigrant affect my eligibility for cash, medical, and food assistance programs?	388-450-0205	Budgeting income deductions for food assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0205, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0156	When am I exempt from deeming?		
388-450-0160	How does the department decide how much of my sponsor's income to count against my benefits?		
388-450-0162	The department uses countable income to determine if you are eligible and the amount of your cash and food assistance benefits.	388-450-0220	Retrospective budgeting. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0220, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0220, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0165	Gross earned income limit for TANF/SFA.		
388-450-0170	TANF/SFA earned income incentive and deduction.		
388-450-0175	Does the department offer an income deduction as an incentive for GA-U clients to work?		
388-450-0185	Does the department count all of my income to determine my eligibility and benefits for Basic Food?	388-450-0235	Discontinued income. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0235, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0235, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0190	How does the department figure my shelter cost income deduction for Basic Food?		
388-450-0195	Utility allowances for Basic Food programs.		
388-450-0200	Will the medical expenses of elderly persons or individuals with disabilities in my assistance unit be used as an income deduction for Basic Food?		
388-450-0210	Countable income for medical programs.		
388-450-0215	How does the department estimate my assistance unit's income to determine my eligibility and benefits?	388-450-0240	Effect of net lump sum payments for cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0240, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-450-0225	How are my assistance unit's benefits calculated for the first month I am eligible for cash assistance?		
388-450-0230	What income does the department count in the month I apply for Basic Food when my assistance unit is destitute?		
388-450-0245	When are my benefits suspended?	388-450-0250	Income of a new assistance unit member. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0250, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0250, filed 7/31/98, effective 9/1/98.] Repealed by 00-01-012, filed 12/3/99, effective 1/1/00. Statutory Authority: RCW 74.04.510.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-450-0020	Income exclusions for SSI-related medical. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1140 and 388-519-1910.] Repealed by 04-09-005, filed 4/7/04, effective 6/1/04. Statutory Authority: RCW 74.04.050, 74.08.090. Later promulgation, see chapter 388-475 WAC.
388-450-0060	Lump sum payments. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0060, filed 7/26/99, effective 9/1/99. Statutory Authority:

WAC 388-450-0005 How does the department decide if I own a type of income and if this income is available to meet my needs? This section applies to cash assistance, medical programs for children, pregnant women and families, and food assistance.

(1) We count all available income owned or held by people in your assistance unit under chapter 388-408 WAC to decide if you are eligible for benefits and calculate your monthly benefits when:

(a) You get or expect to get the income in the month.
 (b) We must count the income based on rules under chapter 388-450 WAC.

(c) You own the income. We use state and federal laws about who owns property to decide if you actually own the income. If you are married, we decide if income is separate or community income according to chapter 26.16 RCW.

(d) You have control over the income, which means the income is actually available to you. If you have a representative payee, protective payee, or other person who manages your income for you as described in chapter 388-460 WAC, we consider this as you having control over this income.

(e) You can use the income to meet your current needs. We count the gross amount of available income in the month your assistance unit gets it. If you normally get the income:

(i) On a specific day, we count it as available on that date.

(ii) Monthly or twice monthly and your pay date changes due to a reason beyond your control, such as a weekend or holiday, we count it in the month you would normally get it.

(iii) Weekly or every-other week and your pay date changes due to a reason beyond your control, we count it in the month you would normally get it.

(2) If income is legally yours, we consider the income as available to you even if it is paid to someone else for you. For example, the father of your child has a court order to pay you two hundred fifty dollars per month in child support. Instead of giving the money directly to you (as required in the court order), he gives the money to your landlord to pay part of your rent. We still count the two hundred fifty dollars as income even though you never actually got the money.

(3) We may also count the income of certain people who live in your home, even if they are not getting or applying for benefits. Their income counts as part of your income.

(a) For cash assistance, we count the income of ineligible, disqualified, or financially responsible people as defined in WAC 388-450-0100.

(b) For food assistance, we count the income of ineligible assistance unit members as defined in WAC 388-408-0035.

(c) For family and SSI-related medical assistance, we count the income of financially responsible people as defined in WAC 388-408-0055 and chapter 388-475 WAC.

(d) For long-term care services, we count the income of financially responsible people as defined in WAC 388-506-0620.

(4) If you have a joint bank account with someone who is not in your AU, we count any money deposited into that account as your income unless:

(a) You can show that all or part of the funds belong **only** to the other account holder and are held or used **only** for the benefit of that holder; or

(b) Social Security Administration (SSA) used that money to determine the other account holder's eligibility for SSI benefits.

(5) Potential income is income you may be able to get that can be used to lower your need for assistance. If we

determine that you have a potential source of income, you must make a reasonable effort to make the income available in order to get cash or medical assistance.

(a) We do not count that income until you actually get it; and

(b) You can choose whether to get TANF/SFA or Supplemental Security Income (SSI) benefits.

(6) If your assistance unit includes a sponsored immigrant, we consider the income of the immigrant's sponsor as available to the immigrant under the rules of this chapter. We use this income when deciding if your assistance unit is eligible for benefits and to calculate your monthly benefits.

(7) For SSI-related medical:

(a) We consider income to be owned by someone and available to the person when the person:

(i) Gets the income; and

(ii) Can use the income to meet their needs for food, clothing and shelter, except as provided in WAC 388-511-1130.

(b) Loans and getting cash in certain other ways are not defined as income for SSI-related medical purposes as described in 20 C.F.R. Sec. 416.1103.

(8) For medical programs, see WAC 388-561-0100 for more information about trusts.

(9) You may give us proof about a type of income at any time, including when we ask for it or if you disagree with a decision we made, about:

(a) Who owns the income;

(b) Who has legal control of the income;

(c) The amount of the income; or

(d) If the income is available.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 06-07-078, § 388-450-0005, filed 3/13/06, effective 5/1/06. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-450-0005, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590 and 388-506-0610.]

WAC 388-450-0010 The department takes some or all of your time-loss benefits if you get cash assistance while waiting for your claim to be processed. (1) Some people who are hurt on the job can get time-loss benefits because of their injury. The time-loss benefits are paid by an agency, such as the department of labor and industries or a private insurance company.

(2) If you are an adult or minor child who gets cash assistance while waiting for your time-loss benefit claim to be processed, you are required to let the department take some or all of your time-loss benefits as repayment for your cash assistance. We will take our portion of the time-loss benefits before you get yours. You agree to this when you sign the application and accept your cash benefits.

(3) The amount of your time-loss benefits that we take will not be more than the total amount of cash assistance you got while waiting for your claim to be approved.

(4) If your assistance unit includes another adult to whom you are not married, the amount of your time-loss benefits we take may be less than the amount of cash assistance you received.

(5) Each time we take our portion from your time-loss benefits, the office of financial recovery (OFR) will send you a letter telling you how much we are taking.

(6) If you or your attorney claim that you are getting more time-loss benefits because of the help of your attorney, OFR will:

(a) First, figure out:

(i) How much of your time-loss benefits are a direct result of your attorney's work; and

(ii) Our proportionate share of your attorney's fees and costs for the amount we are taking; and

(b) Then, either:

(i) Subtract our share of your attorney's fees and costs from the amount we are taking; or

(ii) Send your attorney their share of the time-loss benefits we have taken.

(c) Send a copy of the account summary to you.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-20-069, § 388-450-0010, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0015 What types of income does the department not use to figure out my benefits? This section applies to cash assistance, children's, family, or pregnancy medical, and basic food benefits.

(1) There are some types of income we do not count to figure out if you can get benefits and the amount you can get. Some examples of income we do not count are:

(a) Bona fide loans as defined in WAC 388-470-0045, except certain student loans as specified under WAC 388-450-0035;

(b) Federal earned income tax credit (EITC) payments;

(c) Title IV-E and state foster care maintenance payments if you choose not to include the foster child in your assistance unit;

(d) Energy assistance payments;

(e) Educational assistance we do not count under WAC 388-450-0035;

(f) Native American benefits and payments we do not count under WAC 388-450-0040;

(g) Income from employment and training programs we do not count under WAC 388-450-0045;

(h) Money withheld from a benefit to repay an overpayment from the same income source. For Basic Food, we **do not** exclude money that is withheld because you were overpaid for purposely not meeting requirements of a federal, state, or local means tested program such as TANF/SFA, GA, and SSI;

(i) Legally obligated child support payments received by someone who gets TANF/SFA benefits;

(j) One-time payments issued under the Department of State or Department of Justice Reception and Replacement Programs, such as Voluntary Agency (VOLAG) payments; and

(k) Payments we are directly told to exclude as income under state or federal law.

(l) **For cash and Basic Food:** Payments made to someone outside of the household for the benefits of the assistance unit using funds that are not owed to the household; and

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(m) **For medical assistance:** Only the portion of income used to repay the cost of obtaining that income source.

(2) For children's, family, or pregnancy medical, we also do not count any insurance proceeds or other income you have recovered as a result of being a Holocaust survivor.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 06-07-078, § 388-450-0015, filed 3/13/06, effective 5/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and Public Law 106-419. 05-03-078, § 388-450-0015, filed 1/17/05, effective 2/17/05. Statutory Authority: RCW 74.08.090 and 74.04.510. 02-14-022, § 388-450-0015, filed 6/21/02, effective 6/22/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 2000 2nd sp.s. c 1 § 210(12). 01-18-006, § 388-450-0015, filed 8/22/01, effective 9/22/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-450-0015, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

WAC 388-450-0025 What is unearned income? This section applies to cash assistance, food assistance, and medical programs for families, children, and pregnant women.

(1) Unearned income is income you get from a source other than employment or self-employment. Some examples of unearned income are:

(a) Railroad Retirement;

(b) Unemployment Compensation;

(c) Social Security benefits (including retirement benefits, disability benefits, and benefits for survivors);

(d) Time loss benefits as described in WAC 388-450-0010, such as benefits from the department of labor and industries (L&I); or

(e) Veteran Administration benefits.

(2) For food assistance we also count the total amount of cash benefits due to you before any reductions caused by your failure (or the failure of someone in your assistance unit) to perform an action required under a federal, state, or local means-tested public assistance program, such as TANF/SFA, GA, and SSI.

(3) When we count your unearned income, we count the amount you get before any taxes are taken out.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-20-069, § 388-450-0025, filed 9/30/02, effective 10/31/02; 99-17-025, § 388-450-0025, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0030 What is earned income? This section applies to cash assistance, food assistance, and medical programs for families, children, and pregnant women.

(1) Earned income money you get from working. This includes:

(a) Wages;

(b) Tips;

(c) Commissions;

(d) Profits from self-employment activities as described in WAC 388-450-0080; and

(e) One-time payments for work you did over a period of time.

(2) For cash and medical assistance, we also consider you to have earned income if you work for something other than money, such as your rent.

(3) When we count your earned income, we count the amount you get before any taxes are taken out.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 02-20-069, § 388-450-0030, filed 9/30/02, effective 10/31/02; 99-17-025, § 388-450-0030, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0035 Educational benefits. This section applies to cash assistance, medical programs for children, pregnant women and families, and food assistance.

(1) We do not count:

(a) Educational assistance in the form of grants, loans or work study, issued from Title IV of the Higher Education Amendments (Title IV - HEA) and Bureau of Indian Affairs (BIA) education assistance programs. Examples of Title IV - HEA and BIA educational assistance include but are not limited to:

- (i) College work study (federal and state);
- (ii) Pell grants; and
- (iii) BIA higher education grants.

(b) Educational assistance in the form of grants, loans or work-study made available under any program administered by the Department of Education (DOE) to an undergraduate student. Examples of programs administered by DOE include, but are not limited to:

- (i) Christa McAuliffe Fellowship Program;
- (ii) Jacob K. Javits Fellowship Program; and
- (iii) Library Career Training Program.

(2) For assistance in the form of grants, loans or work-study under the Carl D. Perkins Vocational and Applied Technology Education Act, P.L. 101-391:

(a) If you are attending school half-time or more, we subtract the following expenses:

- (i) Tuition;
- (ii) Fees;
- (iii) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study;
- (iv) Books;
- (v) Supplies;
- (vi) Transportation;
- (vii) Dependent care; and
- (viii) Miscellaneous personal expenses.

(b) If you are attending school less than half-time, we subtract the following expenses:

- (i) Tuition;
- (ii) Fees; and
- (iii) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study.

(c) For cash assistance and medical programs for children, pregnant women and families, we also subtract the difference between the appropriate need standard and payment standard for your family size.

(d) Any remaining income is unearned income and budgeted using the appropriate budgeting method for the assistance unit.

(3) If you are participating in WorkFirst work study, that work study income is:

- (a) Not counted for cash and medical assistance;

(b) Counted as earned income for food assistance.

(4) If you are participating in a work study program that is not excluded in subsection (1), of this section, we count that work study income as earned income:

(a) You get any applicable earned income disregards;

(b) For cash assistance, and medical programs for children, pregnant women and families, we also subtract the difference between the need standard and payment standard for your family size as described in chapter 388-478 WAC; and

(c) Budgeting remaining income using the appropriate budgeting method for the assistance unit.

(5) If you get Veteran's Administration Educational Assistance:

(a) All applicable attendance costs as subtracted; and

(b) The remaining unearned income is budgeted using the appropriate budgeting method for the assistance unit.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-450-0035, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and 74.04.050, 00-18-057, § 388-450-0035, filed 9/1/00, effective 9/4/00. Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-450-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0040 Native American benefits and payments. This section applies to TANF/SFA, RCA, GA medical and food assistance programs.

(1) The following types of income are not counted when a client's benefits are computed:

(a) Up to two thousand dollars per individual per calendar year received under the Alaska Native Claims Settlement Act, P.L. 92-203 and 100-241;

(b) Income received from Indian trust funds or lands held in trust by the Secretary of the Interior for an Indian tribe or individual tribal member. Income includes:

- (i) Interest; and
- (ii) Investment income accrued while such funds are held in trust.

(c) Income received from Indian judgement funds or funds held in trust by the Secretary of the Interior distributed per capita under P.L. 93-134 as amended by P.L. 97-458 and 98-64. Income includes:

- (i) Interest; and
- (ii) Investment income accrued while such funds are held in trust.

(d) Up to two thousand dollars per individual per calendar year received from leases or other uses of individually owned trust or restricted lands, P.L. 103-66;

(e) Payments from an annuity fund established by the Puyallup Tribe of Indians Settlement Act of 1989, P.L. 101-41, made to a Puyallup Tribe member upon reaching twenty-one years of age; and

(f) Payments from the trust fund established by the P.L. 101-41 made to a Puyallup Tribe member.

(2) Other Native American payments and benefits that are excluded by federal law are not counted when determining a client's benefits. Examples include but are not limited to:

- (a) White Earth Reservation Land Settlement Act of 1985, P.L. 99-264, Section 16;

(b) Payments made from submarginal land held in trust for certain Indian tribes as designated by P.L. 94-114 and P.L. 94-540; and

(c) Payments under the Seneca Nation Settlement Act, P.L. 101-503.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1140.]

WAC 388-450-0045 How do we count income from employment and training programs? This section applies to cash assistance, Basic Food, and medical programs for families, children, and pregnant women.

(1) We treat payments issued under the Workforce Investment Act (WIA) as follows:

(a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.

(b) For Basic Food:

(i) We exclude OJT earnings for children who are eighteen years of age or younger and under parental control as described in WAC 388-408-0035.

(ii) We count OJT earnings as earned income for people who are:

(A) Age nineteen and older; or

(B) Age eighteen or younger and not under parental control.

(iii) We exclude all other payments.

(2) We exclude **all** payments issued under the National and Community Service Trust Act of 1993. This includes payments made through the AmeriCorps program.

(3) We treat payments issued under Title I of the Domestic Volunteer Act of 1973, such as VISTA, AmeriCorps Vista, university year for action, and urban crime prevention program as follows:

(a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.

(b) For Basic Food, we count most payments as earned income. We exclude the payments if you:

(i) Received Basic Food or cash assistance at the time you joined the Title I program; or

(ii) Were participating in the Title I program and received an income disregard at the time of conversion to the Food Stamp Act of 1977. We continue to exclude the payments even if you do not get Basic Food every month.

(4) We exclude **all** payments issued under Title II of the Domestic Volunteer Act of 1973. These include:

(a) Retired senior volunteer program (RSVP);

(b) Foster grandparents program; and

(c) Senior companion program.

(5) We count training allowances from vocational and rehabilitative programs as earned income when:

(a) The program is recognized by federal, state, or local governments; and

(b) The allowance is not a reimbursement.

(6) When GAU clients receive training allowances we allow:

(a) The earned income incentive and work expense deduction specified under WAC 388-450-0175, when applicable; and

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(b) The actual cost of uniforms or special clothing required for the course as a deduction, if enrolled in a remedial education or vocational training course.

(7) We exclude support service payments received by or made on behalf of WorkFirst participants.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-17-017, § 388-450-0045, filed 8/4/06, effective 9/4/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-03-071, § 388-450-0045, filed 1/15/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 02-03-019, § 388-450-0045, filed 1/4/02, effective 2/1/02; 99-16-024, § 388-450-0045, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0050 How does your participation in the community jobs (CJ) program affect your cash assistance and Basic Food benefits? (1) There are two different types of income in the community jobs program. They are:

(a) Subsidized, where your wages are paid from TANF or SFA funds; and

(b) Unsubsidized, where your wages are paid entirely by your employer.

(2) We figure your total monthly subsidized or unsubsidized income by:

(a) Estimating the number of hours you, your case manager, and the CJ contractor expect you to work for the month; and

(b) Multiplying the number of hours by the federal or state minimum wage, whichever is higher.

(3) Because you are expected to participate and meet the requirements of CJ, once we determine what your total monthly income is expected to be, we do not change your TANF grant if your actual hours are more or less than anticipated.

(4) We treat the total income we expect you to get each month from your CJ position as:

(a) Earned income for cash assistance, except we do not count any of the CJ income for the first month you receive your paycheck.

(b) Earned income for Basic Food after you have been transferred to your employer's regular unsubsidized payroll; or

(c) Unearned income for Basic Food while you have subsidized income.

(5) If your anticipated subsidized income is more than your grant amount, your cash grant is suspended. This means that you are still considered a TANF/SFA recipient, but you do not get a grant.

(a) Your grant can be suspended up to a maximum of nine months.

(b) You can keep participating in CJ even though your grant is suspended, as long as you would be eligible for a grant if we did not count your subsidized income.

(c) The months your grant is suspended do not count toward your sixty-month lifetime limit.

(6) If your unsubsidized income, after we subtract half of what you have earned is greater than your grant, your TANF/SFA case will close. This happens because your income is over the maximum you are allowed. You will still be able to participate in the CJ program for up to a total of nine months.

(7) If your income from other sources alone, not counting CJ income makes you ineligible for a cash grant, we terminate your grant and end your participation in CJ.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340, 04-14-043, § 388-450-0050, filed 6/29/04, effective 7/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 03-06-095, § 388-450-0050, filed 3/4/03, effective 5/1/03. Statutory Authority: RCW 74.04.050, 74.04.-057, 74.04.510, 01-23-044, § 388-450-0050, filed 11/15/01, effective 1/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 99-09-054, § 388-450-0050, filed 4/19/99, effective 6/1/99; 98-16-044, § 388-450-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0055 How does needs-based assistance from other agencies or organizations count against my benefits? (1) For cash assistance and medical programs for children, pregnant women, and families:

(a) We do not count needs-based assistance payments given to you by other agencies or organizations if the assistance is given to you for reasons other than ongoing living expenses which do not duplicate the purpose of cash assistance programs. Ongoing living expenses include the following items:

- (i) Clothing;
- (ii) Food;
- (iii) Household supplies;
- (iv) Medical supplies (nonprescription);
- (v) Personal care items;
- (iv) Shelter;
- (vii) Transportation; and
- (viii) Utilities (e.g., lights, cooking fuel, the cost of heating or heating fuel).

(b) If the needs-based assistance given to you is supposed to be used for ongoing living expenses, then it duplicates the purpose of cash assistance programs. We count the amount remaining after we subtract the difference between the need standard and the payment standard for your family size as described in chapter 388-478 WAC.

(c) "Needs-based" means eligibility is based on an asset test of income and resources relative to the federal poverty level (FPL). This definition excludes such incomes as retirement benefits or unemployment compensation which are not needs-based.

(2) For food assistance:

(a) We do not count money given to you if:

- (i) It is given to you by a private, nonprofit, charitable agency or organization; and
- (ii) The amount of money you get is no more than three hundred dollars in any one of the following calendar quarters:
 - (A) January - February - March,
 - (B) April - May - June,
 - (C) July - August - September,
 - (D) October - November - December.

(b) We count the entire amount if the requirements in (a) of this subsection are not met.

(3) For cash assistance, food assistance, and medical programs for children, pregnant women, and families, if we do count the needs-based assistance you get, we treat it as unearned income under WAC 388-450-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 06-04-071, § 388-450-0055, filed 1/30/06, effective 3/2/06. Statutory Authority: RCW 74.08.090 and 74.04.510, 02-14-022, § 388-450-0055, filed 6/21/02, effective 6/22/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-

057 and 74.08.090, 98-16-044, § 388-450-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0065 Gifts—Cash and noncash. A gift is an item furnished to a client without work or cost on his or her part.

(1) A cash gift is a gift that is furnished as money, cash, checks or any other readily negotiable form.

(a) For cash assistance and medical programs for children, pregnant women and families, cash gifts totaling no more than thirty dollars per calendar quarter for each assistance unit member are disregarded as income.

(b) For food assistance programs:

(i) Cash gifts to the assistance unit are excluded if they total thirty dollars or less per quarter;

(ii) Cash gifts in excess of thirty dollars per quarter are counted in full as unearned income.

(2) For cash assistance and medical programs for children, pregnant women and families, and food assistance, a noncash gift is treated as a resource.

(a) If the gift is a countable resource, its value is added to the value of the client's existing countable resources and the client's eligibility is redetermined as specified in chapter 388-470 WAC.

(b) If the gift is an excluded or noncountable resource, it does not affect the client's eligibility or benefit level.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-450-0065, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and 74.04.510, 99-16-024, § 388-450-0065, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0070 How do we count the earned income of a child? (1) For food assistance and medical programs for families, children, and pregnant women, we do not count the earnings of a child if the child is:

- (a) In school;
- (b) Age seventeen or younger;
- (c) Not married; and
- (d) Not emancipated.

(2) For cash assistance, we do not count the earnings of a child if the child is:

- (a) In school; and
- (b) Meets the age and attendance requirements in WAC 388-404-0005.

(3) School includes:

- (a) Participating in a home-school program that is approved by the superintendent of public instruction; or
- (b) On break between school terms when the child:
 - (i) Was enrolled during the previous school term; and
 - (ii) Plans to return to school when it reopens.

(4) For medical programs, if we count the earnings of the child, we put the child in a separate MAU as described in WAC 388-408-0055.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 02-03-020, § 388-450-0070, filed 1/4/02, effective 2/1/02. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0070, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0080 What is self-employment income? This section applies to cash assistance, Basic Food,

and medical programs for children, pregnant women and families.

(1) Self-employment income is income you earn from running a business, performing a service, selling items you make, or reselling items to make a profit.

(2) You are self-employed if you earn income without having an employer/employee relationship with the person who pays you. This includes, but is not limited to, when:

(a) You have primary control of the way you do your work; or

(b) You report your income using IRS Schedule C, Schedule C-EZ, Schedule K-1, or Schedule SE.

(3) You usually have an employer/employee relationship when:

(a) The person you provide services for has primary control of how you do your work; or

(b) You get an IRS form W-2 to report your income.

(4) Your self-employment does not have to be a licensed business for your business or activity to qualify as self-employment. Some examples of self-employment include:

(a) Child care that requires a license under chapter 74.15 RCW;

(b) Driving a taxi cab;

(c) Farming/fishing;

(d) Odd jobs such as mowing lawns, house painting, gutter cleaning, or car care;

(e) Running a lodging for roomers and/or boarders. Roomer income includes money paid to you for shelter costs by someone not in your assistance unit who lives with you when:

(i) You own or are buying your residence; or

(ii) You rent all or a part of your residence and the total rent you charge all others in your home is more than your total rent.

(f) Running an adult family home;

(g) Providing services such as a massage therapist or a professional escort;

(h) Retainer fees to reserve a bed for a foster child;

(i) Selling items you make or items that are supplied to you;

(j) Selling or donating your own biological products such as providing blood or reproductive material for profit;

(k) Working as an independent contractor; and

(l) Running a business or trade either on your own or in a partnership.

(5) If you are an employee of a company or person who does the activities listed in subsection (2) above as a part of your job, we do not count the work you do as self-employment.

(6) Self-employment income is counted as earned income as described in WAC 388-450-0030 except as described in subsection (7).

(7) For cash assistance and Basic Food there are special rules about renting or leasing out property or real estate that you own.

(a) We count the income you get as unearned income unless you spend at least twenty hours per week managing the property.

(b) For TANF/SFA, we count the income as unearned income unless the use of the property is a part of your approved individual responsibility plan.

(2007 Ed.)

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-15-049, § 388-450-0080, filed 7/12/06, effective 9/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-13-045, § 388-450-0080, filed 6/11/03, effective 8/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-19-020, § 388-450-0080, filed 9/11/01, effective 10/1/01; 99-16-024, § 388-450-0080, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0080, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0085 Does the department count all of my self-employment income to determine if I am eligible for benefits? This section applies to cash assistance, Basic Food, and medical programs for children, pregnant women and families.

(1) We decide how much of your self-employment income to count by:

(a) Adding together your gross self-employment income and any profit you make from selling your business property or equipment;

(b) Subtracting your business expenses as described in subsection (2) below; and

(c) Dividing the remaining amount of self-employment income by the number of months over which the income will be averaged.

(2) We subtract one hundred dollars as a business expense even if your costs are less than this. If you want us to subtract your actual costs of more than one hundred dollars, you must list and give us proof of your expenses for us to count them. We never allow the following expenses:

(a) Federal, state, and local income taxes;

(b) Money set aside for retirement purposes;

(c) Personal work-related expenses (such as travel to and from work);

(d) Net losses from previous periods;

(e) Depreciation; or

(f) Any amount that is more than the payment you get from a boarder for lodging and meals.

(3) If you have worked at your business for less than a year, we figure your gross self-employment income by averaging:

(a) The income over the period of time the business has been in operation; and

(b) The monthly amount we estimate you will get for the coming year.

(4) For cash and medical assistance, if your self-employment expenses are more than your self-employment income, we do not use this "loss" to reduce income from other self-employment businesses or other sources of income to your assistance unit.

(5) For Basic Food, we use a "loss" from self-employment farming or fishing income to reduce other sources of income **only** if you meet the following three conditions:

(a) Someone in your assistance unit is a self-employed farmer or fisher;

(b) Your gross yearly income from farming or fishing is or is expected to be at least one thousand dollars; and

(c) Your allowable costs for farming or fishing are more than your income from farming or fishing.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. 273.9 and 273.11. 06-08-045, § 388-450-0085, filed 3/30/06, effective 5/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-13-045, § 388-450-0085, filed 6/11/03, effective 8/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-19-020,

§ 388-450-0085, filed 9/11/01, effective 10/1/01; 99-16-024, § 388-450-0085, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0085, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0095 Allocating income—General.

This section applies to TANF/SFA, RCA, and GA assistance programs.

(1) Allocation is the process of determining how much of a financially responsible person's income is considered available to meet the needs of legal dependents within or outside of an assistance unit.

(2) In-bound allocation means income possessed by a financially responsible person outside the assistance unit which is considered available to meet the needs of legal dependents in the assistance unit.

(3) Out-bound allocation means income possessed by a financially responsible assistance unit member which is set aside to meet the needs of a legal dependent outside the assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0095, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0100 Allocating income—Definitions.

The following definitions apply to the allocation rules for TANF/SFA, RCA, and GA programs:

(1) **"Dependent"** means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) **"Financially responsible person"** means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(3) A **"disqualified assistance unit member"** means a person who is:

(a) An unmarried pregnant or parenting minor under age eighteen who has not completed a high school education or general education development (GED) certification and is not participating in those educational activities which would lead to the attainment of a high school diploma or GED;

(b) An unmarried pregnant or parenting minor under age eighteen who is not living in a department-approved living situation;

(c) The financially responsible person who does not report to the department within five days of the date it becomes reasonably clear that the absence of a child will exceed ninety days;

(d) A person who has been convicted in federal or state court of having made a fraudulent statement or representation about their place of residence in order to receive assistance from two or more states at the same time as defined in WAC 388-446-0010; and

(e) A person who has been convicted of unlawfully receiving public assistance as defined under WAC 388-446-0005.

(4) **"Ineligible assistance unit member"** means an individual who is:

(a) Ineligible for cash assistance due to the citizenship/alien status requirements in WAC 388-424-0010;

(b) Ineligible to receive assistance under WAC 388-442-0010 for having been convicted after August 21, 1996, under

federal or state law, of possession, use or distribution of a controlled substance;

(c) Ineligible to receive assistance under WAC 388-442-0010 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime;

(d) Ineligible to receive assistance under WAC 388-442-0010 for violating a condition of probation or parole which was imposed under a federal or state law as determined by an administrative body or court of competent jurisdiction;

(e) The spouse of a woman who receives cash benefits from the GA-S program; or

(f) The adult parent of a minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-450-0100, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0100, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0100, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0105 Allocating the income of a financially responsible person included in the assistance unit.

This section applies to TANF/SFA, RCA, and RMA. Refer to WAC 388-408-0055 for the rules concerning the treatment of income of financially responsible person for medical programs. The income of a financially responsible person included in the assistance unit is countable to meet the needs of the assistance unit after the income is reduced by the following:

(1) Any applicable earned income incentive and work expense or deduction for the financially responsible person in the assistance unit, if that person is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.-415. 02-17-030, § 388-450-0105, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0105, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0106 How does the department count my income if someone in my family cannot get assistance because of their alien status? This section applies to TANF/SFA, RCA, and RMA. We count your income differently if you are applying for medical assistance only. See WAC 388-408-0055.

If you are included in the assistance unit and you are financially responsible for someone, as defined in WAC 388-450-0100, who does not meet the alien requirements described in WAC 388-424-0010, we do not count all of your income. We subtract some of it so that you can use that part to help support the people who cannot get assistance. To figure out how much we count, we take the following seven steps:

(1) We start by only counting fifty percent of your earned income, as defined in WAC 388-450-0030;

(2) We add all of your unearned income, as defined in WAC 388-450-0025.

(3) We subtract the difference between the following payment standards (payment standards can be found in WAC 388-478-0020):

(a) One that includes both eligible assistance unit members and those who cannot get assistance because of their alien status; and

(b) One that includes only the eligible assistance unit members.

(4) We subtract the payment standard for the number of people who are ineligible for reasons other than alien status, as defined in WAC 388-450-0100 (4)(b) through (f).

(5) We subtract any court or administratively ordered child support you pay for legal dependents. This includes both current and back support. The amount cannot be more than the need standard in WAC 388-478-0015 for the number of dependents.

(6) We subtract any employment-related child care expenses you have.

(7) Then, we count whatever is left as unearned income.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-450-0106, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090 and 74.04.510. 02-21-097, § 388-450-0106, filed 10/21/02, effective 10/24/02; 99-16-024, § 388-450-0106, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0106, filed 11/24/98, effective 12/25/98.]

WAC 388-450-0110 Allocating the income of a GA-U client to legal dependents. This section applies to the GA-U program.

(1) The income of a GA-U client is reduced by the following:

(a) The GA-U earned income disregard and work expense disregard, as specified in WAC 388-450-0175; and

(b) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(2) When a GA-U client in a medical institution, alcohol or drug treatment center, congregate care facility or adult family home has income, the income is countable to meet the client's needs after the income is reduced by the following:

(a) The payment standard amount for the nonapplying spouse and legal dependents living in the home; and

(b) The standard of assistance the client is eligible for while in an alternative care facility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1910.]

WAC 388-450-0115 Allocating the income of a financially responsible person excluded from the assistance unit. This section applies to TANF/SFA, RCA and GA-S programs.

The income of a financially responsible person excluded from the assistance unit is available to meet the needs of the assistance unit after the income is reduced by the following:

(1) A ninety dollar work expense deduction from the financially responsible person(s) excluded from the assistance unit who is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

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(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0115, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0116 How does the department count my income if I cannot get assistance because I am an alien? This section applies to TANF/SFA, RCA, and RMA programs. We count your income differently if you are applying for medical assistance only. See WAC 388-408-0055.

Some people cannot get assistance because they do not meet the alien requirements described in WAC 388-424-0010. If you do not meet those requirements but you are financially responsible for someone in the assistance unit, as defined in WAC 388-450-0100, we count some of your income as part of the assistance unit's income. To figure out how much we count, we take the following seven steps:

(1) We start by only counting fifty percent of your earned income, as described in WAC 388-450-0030.

(2) We add all of your unearned income, as described in WAC 388-450-0025.

(3) We subtract the difference between the following payment standards:

(a) One that includes both eligible assistance unit members and those who cannot get assistance because of their alien status; and

(b) One that includes only the eligible assistance unit members.

(4) We subtract the payment standard for the number of people who are ineligible for reasons other than alien status, as defined in WAC 388-450-0100 (4)(b) through (f).

(5) We subtract any court or administratively ordered child support you pay for legal dependents. This includes both current and back support. The amount cannot be more than the need standard in WAC 388-478-0005 for the number of dependents.

(6) We subtract any employment-related childcare expenses you have.

(7) Then, we count whatever is left as unearned income.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-450-0116, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090 and 74.04.510. 02-14-021, § 388-450-0116, filed 6/21/02, effective 6/22/02; 99-16-024, § 388-450-0116, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0116, filed 11/24/98, effective 12/25/98.]

WAC 388-450-0120 Allocating the income of financially responsible parents to a pregnant or parenting minor. This section applies to TANF/SFA, RCA and GA-S programs.

The income of nonapplying financially responsible parent(s) of a pregnant or parenting minor is countable to meet the needs of the minor and the child(ren) after the income is reduced by the following:

(1) A ninety dollar work expense from the financially responsible parent's gross income from employment;

(2) An amount not to exceed the department's standard of need for:

(a) The financially responsible parent and dependent living in the home who are not applying for or receiving cash benefits and not a disqualified individual; and

(b) Court or administratively ordered current or back support for legal dependents.

(3) Spousal maintenance payments made to meet the needs of individuals not living in the home.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0120, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0130 Allocating the income of a non-applying spouse to a caretaker relative. This section applies to TANF/SFA and RCA programs.

(1) The community income of the nonapplying spouse and applying spouse is combined. See WAC 388-450-0005 to determine what income is available as community income.

(2) Subtract a one person payment standard as specified in WAC 388-478-0020.

(3) The remainder is allocated to the caretaker relative.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0130, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0135 Allocating income of an ineligible spouse to a GA-U client. (1) This section applies to the GA-U program.

(2) When a GA-U client is married and lives with the nonapplying spouse, the following income is available to the client:

(a) The remainder of the client's wages, retirement benefits or separate property after reducing the income by:

(i) The GA-U work incentive and work expense deduction, as specified in WAC 388-450-0175; and

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(b) The remainder of the nonapplying spouse's wages, retirement benefits and separate property after reducing the income by:

(i) The GA-U work expense deduction;

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents; and

(iii) The payment standard amount as specified under WAC 388-478-0030 which includes ineligible assistance unit members.

(c) One-half of all other community income, as provided in WAC 388-450-0005.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0135, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0140 How does the income of an ineligible assistance unit member affect my eligibility and benefits for Basic Food? The department decides who must be in your assistance unit (AU) under WAC 388-408-0035. If an AU member is ineligible for Basic Food under WAC 388-408-0035, this affects your AU's eligibility and benefits as follows:

(1) We do not count the ineligible member(s) to determine your AU size for the gross monthly income limit, net

monthly income limit, or maximum allotment under WAC 388-478-0060.

(2) If an AU member is ineligible because they are disqualified for an intentional program violation (IPV), they failed to meet work requirements under chapter 388-444 WAC, or they are ineligible fleeing felons under WAC 388-442-0010:

(a) We count all of the ineligible member's gross income as a part of your AU's income; and

(b) We count all of the ineligible member's allowable expenses as part of your AU's expenses.

(3) If an AU member is an ineligible ABAWD under WAC 388-444-0030, is ineligible due to their alien status, failed to sign the application to state their citizenship or alien status, or refused to get or provide us a Social Security number:

(a) We allow the twenty percent earned income disregard for the ineligible member's earned income;

(b) We prorate the remaining income of the ineligible member among all the AU members by excluding the ineligible member's share and counting the remainder to the eligible members; and

(c) We divide the ineligible member's allowable expenses evenly among all members of the AU when the ineligible member has income.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-14-040, § 388-450-0140, filed 6/29/04, effective 7/30/04. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 02-06-089, § 388-450-0140, filed 3/1/02, effective 3/26/02; 01-21-060, § 388-450-0140, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0140, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0140, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0145 Income of a person who is not a member of a food assistance unit. (1) A cash payment made to a food assistance unit from a person who is not a member of the assistance unit is counted as unearned income.

(2) The following types of income are not available to the assistance unit:

(a) The nonmember's income; and

(b) Payments made by a nonmember to a third party for the benefit of the assistance unit.

(3) When the nonmember's earnings are not clearly separate from the earnings of food assistance unit members, the earnings are:

(a) Divided equally among the working persons, including the nonmember; and

(b) The portion of the nonmember is not counted.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0145, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0155 How does being a sponsored immigrant affect my eligibility for cash, medical, and food assistance programs? (1) The following definitions apply to this section:

(a) **"INS"** means the United States Immigration and Naturalization Service.

(b) **"Sponsor"** means a person who agreed to meet the needs of a sponsored immigrant by signing an INS Affidavit of Support form I-864 or I-864A. This includes a sponsor's spouse if the spouse signed the affidavit of support.

(c) **"Sponsored immigrant"** means a person who must have a sponsor under the Immigration and Nationality Act (INA) to be admitted into the United States for residence.

(d) **"Deeming"** means the department counts a part of the sponsor's income and resources as available to the sponsored immigrant.

(e) **"Exempt"** means you meet one of the conditions of WAC 388-450-0156. If you are exempt:

(i) You do not need to provide us information about your sponsor's income and resources; and

(ii) We do not deem your sponsor's income or resources to you.

(2) If you are a sponsored immigrant and you are **not** exempt, you must do the following to be eligible for benefits even if your sponsor is not supporting you:

(a) Give us the name and address of your sponsor;

(b) Get your sponsor to provide us the information we need about their income and resources; and

(c) Give us the information and proof we need to decide:

(i) If we must deem income to your assistance unit (AU); and

(ii) The amount of income we deem to your AU.

(3) If you are not eligible for benefits because we do not have the information we need about your sponsor, we do not delay benefits to the unsponsored people in your AU who are eligible for benefits. We do not count your needs when we decide if your AU is eligible for benefits, but we count:

(a) All earned or unearned income you have that is not excluded under WAC 388-450-0015; and

(b) All deductions you would be eligible for under chapter 388-450 WAC.

(4) If you refuse to provide us with the information we need about your sponsor, the other adult members in your AU must provide the information. If the same person sponsored everyone in your AU, your AU is not eligible for benefits until someone in your AU provides us the information we need.

(5) If you are an ineligible member of your AU, but you must be the AU under chapter 388-408 WAC, we do not deem your sponsor's income or resources to the AU.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-450-0155, filed 10/9/01, effective 11/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0155, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0156 When am I exempt from deeming? (1) If you meet any of the following conditions, you are **permanently** exempt from deeming and we do not count your sponsor's income or resources against your benefits:

(a) The Immigration and Nationality Act (INA) does not require you to have a sponsor. Immigrants who are not required to have a sponsor include those with the following status with Immigration and Naturalization Service (INS):

(i) Refugee;

(ii) Parolee;

(iii) Asylee;

(iv) Cuban entrant; or

(v) Haitian entrant.

(b) You were sponsored by an organization or group as opposed to an individual;

(2007 Ed.)

(c) You do not meet the alien status requirements to be eligible for benefits under chapter 388-424 WAC;

(d) You have worked or can get credit for forty qualifying quarters of work under Title II of the Social Security Act. We do not count a quarter of work toward this requirement if the person working received TANF, food stamps, Basic Food, SSI, CHIP, or nonemergency Medicaid benefits. We count a quarter of work by the following people toward your forty qualifying quarters:

(i) Yourself;

(ii) Each of your parents for the time they worked before you turned eighteen years old (including the time they worked before you were born); and

(iii) Your spouse if you are still married or your spouse is deceased.

(e) You become a United States (U.S.) Citizen;

(f) Your sponsor is dead; or

(g) If INS or a court decides that you, your child, or your parent was a victim of domestic violence from your sponsor and:

(i) You no longer live with your sponsor; and

(ii) Leaving your sponsor caused your need for benefits.

(2) You are exempt from the deeming process while you are in the same AU as your sponsor;

(3) For Basic Food, you are exempt from deeming while you are under age eighteen.

(4) For state family assistance, general assistance, state-funded Basic Food benefits, and state-funded medical assistance for legal immigrants you are exempt from the deeming process if:

(a) Your sponsor signed the affidavit of support more than five years ago;

(b) Your sponsor becomes permanently incapacitated; or

(c) You are a qualified alien according to WAC 388-424-0001 and you:

(i) Are on active duty with the U.S. armed forces or you are the spouse or unmarried dependent child of someone on active duty;

(ii) Are an honorably-discharged veteran of the U.S. armed forces or you are the spouse or unmarried dependent child of a honorably-discharged veteran;

(iii) Were employed by an agency of the U.S. government or served in the armed forces of an allied country during a military conflict between the U.S. and a military opponent; or

(iv) Are a victim of domestic violence and you have petitioned for legal status under the Violence Against Women Act.

(5) If you, your child, or your parent was a victim of domestic violence, you are exempt from the deeming process for twelve months if:

(a) You no longer live with the person who committed the violence; and

(b) Leaving this person caused your need for benefits.

(6) If your AU has income at or below one hundred thirty percent of the Federal Poverty Level (FPL), you are exempt from the deeming process for twelve months. For this rule, we count the following as income to your AU:

(a) Earned and unearned income your AU receives from any source; and

(b) Any noncash items of value such as free rent, commodities, goods, or services you receive from an individual or organization.

(7) If you are exempt from deeming because your AU does not have income over one hundred thirty percent of the FPL, we give the United States Attorney General the following information:

(a) The names of the sponsored people in your AU;

(b) That you are exempt from deeming due to your income; and

(c) Your sponsor's name.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-450-0156, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-030, § 388-450-0156, filed 2/10/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-450-0156, filed 10/9/01, effective 11/1/01.]

WAC 388-450-0160 How does the department decide how much of my sponsor's income to count against my benefits? (1) We must count some of your sponsor's income as unearned income to your assistance unit (AU) if:

(a) Your sponsor signed the INS affidavit of support form I-864 or I-864A; and

(b) You are not exempt from the deeming process under WAC 388-450-0156.

(2) We take the following steps to decide the monthly amount of your sponsor's income we deem as your income and count against your benefits:

(a) We start with your sponsor's earned and unearned income that is not excluded under WAC 388-450-0015;

(b) If your sponsor's spouse signed the affidavit of support, we add all of the spouse's earned and unearned income that is not excluded under WAC 388-450-0015;

(c) We subtract twenty percent of the above amount that is earned income under WAC 388-450-0030;

(d) For cash and medical assistance, we subtract the need standard under WAC 388-478-0015. We count the following people who live in your sponsor's home as a part of your sponsor's AU to decide the need standard:

(i) Your sponsor;

(ii) Your sponsor's spouse; and

(iii) Everyone else in their home that they could claim as a dependent for federal income tax purposes.

(e) For food assistance, we subtract the maximum gross monthly income under WAC 388-478-0060. We count the following people that live in your sponsor's home as a part of your sponsor's AU to decide the maximum gross monthly income:

(i) Your sponsor;

(ii) Your sponsor's spouse; and

(iii) Everyone else in their home that they could claim as a dependent for federal income tax purposes.

(f) If you can show that your sponsor has sponsored other people as well, we divide the result by the total number of people who they sponsored.

(3) After we have decided how much income to deem to you, we count the greater amount of the following against your benefits:

(a) The amount of income calculated from deeming; or

(b) The amount of money your sponsor actually gives you for your needs.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-450-0160, filed 10/9/01, effective 11/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0160, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0160, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0162 The department uses countable income to determine if you are eligible and the amount of your cash and food assistance benefits. The department uses countable income to determine if the client is eligible and the amount of the cash and food assistance benefits.

(1) Countable income is all income that remains after we subtract the following:

(a) Excluded or disregarded income under WAC 388-450-0015;

(b) Deductions or earned income incentives under WAC 388-450-0170 through 388-450-0200;

(c) Allocations to someone outside of the assistance unit under WAC 388-450-0095 through 388-450-0160.

(2) Countable income includes all income that must be deemed or allocated from financially responsible persons who are not members of your assistance unit.

(3) For cash assistance:

(a) We compare your countable income to the payment standard in WAC 388-478-0020 and 388-478-0030.

(b) You are not eligible for benefits when your assistance unit's countable income is equal to or greater than the payment standard plus any authorized additional requirements.

(c) Your benefit level is the payment standard and authorized additional requirements minus your assistance unit's countable income.

(4) For food assistance:

(a) We compare your countable income to the monthly net income standard specified in WAC 388-478-0060.

(b) You are not eligible for benefits when your assistance unit's income is equal to or greater than the monthly net income standard.

(c) Your benefit level is the maximum allotment in WAC 388-478-0060 minus thirty percent of your countable income.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0162, filed 11/19/99, effective 1/1/00.]

WAC 388-450-0165 Gross earned income limit for TANF/SFA. When applying the gross earned income limit as required under WAC 388-478-0035:

(1) "Family" means:

(a) All adults and children who would otherwise be included in the assistance unit under WAC 388-408-0015, but who do not meet TANF/SFA eligibility requirements;

(b) The unborn child of a woman in her third trimester of pregnancy; and

(c) The husband of a woman in her third trimester of pregnancy, when residing together.

(2) "Gross earned income" does not include excluded income, as provided in WAC 388-450-0015.

(3) The following amounts are disregarded when determining a family's gross earned income:

(a) Court or administratively ordered current or back support paid to meet the needs of legal dependents, up to:

- (i) The amount actually paid; or
- (ii) A one-person need standard for each legal dependent.

(b) Authorized ongoing additional requirement payment as defined in chapter 388-473 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-010, § 388-450-0165, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0165, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0170 TANF/SFA earned income incentive and deduction. This section applies to TANF/SFA, RCA, and medical programs for children, pregnant women, and families except as specified under WAC 388-450-0210.

(1) If a client works, the department only counts some of the income to determine eligibility and benefit level.

(2) We only count fifty percent of your monthly gross earned income. We do this to encourage you to work.

(3) If you pay for care before we approve your benefits, we subtract the amount you pay for those dependent children or incapacitated adults who get cash assistance with you.

(a) The amount we subtract is:

(i) Prorated according to the date you are eligible for benefits;

(ii) Cannot be more than your gross monthly income; and

(iii) Cannot exceed the following for each dependent child or incapacitated adult:

Dependent Care Maximum Deductions

Hours Worked Per Month	Child Two Years of Age & Under	Child Over Two Years of Age or Incapacitated Adult
0 - 40	\$ 50.00	\$ 43.75
41 - 80	\$ 100.00	\$ 87.50
81 - 120	\$ 150.00	\$ 131.25
121 or More	\$ 200.00	\$ 175.00

(b) In order to get this deduction:

(i) The person providing the care must be someone other than the parent or stepparent of the child or incapacitated adult; and

(ii) You must verify the expense.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-03-051, § 388-450-0170, filed 1/15/04, effective 2/15/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-030, § 388-450-0170, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0170, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0175 Does the department offer an income deduction as an incentive for GA-U clients to work? The department gives special deductions to people who receive income from work while receiving General Assistance-Unemployable (GA-U). We allow the following deductions before using your earnings to determine your eligibility and monthly benefits:

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(1) We subtract eighty-five dollars plus one half of the remainder of your monthly gross earned income as an incentive to employment.

(2) We also subtract an amount equal to twenty percent of your gross earned income to allow for work expenses.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090, 06-07-078, § 388-450-0175, filed 3/13/06, effective 5/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-450-0175, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0185 Does the department count all of my income to determine my eligibility and benefits for Basic Food? We subtract the following amounts from your assistance unit's (AU's) countable income before we determine your Basic Food benefit amount:

(1) A standard deduction based on the number of people in your AU under WAC 388-408-0035:

Eligible and ineligible

AU members	Standard deduction
1	\$134
2	\$134
3	\$134
4	\$139
5	\$162
6 or more	\$186

(2) Twenty percent of your AU's gross earned income (earned income deduction);

(3) Your AU's expected monthly dependent care expense as described below:

(a) The dependent care must be needed for AU member to:

(i) Keep work, look for work, or accept work;

(ii) Attend training or education to prepare for employment; or

(iii) Meet employment and training requirements under chapter 388-444 WAC.

(b) We subtract allowable dependent care expenses that are payable to someone outside of your AU:

(i) Up to two hundred dollars for each dependent under age two; and

(ii) Up to one hundred seventy-five dollars for each dependent age two or older.

(4) Medical expenses over thirty-five dollars a month owed or anticipated by an elderly or disabled person in your AU as allowed under WAC 388-450-0200.

(5) Legally obligated current or back child support paid to someone outside of your AU:

(a) For a person who is not in your AU; or

(b) For a person who is in your AU to cover a period of time when they were not living with you.

(6) A portion of your shelter costs as described in WAC 388-450-0190.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9, 06-21-012, § 388-450-0185, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090, 05-21-101, § 388-450-0185, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-23-025, § 388-450-0185, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 03-21-030, § 388-450-0185, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and H.R. 2646 Farm Security

and Rural Investment Act of 2002. 02-22-044, § 388-450-0185, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-450-0185, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0185, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0190 How does the department figure my shelter cost income deduction for Basic Food? The department calculates your shelter cost income deduction as follows:

(1) First, we add up the amounts your assistance unit (AU) must pay each month for shelter. We do not count any overdue amounts, late fees, penalties or mortgage payments you make ahead of time as an allowable cost. We count the following expenses as an allowable shelter cost in the month the expense is due:

- (a) Monthly rent, lease, and mortgage payments;
- (b) Property taxes;
- (c) Homeowner's association or condo fees;
- (d) Homeowner's insurance for the building only;
- (e) Utility allowance your AU is eligible for under WAC 388-450-0195;
- (f) Out-of-pocket repairs for the home if it was substantially damaged or destroyed due to a natural disaster such as a fire or flood;

(g) Expense of a temporarily unoccupied home because of employment, training away from the home, illness, or abandonment caused by a natural disaster or casualty loss if your:

- (i) AU intends to return to the home;
- (ii) AU has current occupants who are not claiming the shelter costs for Basic Food purposes; and
- (iii) AU's home is not being leased or rented during your AU's absence.

(2) Second, we subtract all deductions your AU is eligible for under WAC 388-450-0185 (1) through (5) from your AU's gross income. The result is your AU's net income.

(3) Finally, we subtract one-half of your AU's net income from your AU's total shelter costs. The result is your excess shelter costs. Your AU's shelter cost deduction is the excess shelter costs:

- (a) Up to a maximum of four hundred seventeen dollars if no one in your AU is elderly or disabled; or
- (b) The entire amount if an eligible person in your AU is elderly or disabled, even if the amount is over four hundred seventeen dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-450-0190, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-450-0190, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-23-025, § 388-450-0190, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-07-138, § 388-450-0190, filed 3/22/04, effective 5/1/04; 03-21-030, § 388-450-0190, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-22-045, § 388-450-0190, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-450-0190, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 01-06-030, § 388-450-0190, filed 3/2/01, effective 4/2/01; 99-16-024, § 388-450-0190, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0190, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0195 Utility allowances for Basic Food programs. (1) For Basic Food, "utilities" include the following:

- (a) Heating or cooling fuel;
- (b) Electricity or gas;
- (c) Water or sewer;
- (d) Well or septic tank installation/maintenance;
- (e) Garbage/trash collection; and
- (f) Telephone service.

(2) The department uses the amounts below if you have utility costs separate from your rent or mortgage payment. We add your utility allowance to your rent or mortgage payment to determine your total shelter costs. We use total shelter costs to determine your Basic Food benefits.

(a) If you have heating or cooling costs, you get a standard utility allowance (SUA) that depends on your assistance unit's size.

Assistance Unit (AU) Size	Utility Allowance
1	\$298
2	\$307
3	\$316
4	\$325
5	\$334
6 or more	\$343

(b) If your AU does not qualify for the SUA and you have any two utility costs listed above, you get a limited utility allowance (LUA) of two hundred thirty-eight dollars.

(c) If your AU has only telephone costs and no other utility costs, you get a telephone utility allowance (TUA) of thirty-eight dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. 273.9 (d)(6)(iii)(b). 06-21-011, § 388-450-0195, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 06-10-056, § 388-450-0195, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. § 273.9. 05-19-062, § 388-450-0195, filed 9/16/05, effective 10/17/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-09-087, § 388-450-0195, filed 4/19/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-23-025, § 388-450-0195, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-450-0195, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-22-045, § 388-450-0195, filed 10/30/02, effective 12/1/02. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-450-0195, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.510. 00-22-065, § 388-450-0195, filed 10/27/00, effective 11/1/00. Statutory Authority: RCW 74.04.510 [74.04.510]. 99-24-052, § 388-450-0195, filed 11/29/99, effective 12/1/99. Statutory Authority: RCW 74.04.510. 99-09-055, § 388-450-0195, filed 4/19/99, effective 5/20/99. Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (d)(6). 99-01-069, § 388-450-0195, filed 12/14/98, effective 1/14/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0195, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0200 Will the medical expenses of elderly persons or individuals with disabilities in my assistance unit be used as an income deduction for Basic Food? (1) If your basic food assistance unit (AU) includes an elderly person or individual with a disability as defined in WAC 388-400-0040, your AU may be eligible for an income deduction for that person's out-of-pocket medical expenses, and certain expenses allowable for Medicare prescription drug card holders certified prior to June 1, 2006. We allow

the deduction for medical expenses over thirty-five dollars each month.

(2) You can use an out-of-pocket medical expense toward this deduction if the expense covers services, supplies, medication, or other medically needed items prescribed by a state-licensed practitioner or other state-certified, qualified, health professional. Examples of expenses you can use for this deduction include those for:

- (a) Medical, psychiatric, naturopathic physician, dental, or chiropractic care;
- (b) Prescribed alternative therapy such as massage or acupuncture;
- (c) Prescription drugs;
- (d) Over the counter drugs;
- (e) Eye glasses;
- (f) Medical supplies other than special diets;
- (g) Medical equipment or medically needed changes to your home;
- (h) Shipping and handling charges for an allowable medical item. This includes shipping and handling charges for items purchased through mail order or the internet;
- (i) Long distance calls to a medical provider;
- (j) Hospital and outpatient treatment including:
 - (i) Nursing care; or
 - (ii) Nursing home care including payments made for a person who was an assistance unit member at the time of placement.
- (k) Health insurance premiums paid by the person including:
 - (i) Medicare premiums; and
 - (ii) Insurance deductibles and co-payments.
- (l) Out-of-pocket expenses used to meet a spenddown as defined in WAC 388-519-0010. We do not allow your entire spenddown obligation as a deduction. We allow the expense as a deduction as it is estimated to occur or as the expense becomes due;
- (m) Dentures, hearing aids, and prosthetics;
- (n) Cost to obtain and care for a seeing eye, hearing, or other specially trained service animal. This includes the cost of food and veterinarian bills. We do not allow the expense of food for a service animal as a deduction if you receive ongoing additional requirements under WAC 388-473-0040 to pay for this need;
- (o) Reasonable costs of transportation and lodging to obtain medical treatment or services; and
- (p) Attendant care necessary due to age, infirmity, or illness. If your AU provides most of the attendant's meals, we allow an additional deduction equal to a one-person allotment.

(3) There are two types of deductions for out-of-pocket expenses:

- (a) One-time expenses are expenses that cannot be estimated to occur on a regular basis. You can choose to have us:
 - (i) Allow the one-time expense as a deduction when it is billed or due;
 - (ii) Average the expense through the remainder of your certification period; or
 - (iii) If your AU has a twenty-four-month certification period, you can choose to use the expense as a one-time deduction, average the expense for the first twelve months of

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your certification period, or average it for the remainder of our certification period.

(b) Recurring expenses are expenses that happen on a regular basis. We estimate your monthly expenses for the certification period.

(4) If the elderly person or individual with a disability in your AU has an active Medicare prescription drug card prior to June 1, 2006:

- (a) Allow any out-of-pocket expenses that meet the criteria in subsections (2) and (3) above;
- (b) Add a standard twenty-three dollars to these expenses; and
- (c) Allow an additional fifty dollar monthly deduction to account for the 2004 and 2005 prescription subsidies:
 - (i) For twenty-four consecutive months if the client applied before January 2005; or
 - (ii) For the average number of months resulting from dividing the total subsidy amount by fifty dollars if the client applies in January 2005 or later.
- (d) Allow the deductions in (b) and (c) of this subsection even if the AU has no out-of-pocket expenses.
- (5) AU members with an active Medicare prescription drug card prior to June 1, 2006 have the option of using their verified pre-card out-of-pocket expenses when this amount is greater than using the standards in subsection (4).
- (6) We do not allow a medical expense as an income deduction if:

- (a) The expense was paid before you applied for benefits or in a previous certification period;
- (b) The expense was paid or will be paid by someone else;
- (c) The expense was paid or will be paid by the department or another agency;
- (d) The expense is covered by medical insurance;
- (e) We previously allowed the expense, and you did not pay it. We do not allow the expense again even if it is part of a repayment agreement;
- (f) You included the expense in a repayment agreement after failing to meet a previous agreement for the same expense; or
- (g) You claim the expense after you have been denied for presumptive SSI; and you are not considered disabled by any other criteria.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 06-04-070, § 388-450-0200, filed 1/30/06, effective 4/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, United States Food and Nutrition Service Administrative Notices 04-39 and 04-45, and 2004 c 175. 05-05-025, § 388-450-0200, filed 2/8/05, effective 3/11/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-057, 74.04.510. 04-02-025, § 388-450-0200, filed 12/30/03, effective 2/1/04. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-450-0200, filed 11/16/99, effective 1/1/00; 99-16-024, § 388-450-0200, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0200, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0210 Countable income for medical programs. (1) For purposes of medical program eligibility, a client's countable income is income which remains when:

- (a) The income cannot be specifically excluded; and
- (b) All appropriate deductions and disregards allowed by a specific program, have been applied.

(2) A client's countable income cannot exceed the income standard for the specific medical programs described in WAC 388-478-0065, 388-478-0070, 388-478-0075, 388-478-0080, or 388-513-1305, 388-513-1315, or 388-513-1395 unless the program allows for those limits to be exceeded.

(3) Unless modified by subsection (4) of this section, the TANF/SFA income rules, as described in this chapter, are used to determine a client's countable income for the following programs:

(a) Family medical program as described in WAC 388-505-0220;

(b) Medical extensions as described in chapter 388-523 WAC;

(c) Pregnant women's program as described in WAC 388-462-0015;

(d) Children's medical program as described in WAC 388-505-0210;

(e) Children's health program as described in WAC 388-505-0210; and

(f) Psychiatric indigent inpatient (PII) program as described in WAC 388-865-0217.

(4) Exceptions to the TANF/SFA cash assistance methodology apply as follows:

(a) The financial responsibility of relatives when a client is applying for medical for families, children, pregnant women or for the psychiatric indigent inpatient program is specified in WAC 388-408-0055;

(b) Actual work-related child and dependent care expenses, which are the client's responsibility, are income deductions (the limits on this deduction in WAC 388-450-0170 (3) and (4) do not apply);

(c) Court or administratively ordered current or back support paid to meet the needs of legal dependents, are income deductions;

(d) Only income actually contributed to an alien client from the alien's sponsor is countable unless the sponsor signed the affidavit of support I-864 or I-864A. See subsection (5) of this section;

(e) TANF/SFA gross earned income limits as described in WAC 388-450-0165 do not apply;

(f) The fifty percent earned income deduction is not used to calculate countable income for CN programs with income levels based upon the federal poverty level (FPL). These programs are listed in subsections (3)(c), (d) and (e) of this section. The only work related income deductions for these programs are:

(i) Ninety dollars; and

(ii) Actual work-related child and dependent care expenses, as described in (b) of this subsection; and

(iii) Child support as described in (c) of this subsection.

(g) When determining medically needy (MN) or MN scope of care coverage for children or pregnant women for the programs described in subsections (3)(c), (d), and (e), the exception described in subsection (4)(f) is not used as the MN income standards are not based on the FPL;

(h) A nonrecurring lump sum payment is considered as income in the month the client receives payment, and a resource if the client retains the payment after the month of receipt;

(i) Diversion cash assistance (DCA), is not countable income;

(j) Effective April 1, 2002, the department will disregard an increase in earned income when:

(i) A family is receiving benefits under the family medical program; and

(ii) The increase occurs during the second or third month of eligibility. The disregard stops the last day of the third month of eligibility for a family medical program.

(5) When an alien's sponsor has signed the affidavit of support I-864 or I-864A, the sponsor's income and resources are counted as described in WAC 388-450-0155, 388-450-0156, 388-450-0160, and 388-470-0060.

(6) Except when this state has adopted more liberal rules, SSI income rules are used to determine a client's countable income for the following programs:

(a) SSI-related CN or MN; and

(b) Medicare savings programs. Refer to chapter 388-475 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-450-0210, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-450-0210, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090, 74.08A.100, and Title XIX State Plan amendment 00-008. 02-03-009, § 388-450-0210, filed 1/4/02, effective 2/4/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580, 388-505-0590 and 388-519-1910.]

WAC 388-450-0215 How does the department estimate my assistance unit's income to determine my eligibility and benefits? The department uses prospective budgeting to determine if your assistance unit (AU) is eligible and to calculate your benefits.

(1) We determine if your AU is eligible for benefits and calculate your monthly benefits based on an estimate of your AU's income and expenses for that month. This is known as prospective budgeting.

(2) We base this estimate on what can be reasonably expected based on your current, past and future circumstances.

(3) We determine if our estimate is reasonable by looking at documents, statements, and other verification.

(4) We use two methods to estimate your AU's income:

(a) **Anticipating monthly income:** We estimate the actual amount of income you expect to receive in the month; and

(b) **Averaging income:** We estimate your income based on adding the total income you expect to receive for a period of time and dividing by the number of months in the time period.

(5) When we use the anticipating monthly method, we estimate the actual amount of income your AU expects to receive in the month. Your benefits will vary based on the income that is expected for that month.

(6) In general, you can choose which method we use to estimate your income. However, we **must** use the anticipating monthly method:

(a) For the month you apply for benefits, any income your AU receives in that month. If we do not have to use the anticipating monthly method for any other reason, we may average this income source for the remaining months of your certification period.

(b) For all your AU's income in the following circumstances:

(i) If you receive SSI-related medical benefits under chapter 388-475 WAC; or

(ii) If you are a destitute migrant or destitute seasonal farmworker under WAC 388-406-0021, we must use the anticipating monthly method for the month your AU applied for benefits.

(c) For the income of any member of your AU who has income allocated to someone receiving SSI-related medical benefits under chapter 388-475 WAC;

(d) For the following sources of income to your AU:

(i) SSI; or

(ii) Social Security benefits.

(7) When we use the averaging method, we take the expected changes in your AU's income into consideration so your benefits do not change as much:

(a) If you receive your income weekly or every other week, we convert this income to a monthly amount. If you are paid:

(i) Weekly, we multiply your expected pay by 4.3; or

(ii) Every other week, we multiply your expected pay by 2.15.

(b) In most cases if you receive your income other than weekly or every other week, we estimate your expected income over the certification period by:

(i) Adding the total income in a representative time period;

(ii) Dividing by the number of pay periods in the time frame; and

(iii) Determining the monthly average from this amount.

(c) If you receive your yearly income over less than a year because you are self employed or work under a contract, we average this income over the year unless you are:

(i) Paid on an hourly or piecework basis; or

(ii) A migrant or seasonal farmworker under WAC 388-406-0021.

(8) If you report a change in your AU's income, and we expect the change to last for at least a month beyond the month you reported the change, we recalculate your AU's income based on this change.

(9) If your actual income is different than the income we estimated, we do not make you repay an overpayment under chapter 388-410 WAC or increase your benefits unless:

(a) You provided incomplete or false information; or

(b) We made an error in calculating your benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-16-109, § 388-450-0215, filed 8/2/05, effective 10/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-06-052, § 388-450-0215, filed 3/1/04, effective 4/1/04; 03-21-029, § 388-450-0215, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-083, § 388-450-0215, filed 11/16/99, effective 1/1/00; 99-16-024, § 388-450-0215, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0215, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

WAC 388-450-0225 How are my assistance unit's benefits calculated for the first month I am eligible for cash assistance? (1) To calculate your AU's cash benefit for your first month's benefits, we compare your AU's countable

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income to the payment standard as described in WAC 388-450-0162.

(2) Even if your AU has countable income over the payment standard, you may still receive additional requirements.

(3) If your countable income is less than the payment standard, we prorate your grant amount based on the date you are eligible.

(4) We do not prorate any approved additional requirements.

(5) We prorate your grant by:

(a) Dividing your AU's grant amount by the number of days in the first month of eligibility; and

(b) Multiplying the result in (5)(a) of this section by the number of days from the date of eligibility to the last day of the month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-21-029, § 388-450-0225, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0225, filed 11/19/99, effective 1/1/00; 99-16-024, § 388-450-0225, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0225, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0230 What income does the department count in the month I apply for Basic Food when my assistance unit is destitute? (1) If your assistance unit (AU) meets the requirements of a destitute migrant or seasonal farmworker under WAC 388-406-0021, we may exclude some of your income in the month you apply for Basic Food.

(2) In the month of application, we:

(a) Count only income your AU received between the first of the month and the date you apply for Basic Food; and

(b) Disregard any income from a new source that you expect to receive after the date you apply for Basic Food.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-21-029, § 388-450-0230, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, and 7 C.F.R. 273.10. 02-17-028, § 388-450-0230, filed 8/12/02, effective 10/1/02. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-450-0230, filed 11/19/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0230, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0245 When are my benefits suspended? (1) For TANF/SFA, RCA, GA and Basic Food, "suspend" means the department stops your benefits for one month.

(2) We suspend your AU's benefits for one month when your expected total countable income under WAC 388-450-0162:

(a) Is more than the dollar limit for your AU; and

(b) If over these limits for only that one month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-21-029, § 388-450-0245, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.04.510. 00-01-012, § 388-450-0245, filed 12/3/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0245, filed 7/31/98, effective 9/1/98.]

Chapter 388-450A WAC INCOME—GARNISHMENT

WAC

388-450A-0010 Can my subsidized income be garnished?

[Title 388 WAC—p. 851]

WAC 388-450A-0010 Can my subsidized income be garnished? (1) Your subsidized income cannot be garnished. Subsidized income is income that is partly or entirely paid from temporary assistance for needy families (TANF) funds. Examples of subsidized income are community jobs and WorkFirst work study.

(2) For how your subsidized income affects your benefits, see WAC 388-450-0035 or 388-450-0050.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.280. 05-13-029, § 388-450A-0010, filed 6/3/05, effective 7/4/05.]

Chapter 388-452 WAC INTERVIEW REQUIREMENTS

WAC

388-452-0005	Do I have to be interviewed in order to get benefits?
388-452-0010	What does the family violence option mean for TANF/SFA recipients?

WAC 388-452-0005 Do I have to be interviewed in order to get benefits? (1) Unless you are applying for medical only, you or your authorized representative must have an interview with the department:

(a) At initial certification; and
(b) At least once every twelve months if your assistance unit (AU) is certified for twelve months or less.

(2) You do not have to attend an interview if you are applying for or recertifying medical benefits only. If we deny your application for cash or Basic Food because you did not have an interview, we continue to process your request for medical benefits.

(3) You will have just one interview even if you are applying for or are having a review for benefits from more than one program.

(4) If we do not interview you on the same day that we get your application, we schedule an interview appointment for you. We schedule your appointment the day we get your application or on the next business day if we get your application outside of our scheduled business hours, on a holiday or a weekend.

(5) We schedule an interview so your AU has at least ten days after the interview to provide needed verification:

(a) Before the end of the thirty-day processing period for applications; or

(b) Before your certification period ends for eligibility reviews or recertifications.

(6) If you miss your first interview and ask for another interview within thirty days of the date you applied for benefits, we schedule a second interview for you.

(7) If you must have an interview for benefits, you or someone who can give us the information we need about your AU must participate in the interview. You may bring any person you choose to your interview.

(8) You may choose someone to take your place in your interview:

(a) For cash assistance if you cannot come to the local office for us to decide if you are eligible for benefits; or

(b) For Basic Food if the person is your authorized representative as described in WAC 388-460-0005.

(9) We usually have interviews at the local office. You can have a scheduled telephone interview if there is **any rea-**

son you cannot attend an interview at the local office. Examples of reasons you may be unable to attend an interview include:

(a) Your work or training schedule make it inconvenient for you to attend an in-office interview during regular business hours;

(b) You are unable to take time off of work to attend an in-office interview, because you would not get paid for this time or you fear you could lose your job;

(c) Someone in your AU is ill, or you have to stay home to care for an AU member;

(d) You are having transportation problems;

(e) You can't safely get to the office because of severe weather;

(f) You live in a remote area and can't easily get to the local office;

(g) All the people in your AU are elderly, mentally disabled, or physically disabled;

(h) Someone in your AU is affected by family violence such as physical or mental abuse, harassment, or stalking by the abuser; or

(i) You have **any other** situation that makes it difficult for you to come into the office for an interview.

(10) If you currently get benefits from the department and you are completing an eligibility review or recertification for ongoing benefits under chapter 388-434 WAC, you can have a scheduled phone interview even if you do not meet the requirements for a phone interview listed above.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 04-10-102, § 388-452-0005, filed 5/4/04, effective 7/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 7 C.F.R. 273.2(e). 03-18-113, § 388-452-0005, filed 9/2/03, effective 11/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.-090. 02-14-023, § 388-452-0005, filed 6/21/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 01-14-060, § 388-452-0005, filed 6/29/01, effective 8/1/01; 00-22-087, § 388-452-0005, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.04.-050, 74.04.057, 74.08.090, 74.09.530 and 42 C.F.R. 435.907. 99-11-075, § 388-452-0005, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-452-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0420.]

WAC 388-452-0010 What does the family violence option mean for TANF/SFA recipients? The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), gave every state the option to have procedures in place to address issues of family violence for recipients receiving temporary assistance for needy families (TANF) or state family assistance (SFA).

(1) For TANF/SFA, it is family violence when a recipient, or family member or household member has been subjected by another family member or household member as defined in RCW 26.50.010(2) to one of the following:

(a) Physical acts that resulted in, or threatened to result in, physical injury;

(b) Sexual abuse;

(c) Sexual activity involving a dependent child;

(d) Being forced as the caretaker relative or a dependent child to engage in nonconsensual sexual acts or activities;

(e) Threats of or attempts at, physical sexual abuse;

(f) Mental abuse;

(g) Neglect or deprivation of medical care; or

(h) Stalking.

(2) Under the family violence option DSHS must:

(a) Screen and identify TANF/SFA recipients for a history of family violence;

(b) Notify TANF/SFA recipients about the family violence option both verbally and in writing;

(c) Maintain confidentiality as stated in RCW 74.04.060;

(d) Offer referral to social services or other resources for recipients who meet the criteria in subsection (1) of this section;

(e) Waive WorkFirst requirements in cases where the requirements would make it more difficult to escape family violence, unfairly penalize victims of family violence or place victims at further risk. Requirements to be waived may include:

(i) Time limits for TANF/SFA recipients, for as long as necessary (after fifty-two months of receiving TANF/SFA);

(ii) Cooperation with the division of child support.

(f) Develop specialized work activities for instances where participation in regular work activities would place the recipient at further risk of family violence.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.08A.340. 06-03-048, § 388-452-0010, filed 1/10/06, effective 2/10/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-452-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-454 WAC LIVING WITH A RELATIVE

WAC

388-454-0005	Can I get TANF or SFA benefits for the child living with me?
388-454-0006	The department makes background checks on adults who are acting in place of a parent without court-ordered custody.
388-454-0010	Do I have to be related to a child in order to get TANF or SFA for the child?
388-454-0015	Temporary absence from the home.
388-454-0020	Temporary absence to attend school or training.
388-454-0025	The department notifies a child's parent when we approve assistance and the child is living with someone other than their parent.

WAC 388-454-0005 Can I get TANF or SFA benefits for the child living with me? (1) You can get temporary assistance for needy families (TANF) or state family assistance (SFA) for a child you live with if you are responsible for the care and control of the child and you are the child's:

(a) Parent or other relative as defined in WAC 388-454-0010;

(b) Court-ordered guardian or court-ordered custodian; or

(c) Other adult acting *in loco parentis* (in the place of a parent).

(2) If a child lives with more than one relative or parent because the relatives share custody of the child:

(a) We include the child in the assistance unit (AU) of the parent or relative that the child lives with for the majority of the time; or

(b) If relatives share physical custody of the child in equal amounts, we include the child in the AU of the parent or relative that first applies for assistance for the child.

(3) If you or the child in your AU is temporarily absent from the home according to WAC 388-454-0015 and 388-454-0020, you can still get TANF or SFA during the absence.

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[Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-454-0005, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0006 The department makes background checks on adults who are acting in place of a parent without court-ordered custody. (1) We check your background when you ask for TANF or SFA benefits for a child who:

(a) Is not related to you; and

(b) Lives with you but you do not have a court order that gives you legal custody of the child.

(2) A child who is not related to you cannot receive TANF/SFA benefits while living with you until we have completed a background check and the results of the background check meet the criteria in subsection (3) through (5).

(3) A child who is not related to you cannot receive benefits while living with you if:

(a) You have been convicted of a crime listed in WAC 388-06-0170; or

(b) You have been convicted of a crime listed in WAC 388-06-0180 within the last five years.

(4) We review your background when you have been convicted of a crime listed in WAC 388-06-0180 more than five years ago to determine your character, suitability, and competence to receive benefits for a child not related to you. We consider the following factors:

(a) The amount of time that has passed since you were convicted;

(b) The seriousness of the crime that led to the conviction;

(c) The number and types of convictions in your background; and

(d) Your age at the time of the conviction.

(5) When you have a conviction for a crime other than those listed in WAC 388-06-0170 or 388-06-0180 we review your background as described in subsection (4) above.

(6) Expunged or sealed conviction records do not count against you.

[Statutory Authority: RCW 13.32A.080, 13.32A.082, 74.04.050, 74.08.090, 74.12.290, 74.12.450, 74.12.460. 02-01-011, § 388-454-0006, filed 12/7/01, effective 1/7/02.]

WAC 388-454-0010 Do I have to be related to a child in order to get TANF or SFA for the child? To get TANF or SFA, a child must live with a parent, other relative, court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis*.

(1) We consider the following people as parents for TANF and SFA:

(a) The child's natural or adoptive parent; or

(b) A stepparent who is legally obligated to support the child.

(2) We consider a man as a child's natural father if the relationship is:

(a) Made under a judgment or order under RCW 26.26.130 that set the relationship between the parent and child; or

(b) Presumed under the Uniform Parentage Act (chapter 26.26 RCW).

(3) When a child lives with a relative, the relative must be one of the following relationships to the child in order for that child to be eligible for TANF or SFA:

(a) The following blood relatives (including relatives of half blood) or their spouses: Siblings, first cousins (including first cousins once removed), nephews and nieces, and persons of earlier generations (including aunts, uncles and grandparents) as shown by the prefixes of great, great-great, or great-great-great;

(b) A natural parent whose parental rights were terminated by a court order;

(c) A stepparent who no longer has to support the child because:

(i) The child's natural or adoptive parent died; or

(ii) Divorce or dissolution ended the marriage between the stepparent and the child's natural or adoptive parent.

(d) A step sibling even if the marriage between the step sibling's parent and the child's natural or adoptive parent ended by death, divorce or dissolution.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-012, § 388-454-0010, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.04.050, 74.04.057, 2000 2nd sp.s. c 1. 01-03-121, § 388-454-0010, filed 1/22/01, effective 3/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0015 Temporary absence from the home. The child or the caretaker is temporarily absent from the home as long as the caretaker continues to be responsible for the care and control of the child. Temporary absences cannot exceed ninety days except as described below. A caretaker must report a child's absence in excess of ninety days as required under WAC 388-418-0005. Temporary absences include:

(1) Receiving care in a hospital or public or private institution. If the temporary care exceeds ninety days, the assistance payment for the person is reduced to the CPI amount specified under chapter 388-478 WAC.

(2) Receiving care in a substance abuse treatment facility. If the care exceeds ninety days, the assistance payment for the person is reduced to the CPI amount specified under chapter 388-478 WAC.

(3) Visits in which the child or parent will be away for ninety days or less, including visits of a child to a parent who does not reside in the child's home.

(4) Placement of a child in foster care when the child's caretaker is receiving care in a residential treatment facility or for other reasons as determined by the division of children and family services (DCFS). DCFS must determine that the child is expected to return to the home within ninety days of the foster care placement.

(5) Placement of a child in foster care or in the temporary care of a relative, when:

(a) A parent or other relative applies for TANF or SFA on behalf of the child;

(b) DCFS has determined the child will be placed in the care of the applying relative within thirty days following the authorization of assistance; and

(c) No concurrent TANF or SFA payments are made for the child while in the temporary care of a relative.

[Title 388 WAC—p. 854]

(6) The child or caretaker is attending school or training as described in WAC 388-454-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0020 Temporary absence to attend school or training. A child or caretaker is temporarily absent from the home to attend school or training when:

(1) The child's caretaker is attending a department approved vocational training program; or

(2) The child attends school or training away from home, as long as:

(a) The child returns to the family home during a year's period, at least for summer vacation; and

(b) The absence is necessary because:

(i) Isolation of the child's home makes it necessary for the child to be away to attend school;

(ii) The child is enrolled in an Indian boarding school administered through the Bureau of Indian Affairs; or

(iii) Specialized education or training is not available in the child's home community and is recommended by local school authorities.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0025 The department notifies a child's parent when we approve assistance and the child is living with someone other than their parent. (1) The department makes a reasonable effort to contact the parent with whom the child last lived when we find out that a child applying for assistance lives with someone other than the child's parent. We tell the parent:

(a) Within seven days of the date we approve assistance for the child;

(b) How to ask for family reconciliation services from the department; and

(c) How to request the child's address and location as allowed under WAC 388-428-0010.

(2) We do not notify the parent when there is evidence to support a claim that the parent has abused or neglected the child.

[Statutory Authority: RCW 13.32A.080, 13.32A.082, 74.04.050, 74.08.090, 74.12.290, 74.12.450, 74.12.460. 02-01-011, § 388-454-0025, filed 12/7/01, effective 1/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0025, filed 7/31/98, effective 9/1/98.]

Chapter 388-455 WAC LUMP SUM INCOME

WAC

388-455-0005
388-455-0010

How lump sum payments affect benefits.
How the department treats lump sum payments as a resource for cash assistance and TANF/SFA-related medical assistance.

388-455-0015

How the department treats lump sum payments as income for cash assistance and TANF/SFA-related medical assistance.

WAC 388-455-0005 How lump sum payments affect benefits. (1) For the purpose of determining benefits for cash assistance, temporary assistance for needy families (TANF)/state family assistance (SFA)-related medical assistance, and

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food assistance, a lump sum payment is money that the client receives but does not expect to receive on a continuing basis.

(2) For cash assistance and TANF/SFA-related medical assistance:

(a) The department counts payments awarded for wrongful death, personal injury, damage, or loss of property as resources as described in WAC 388-455-0010.

(b) We count all other lump sum payments as income as described in WAC 388-455-0015.

(3) For food assistance, all lump sum payments are counted as resources as described in WAC 388-470-0055.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0005, filed 11/19/99, effective 1/1/00.]

WAC 388-455-0010 How the department treats lump sum payments as a resource for cash assistance and TANF/SFA-related medical assistance. This section applies to cash assistance and TANF/SFA-related medical assistance.

(1) In the month the payment is received, the department does not count any amount of a lump sum payment awarded for:

- (a) Wrongful death;
- (b) Personal injury;
- (c) Damage; or
- (d) Loss of property.

(2) In the month following the month of receipt, we count the entire amount as a resource except for the portion of the payment designated for:

- (a) Repair or replacement of damaged or lost property; or
- (b) Medical bills.

(3) We do not count the portion described in subsection (2) of this section for sixty days following the month the payment is received. At the end of the sixty-day period, we count any amount that remains as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0010, filed 11/19/99, effective 1/1/00.]

WAC 388-455-0015 How the department treats lump sum payments as income for cash assistance and TANF/SFA-related medical assistance. For cash assistance and TANF/SFA-related medical assistance, lump sum payments not awarded for wrongful death, personal injury, damage, or loss of property are counted as income. They are budgeted against the client's benefits according to the effective dates in WAC 388-418-0020. The rules in this section describe what portion is countable and when the department counts it. For rules on how lump sum payments awarded for wrongful death, personal injury, damage, or loss of property affect benefits, see WAC 388-450-0010.

(1) To identify what portion of the lump sum the department will count as income, we take the following steps:

(a) First, we subtract the value of your existing resources from the resource limit as described in WAC 388-470-0005;

(b) Then, we subtract the difference in (1)(a) from the total amount of the lump sum; and

(c) The amount left over is the countable amount of the lump sum.

(2) For cash assistance, the amount of the lump sum that is countable may change if any or all of the lump sum becomes unavailable for reasons beyond your control. See

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WAC 388-450-0005. When the countable amount of the lump sum is:

(a) Less than your payment standard plus additional requirements, we consider it as income in the month it is received.

(b) More than one month's payment standard plus additional requirements but less than two months:

(i) We consider the portion equal to one month's payment standard plus additional requirements as income in the month it is received; and

(ii) We consider the remainder as income the following month.

(c) Equal to or greater than the total of the payment standard plus additional requirements for the month of receipt and the following month, we consider the payment as income for those months.

(3) If you are ineligible or disqualified from receiving cash benefits and you receive a one-time lump sum payment:

(a) We allocate the payment to meet your needs as specified in WAC 388-450-0105; and

(b) The remainder is treated as a lump sum payment available to the eligible assistance unit members according to the rules of this section.

(4) You can avoid having the lump sum budgeted against your benefits if you request termination of your cash assistance the month before you receive the lump sum.

(5) For TANF/SFA-related medical assistance:

(a) We consider lump sum payments as income in the month of receipt.

(b) We consider any money that remains on the first of the next month as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-24-008, § 388-455-0015, filed 11/19/99, effective 1/1/00.]

Chapter 388-458 WAC NOTICES TO CLIENTS

WAC

388-458-0002	The department of social and health services (DSHS) sends you letters to tell you about your case.
388-458-0006	DSHS sends you a letter when you withdraw your application.
388-458-0011	DSHS sends you a denial letter when you can't get benefits.
388-458-0016	DSHS sends you an approval letter when you can get benefits.
388-458-0020	You get a request letter when we need more information.
388-458-0025	We send you a change letter if the amount of benefits you are getting is changing.
388-458-0030	We send you a termination letter when your benefits stop.
388-458-0035	Why do you give me ten days notice before you reduce or stop my benefits?
388-458-0040	What happens if I ask for a fair hearing before the change happens?
388-458-0045	Will I get other kinds of letters?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-458-0001	How the department requests information or action needed when a client applies for assistance or reports a change. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-458-0001, filed 11/10/99, effective 1/1/00.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.
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- 388-458-0005 Adequate notice of denial or withdrawal. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0005, filed 7/31/98, effective 9/1/98.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-458-0010 Adequate notice of adverse action to recipients. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-23-034, § 388-458-0010, filed 11/10/99, effective 1/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2520.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-458-0015 Translation of written communications with limited English proficient clients. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0015, filed 7/31/98, effective 9/1/98.] Repealed by 01-16-087, filed 7/25/01, effective 9/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-458-0002 The department of social and health services (DSHS) sends you letters to tell you about your case. (1) When you apply for or get benefits, we send you letters to tell you about your case.

(2) If you speak another language and cannot read English, we send letters to you in your primary language.

(3) There are seven basic types of letters that we send to you:

- (a) Withdrawals;
- (b) Denials;
- (c) Approvals;
- (d) Requests;
- (e) Changes;
- (f) Terminations; and
- (g) Other.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0002, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0006 DSHS sends you a letter when you withdraw your application. (1) We send you a withdrawal letter when you tell us that you no longer want to apply for benefits.

(2) On this letter, we tell you:

- (a) The date we stopped processing your application; and
- (b) Your right to have your case reviewed or ask for a fair hearing.

(3) We send this letter to you according to the rules in chapter 388-406 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0006, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0011 DSHS sends you a denial letter when you can't get benefits. (1) When we finish processing your application, we send you a denial letter if you cannot get benefits.

(2) On this letter, we tell you:

- (a) Why you cannot get benefits;
- (b) The rules that support our decision;
- (c) The date we stopped processing your application; and
- (d) Your right to have your case reviewed or ask for a fair hearing.

(3) If we are denying your application because you did not give us some information that we needed and we can't figure

out if you are eligible without it, we also tell you on the letter:

- (a) What information you didn't give to us;
- (b) The date we asked for the information and the date it was due;
- (c) That we cannot figure out if you can get benefits without this information; and
- (d) That we will review your eligibility if:
 - (i) For cash and medical, you give us the information within thirty days of the date of the notice;
 - (ii) For food assistance, you give us the information within sixty days of the date you applied; and
 - (iii) Your circumstances have not changed.
- (4) We send denial letters to you according to the rules in chapter 388-406 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0011, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0016 DSHS sends you an approval letter when you can get benefits. (1) When we finish processing your application, we send you an approval letter if you can get benefits.

(2) On this letter, we tell you:

- (a) What kind of benefits you get;
- (b) If you applied for cash or food assistance, the amount of benefits you get;
- (c) If you applied for medical, what type of medical;
- (d) How long you will get the benefits; and
- (e) Your right to have your case reviewed or ask for a fair hearing.

(3) We send approval letters to you according to the rules in chapter 388-406 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0016, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0020 You get a request letter when we need more information. (1) We send a request letter to you when we need some information from you or you have to do something in order to get benefits.

(2) On the letter, we tell you:

- (a) What is needed;
- (b) The date it is due; and
- (c) What will happen to your benefits if you don't do what we ask.

(3) You get at least ten days to give us the information or do the activity. You can ask for more time if you need it.

(4) If the tenth day is on a weekend or holiday, you have until the next business day to do what we need.

(5) If we don't get what we need by the due date, we may deny, reduce, or stop your benefits. We will send you another letter if this happens.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0020, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0025 We send you a change letter if the amount of benefits you are getting is changing. (1) We send you a change letter if the amount of benefits you are getting is changing.

(2) On the letter, we tell you:

- (a) What your benefits are changing to;

- (b) When the change is going to happen;
- (c) The reason for the change;
- (d) The rules that support our decision; and
- (e) Your right to have your case reviewed or ask for a fair hearing.

(3) We send the letter to you before the change happens. If your benefits are going down, we give you at least ten days notice unless:

- (a) You ask us to reduce your benefits;
- (b) We have to change benefits for a lot of people at once because of a law change;
- (c) For cash and food assistance:
 - (i) We told you on your approval letter that your benefits might change every month because you have fluctuating income; or
 - (ii) We already told you that the supplement would end.
- (d) For cash assistance, we told you that the AREN payment described in WAC 388-436-0002 was for one month only.
- (4) The ten-day count starts on the day we mail or give you the letter and ends on the tenth day.
- (5) If we don't have to give you ten days notice, we send the letter to you:
 - (a) For cash and medical, by the date of the action.
 - (b) For food assistance, by the date you normally get your benefits.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0025, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0030 We send you a termination letter when your benefits stop. (1) We send you a termination letter when your benefits stop.

- (2) On the letter, we tell you:
 - (a) When your benefits are going to end;
 - (b) The reason they are ending;
 - (c) The rules that support our decision; and
 - (d) Your right to have your case reviewed or ask for a fair hearing.
- (3) We tell you at least ten days before your benefits end unless:
 - (a) You asked us to stop your benefits;
 - (b) We have proof that everyone in your assistance unit has moved to another state or will move to another state before the next benefits are issued;
 - (c) We have proof that everyone in your assistance unit has died;
 - (d) We have to change benefits for a lot of people at once because of a law change;
 - (e) We got returned mail from the post office that says you have moved and we do not have a forwarding address; or
 - (f) For food assistance, your certification period is ending.
- (4) The ten-day count starts on the day we mail or give you the letter and ends on the tenth day.
- (5) If we don't have to give you ten days notice, we send the letter to you:
 - (a) For cash and medical, by the date of the action.
 - (b) For food assistance, by the date you normally get your benefits.

[Statutory Authority: RCW 74.08.090, 74.04.057, and 74.04.510. 02-14-086, § 388-458-0030, filed 6/28/02, effective 7/1/02. Statutory Authority:

(2007 Ed.)

RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0030, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0035 Why do you give me ten days notice before you reduce or stop my benefits? (1) We give you ten days notice before reducing or stopping your benefits so that you have some time to either:

- (a) Get the needed information to us; or
 - (b) Prepare yourself and your family for the change.
- (2) You can also use this time to request a fair hearing.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0035, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0040 What happens if I ask for a fair hearing before the change happens? (1) If you ask for a fair hearing within the ten-day notice period, you may keep getting the amount of benefits you were getting before the change. This is called continued benefits.

(2) If the tenth day falls on a weekend or holiday, you have until the next business day to ask for a fair hearing and still be able to get continued benefits.

(3) If the tenth day happens before the end of the month, you have until the end of the month to ask for a fair hearing and still be able to get continued benefits.

(4) For food assistance, you cannot get continued benefits if your certification period is ending.

(5) If you get continued benefits, you keep getting them through the end of the month the fair hearing decision is mailed unless:

- (a) You:
 - (i) Tell us in writing that you do not want continued benefits;
 - (ii) Withdraw your fair hearing request in writing; or
 - (iii) Do not follow through with the fair hearing process.
- (b) An administrative law judge (ALJ) tells us in writing to stop your continued benefits before the hearing.
- (c) For food assistance, your certification period ends.
- (6) After the fair hearing, you have to pay back continued benefits you get, as described in chapter 388-410 WAC, if the ALJ agrees with our decision.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0040, filed 7/25/01, effective 9/1/01.]

WAC 388-458-0045 Will I get other kinds of letters? Yes. We also send you letters in special circumstances. These letters are specific to your situation. Here are some examples:

- (1) Appointment letters;
- (2) Overpayment letters; and
- (3) Fair Hearing letters.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 01-16-087, § 388-458-0045, filed 7/25/01, effective 9/1/01.]

Chapter 388-460 WAC

PAYEES ON BENEFIT ISSUANCES

WAC

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|--------------|--|
| 388-460-0001 | Who may be issued cash, child care, medical and Basic Food benefits? |
| 388-460-0005 | Can I choose someone to apply for Basic Food for my assistance unit? |

388-460-0010	Do I have an authorized representative for Basic Food if I live in a treatment center or group home?
388-460-0015	Who will the department not allow as an authorized representative for Basic Food?
388-460-0020	Who is a protective payee?
388-460-0025	Who can be a protective payee?
388-460-0030	When is an emergency or temporary protective payee (TANF/SFA) used?
388-460-0035	When is a protective payee assigned for mismanagement of funds?
388-460-0040	When is a protective payee assigned to TANF/SFA pregnant or parenting minors?
388-460-0050	When is a client transferred from a protective payee to guardianship?
388-460-0055	What are the protective payee's responsibilities?
388-460-0060	When are protective payee plans done?
388-460-0065	When is the protective payee status ended and how is a protective payee changed?
388-460-0070	What are your fair hearing rights regarding protective payment?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-460-0045	Are clients in WorkFirst sanction status assigned protective payees? [Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-14-083, § 388-460-0045, filed 6/28/02, effective 7/1/02.] Repealed by 06-10-034, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW.
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WAC 388-460-0001 Who may be issued cash, child care, medical and Basic Food benefits? (1) Cash and child care assistance may be issued in the name of the following persons:

- (a) A client who is the recipient of the benefits;
 - (b) An ineligible parent or other relative getting benefits on behalf of an eligible child;
 - (c) A person, facility, organization, institution or agency acting as a protective payee or representative payee for a client;
 - (d) A guardian or agent acting on behalf of a client; or
 - (e) A vendor of goods or services supplied to an eligible client.
- (2) When medical coverage accompanies cash assistance, the medical identification (MAID) card for the assistance unit members is issued in the name of the person listed as payee for the cash benefit.
- (3) For other medical assistance units, the MAID card is issued to the person named as the head of the assistance unit.
- (4) Basic Food benefits are issued to the person named as the head of the assistance unit for Basic Food.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 03-22-038, § 388-460-0001, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050, 02-14-083, § 388-460-0001, filed 6/28/02, effective 7/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-460-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0005 Can I choose someone to apply for Basic Food for my assistance unit? Your Basic Food assistance unit (AU) can choose an adult who is not a member of the AU to act on their behalf. This is called an authorized representative.

(1) A responsible member of the AU can name, in writing, an authorized representative. A responsible member of the AU is either:

- (a) The applicant;

- (b) The applicant's spouse;
 - (c) Another member of the AU the applicant states is able to conduct business on behalf of all members in the AU.
- (2) The AU's authorized representative has the authority to apply for Basic Food on the AU's behalf.
- (3) If you receive Basic Food benefits in a qualified drug and alcohol treatment facility under WAC 388-408-0040, you **must** have an employee of the facility as your authorized representative for Basic Food.
- (4) If the authorized representative provides information to the department that causes an AU to have an overpayment, the AU members are liable for the overpayment.
- (5) An authorized representative may act on behalf of more than one Basic Food AU **only** if the community services office administrator approves.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 03-22-038, § 388-460-0005, filed 10/28/03, effective 12/1/03; 03-03-072, § 388-460-0005, filed 1/15/03, effective 3/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-460-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0010 Do I have an authorized representative for Basic Food if I live in a treatment center or group home? (1) If you live in a qualified DDD group home under WAC 388-408-0040, you may choose to apply for Basic Food benefits:

- (a) On your own behalf;
 - (b) Through an authorized representative of your choice; or
 - (c) Through the DDD group home acting as your authorized representative.
- (2) If you live in a qualified drug and alcohol treatment center under WAC 388-408-0040, you **must** have an employee of the facility as your authorized representative for Basic Food.
- (3) The person acting as authorized representative for residents in a qualified drug and alcohol treatment facility or qualified DDD group home must:
- (a) Be aware of the resident's circumstances;
 - (b) Notify the department of any changes in income, resources or circumstances within ten days of the change;
 - (c) Use the resident's Basic Food benefits for meals served to the resident; and
 - (d) Keep enough benefits in the facility's account to transfer one-half of a client's monthly allotment to the client's own account. If the client leaves the facility on or before the fifteenth of the month, the facility must return one half of the client's Basic Food allotment for that month.

(4) When a facility assigns an employee as the authorized representative for residents, the facility accepts responsibility for:

- (a) Any misrepresentation or intentional program violation; and
- (b) Liability for Basic Food benefits held at the facility on behalf of the resident.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 03-22-038, § 388-460-0010, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 99-02-039, § 388-460-0010, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-460-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0015 Who will the department not allow as an authorized representative for Basic Food? (1) If you are acting as an authorized representative for Basic Food, we disqualify you from being an authorized representative for one year if we determine that you:

- (a) Knowingly provided false information to the department;
- (b) Misrepresented the circumstances of the Basic Food assistance unit (AU); or
- (c) Misused the Basic Food benefits.

(2) If we disqualify you from being an authorized representative for Basic Food, we notify you and the head of the Basic Food AU thirty days before your disqualification starts.

(3) If you are a department employee, a retailer authorized to receive Basic Food benefits, or are disqualified from receiving Basic Food because of an intentional program violation under WAC 38-446-0015, you generally cannot be an authorized representative. If you are in any of these three categories and want to be an authorized representative for Basic Food:

- (a) The AU must have no one else available to be an authorized representative; and
 - (b) You must have written approval from the community services office administrator to be the AU's authorized representative.
- (4) A public or private nonprofit organization providing meals for homeless persons may not be an authorized representative under any conditions.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-460-0015, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0020 Who is a protective payee? (1) A protective payee is a person or an employee of an agency who manages client cash benefits to provide for basic needs - housing, utilities, clothing, child care, and food. They may also provide services such as training clients how to manage money.

(2) Clients are assigned to protective payees for the following reasons:

- (a) Emergency or temporary situations where a child is left without a caretaker (TANF/SFA) per WAC 388-460-0030;
- (b) Mismanagement of money (TANF/SFA, GA, or WCCC) per WAC 388-460-0035; or
- (c) Pregnant or parenting minors per WAC 388-460-0040.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW. 06-10-034, § 388-460-0020, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0020, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0025 Who can be a protective payee? (1) Clients may ask for a particular protective payee, but the department makes the final choice.

(2) Protective payees must contract with the department, except for employees of the department who are assigned this function as part of their job duties.

(3) The contracted protective payee and their staff must pass a criminal background check according to the criteria in WAC 388-06-0170, 388-06-0180 and 388-06-0190.

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(4) A departmental employee acting as a protective payee must pass a criminal background check and cannot:

- (a) Have the client in their caseload,
- (b) Have the client in the caseloads of other employees under their supervision,
- (c) Be responsible for determining or issuing benefits for the client,
- (d) Be the office administrator, or
- (e) Be a special investigator.

(5) For TANF/SFA, a department employee cannot act as a protective payee when the department has legal custody or responsibility for placement and care of the child.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0025, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0030 When is an emergency or temporary protective payee (TANF/SFA) used? An emergency or temporary protective payee is assigned when a caretaker relative or adult acting in loco parentis per WAC 388-454-0005 is not available to take care of and supervise a child due to an emergency.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0030, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0035 When is a protective payee assigned for mismanagement of funds? (1) The decision to assign a person to a protective payee because of mismanagement of funds must be based on law or with proof the client is unable to manage their cash benefits. The proof must be current and show how this threatens the well being of a child or client on TANF/SFA, GA or WCCC. Examples of proof are:

- (a) Department employees or others observe that the client or client's children are hungry, ill, or not adequately clothed;
- (b) Repeated requests from the client for extra money for basic essentials such as food, utilities, clothing, and housing;
- (c) A series of evictions or utility shut off notices within the last twelve months;
- (d) Medical or psychological evaluations showing an inability to handle money;
- (e) Persons having had an ADATSA assessment and who are participating in ADATSA-funded chemical dependency treatment;
- (f) Not paying an in home child care provider for services when payment has been issued to the client by the department for that purpose;
- (g) A complaint from businesses showing a pattern of failure to pay bills or rent;
- (h) Using public assistance electronic benefits transfer (EBT) card or cash obtained through EBT to purchase or pay for lottery tickets, pari-mutuel wagering, or any of the activities authorized under chapter 9.46 RCW.

(2) A lack of money or a temporary shortage of money because of an emergency does not constitute mismanagement.

(3) When a client has a history of mismanaging money, benefits can be paid through a protective payee or directly to a vendor.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0035, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0040 When is a protective payee assigned to TANF/SFA pregnant or parenting minors? Pregnant or parenting minors who are not emancipated under court order must be assigned to protective payees if the clients are:

- (1) Head of a household;
- (2) Under age eighteen;
- (3) Unmarried; and
- (4) Pregnant or have a dependent child.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0040, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0050 When is a client transferred from a protective payee to guardianship? (1) In emergency cases where a person is physically or mentally unable to manage their own funds, the client is referred to other divisions of the department for full care, including guardianship.

(2) In cases where a child is eligible for TANF/SFA and the caretaker relative does not use the benefits for adequate care of the child, the case can be referred to the attorney general to establish a limited guardianship.

(3) Guardianships are used only if it appears there is a need for services that are expected to last longer than two years.

(4) These guardianships are limited to management of DSHS benefits.

(5) The protective payee plan is changed if a guardian is appointed. The guardian is designated as the payee.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0050, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0055 What are the protective payee's responsibilities? The protective payee's responsibilities are to:

(1) Manage client cash and child care assistance benefits to pay bills for basic needs, such as housing and utilities, or as directed in the protective payee plans;

(2) Provide money management for client if this item is included in the protective payee plans; and

(3) Provide reports to the department on client progress.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and chapter 74.08A RCW. 06-10-034, § 388-460-0055, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0055, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0060 When are protective payee plans done? A protective payee plan may be developed when a case is assigned to a protective payee.

(1) A copy of the plan is provided to the protective payee and the client.

(2) All cases must be reviewed:

- (a) After an initial three-month period; and
- (b) At least every six months beyond the initial period for on going cases.

(3) Reviews include evaluation of:

(a) The need for the client to continue in protective payee status; or

(b) The need to change the plan; or

(c) The client's potential to assume control of their funds (or be removed from protective payee status); and

(d) Protective payee performance.

[Title 388 WAC—p. 860]

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0060, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0065 When is the protective payee status ended and how is a protective payee changed? A client may be removed from a protective payee status when a:

- (1) Protective payee requests the client be reassigned;
- (2) The department assigns a different protective payee;

or

(3) Protective payee is no longer required.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0065, filed 6/28/02, effective 7/1/02.]

WAC 388-460-0070 What are your fair hearing rights regarding protective payment? You have the right for a fair hearing if you disagree with the department's decision to:

(1) Assign payment of benefits through a protective payee,

(2) Continue the assignment,

(3) Change the protective payee selected for you, or

(4) Change the contents of your protective payee plan.

[Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-14-083, § 388-460-0070, filed 6/28/02, effective 7/1/02.]

Chapter 388-462 WAC PREGNANCY

WAC

388-462-0010	Temporary assistance for needy families (TANF) or state family assistance (SFA) eligibility for pregnant women.
388-462-0011	Post adoption cash benefit.
388-462-0015	Medical eligibility for pregnant women.
388-462-0020	Breast and cervical cancer treatment program (BCCTP) for women—Client eligibility.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-462-0005	Pregnancy requirement for GA-S. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0005, filed 7/31/98, effective 9/1/98.] Repealed by 99-14-045, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
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WAC 388-462-0010 Temporary assistance for needy families (TANF) or state family assistance (SFA) eligibility for pregnant women. (1) If you are already receiving TANF or SFA benefits, your pregnancy will not change your eligibility or benefit level.

(2) If you are not currently receiving TANF or SFA benefits, you may be eligible for these benefits if your pregnancy and expected date of delivery has been verified by a licensed medical practitioner.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-14-045, § 388-462-0010, filed 6/30/99, effective 8/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-462-0011 Post adoption cash benefit. (1) Under RCW 74.04.005 (6)(g) recipients of TANF or SFA who lose their eligibility solely because of the birth and relinquishment of the qualifying child may receive general assis-

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tance through the end of the month in which the period of six weeks following the birth of the child falls.

(2) The department will consider income and resources when determining eligibility and benefit amount for post adoption cash benefit in the same manner as TANF. Refer to chapters 388-450, 388-470, and 388-488 WAC.

(3) To receive the post adoption cash benefit, a client must have been receiving TANF or SFA in Washington state.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 99-14-045, § 388-462-0011, filed 6/30/99, effective 8/1/99.]

WAC 388-462-0015 Medical eligibility for pregnant women. Eligibility requirements for pregnancy medical are described below.

(1) A pregnant woman is eligible for categorically needy (CN) scope of care if she meets the following requirements:

(a) Citizenship or immigration status (chapter 388-424 WAC); and

(b) Social Security account number (chapter 388-474 WAC); and

(c) Is a Washington state resident (chapter 388-468 WAC); and

(d) Has countable income as described in WAC 388-478-0075.

(2) A pregnant woman is considered for medically needy (MN) scope of care if she meets the requirements in subsection (1)(a) through (c) of this section and:

(a) Has countable income that exceeds the standard in subsection (1)(d) of this section; and

(b) Has countable resources that do not exceed the standard in WAC 388-478-0070.

(3) A pregnant woman may be eligible for noncitizen pregnancy medical if she is not eligible for medical described in subsections (1) and (2) of this section due to citizenship, immigrant status, or social security number requirements.

(4) A pregnant woman meeting the eligibility criteria in subsection (3) is eligible for:

(a) CN scope of care when the countable income is at or below the income standard described in subsection (1)(d); or

(b) MN scope of care when:

(i) The countable income exceeds the standard in subsection (1)(d); and

(ii) The resources do not exceed the standard described in WAC 388-478-0070.

(5) Consider as income to the pregnant woman the amount that is actually contributed to her by the father of her unborn child when the pregnant woman is not married to the father.

(6) The assignment of child support and medical support rights as described in chapter 388-422 WAC do not apply to pregnant women.

(7) A woman who was eligible for and received medical coverage on the last day of pregnancy is eligible for extended medical benefits for postpartum care for a minimum of sixty days from the end of her pregnancy. This extension continues through the end of the month in which the sixtieth day falls.

(8) A woman who was eligible for medical coverage on the last day of pregnancy is eligible for family planning services for twelve months from the end of the pregnancy even when eligibility for pregnancy was determined after the pregnancy ended.

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[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2), 05-07-032, § 388-462-0015, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.-415, 02-17-030, § 388-462-0015, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-462-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0820, 388-508-0830, 388-522-2230 and 388-508-0835.]

WAC 388-462-0020 Breast and cervical cancer treatment program (BCCTP) for women—Client eligibility.

(1) Effective July 1, 2001, a woman is eligible for categorically needy (CN) coverage under the BCCTP only when she:

(a) Has been screened for breast or cervical cancer under the center for disease control (CDC) breast and cervical cancer early detection program (BCCEDP);

(b) Is found to require treatment for either breast or cervical cancer or for a related precancerous condition;

(c) Is under sixty-five years of age;

(d) Is not eligible for another CN Medicaid program;

(e) Is uninsured or does not otherwise have creditable coverage;

(f) Meets residency requirements as described in WAC 388-468-0005;

(g) Meets Social Security number requirements as described in WAC 388-476-0005; and

(h) Meets the requirements for citizenship or U.S. national status as defined in WAC 388-424-0001 or "qualified alien" status as described in WAC 388-424-0006 (1) or (4).

(2) The certification periods described in WAC 388-416-0015 (1), (4), and (6) apply to the BCCTP. Eligibility for Medicaid continues throughout the course of treatment as certified by the CDC-BCCEDP.

(3) Income and asset limits are set by the CDC-BCCEDP.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 04-15-057, § 388-462-0020, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, 74.09.510, and Public Law 106-354, 02-01-134, § 388-462-0020, filed 12/19/01, effective 1/19/02.]

**Chapter 388-464 WAC
QUALITY ASSURANCE**

WAC

388-464-0001

Requirement to cooperate with quality assurance.

WAC 388-464-0001 Requirement to cooperate with quality assurance. (1) To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or federal food stamp benefits, the following clients are required to cooperate in the quality assurance review process:

(a) All adult recipients or payees in a TANF or SFA assistance unit; or

(b) All household members in a food assistance unit.

(2) Assistance units become ineligible for benefits upon a determination of noncooperation by quality assurance and remain ineligible until the client meets quality assurance requirements or:

(a) For TANF/SFA clients, one hundred twenty days from the end of the annual quality assurance review period; or

(b) For food assistance household members, ninety-five days from the end of the annual quality assurance review period.

(3) The quality assurance review period covers the federal fiscal year which runs from October 1st of one calendar year through September 30th of the following year.

(4) Individuals reapplying for TANF, SFA, or federal food stamps after the sanction period has ended must provide verification of all eligibility requirements. However, individuals meeting expedited service criteria only need to provide expedited service verification requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-464-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-466 WAC REFUGEE PROGRAM

WAC

388-466-0005	Immigration status requirement for refugee assistance.
388-466-0120	Refugee cash assistance (RCA).
388-466-0130	Refugee medical assistance (RMA).
388-466-0140	Income and resources for refugee assistance eligibility.
388-466-0150	Refugee employment and training services.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-466-0010	Treatment of income and resources for refugee assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0010, filed 7/31/98, effective 9/1/98.] Repealed by 02-04-057, filed 1/30/02, effective 2/1/02. Statutory Authority: RCW 74.08.090, 74.08A.320.
388-466-0015	Work and training requirements for refugee cash assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0015, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.
388-466-0020	Exemptions to work and training requirements. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0020, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.
388-466-0025	Penalties for not complying with work and training requirements. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0025, filed 7/31/98, effective 9/1/98.] Repealed by 00-22-085, filed 10/31/00, effective 12/1/00. Statutory Authority: RCW 74.08.090.

WAC 388-466-0005 Immigration status requirement for refugee assistance. (1) To be eligible for refugee cash assistance (RCA) and refugee medical assistance (RMA), a person must prove, by providing documentation issued by the Immigration and Naturalization Service (INS), that he or she was:

- (a) Admitted as a refugee under section 207 of the Immigration and Nationalities Act (INA);
- (b) Paroled into the U.S. as a refugee or asylee under section 212 (d)(5) of the INA;
- (c) Granted conditional entry under section 203 (a)(7) of the INA;
- (d) Granted asylum under section 208 of the INA;
- (e) Admitted as an Amerasian Immigrant from Vietnam through the orderly departure program, under section 584 of the Foreign Operations Appropriations Act, incorporated in the FY88 Continuing Resolution P.L. 100-212;

[Title 388 WAC—p. 862]

(f) A Cuban-Haitian entrant who was admitted as a public interest parolee under section 212 (d)(5) of the INA.

(2) A permanent resident alien meets the immigration status requirements for RCA and RMA if the individual was previously in one of the statuses described in subsections (1)(a) through (f) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-466-0120 Refugee cash assistance (RCA).

(1) Who can apply for refugee cash assistance (RCA)?

Any individual can apply to the department of social and health services (DSHS) for refugee cash assistance and have their eligibility determined within thirty days.

(2) How do I know if I qualify for RCA?

You may be eligible for RCA if you meet all of the following conditions:

(a) You have resided in the United States for less than eight months;

(b) You meet the immigration status requirements of WAC 388-466-0005;

(c) You meet the income and resource requirements under chapters 388-450 and 388-470 WAC;

(d) You meet the work and training requirements of WAC 388-466-0150; and

(e) You provide the name of the voluntary agency (VOLAG) which helped bring you to this country.

(3) What are the other reasons for not being eligible for RCA?

Even if you meet the eligibility requirements named in subsection (2) above you may be not eligible if you:

(a) Are eligible for temporary assistance for needy families (TANF) or Supplemental Security Income (SSI); or

(b) Have been denied TANF due to your refusal to meet TANF eligibility requirements; or

(c) Are employable and have voluntarily quit or refused to accept a bona fide offer of employment within thirty consecutive days immediately prior to your application for RCA; or

(d) Are a full-time student in a college or university.

(4) If I am an asylee, what date will be used as an entry date?

If you are an asylee, your entry date will be the date that your asylum status is granted. For example: You entered the United States on December 1, 1999 as a tourist, then applied for asylum on April 1, 2000, interviewed with the asylum office on July 1, 2000 and were granted asylum on September 1, 2000. Your entry date is September 1, 2000. On September 1, 2000, you may be eligible for refugee cash assistance.

(5) If I am a victim of human trafficking, can I be eligible for RCA?

(a) If you are an adult victim you are eligible for RCA to the same extent as a refugee, if you provide the original certification letter from the U.S. Department of Health and Human Services (DHHS) and meet eligibility requirements in subsection (2)(c) and (d) of this section. You do not have to provide any other documentation of your immigration status. Your entry date will be the date on your certification letter.

(b) If you are a child victim under eighteen years old you are eligible for benefits to the same extent as a refugees and

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do not need to be certified. DHHS issues a special letter for children. Children also have to meet income eligibility requirement.

(6) Does getting a onetime cash grant from a voluntary agency (VOLAG) affect my eligibility for RCA?

No. In determining your eligibility for RCA DSHS does not count a onetime resettlement cash grant provided to you by your VOLAG.

(7) What is the effective date of my eligibility for RCA?

The date DSHS has sufficient information to make eligibility decision is the date your RCA begins.

(8) When does my RCA end?

(a) Your RCA ends on the last day of the eighth month starting from the month of your arrival to the United States. Count the eight months from the first day of the month of your entry into the United States. For example, if you entered the United States on May 28, 2000, May is your first month and December 2000 is your last month of RCA.

(b) If you get a job, your income will affect your RCA based on the TANF rules (chapter 388-450 WAC). If you earn more than is allowed by WAC 388-478-0035, you are no longer eligible for RCA. Your medical coverage may continue for up to eight months from your month of arrival in the United States (WAC 388-466-0130).

(9) Are there other reasons why RCA may end?

Your RCA also ends if:

- (a) You move out of Washington state;
- (b) Your unearned income and/or resources go over the maximum limit (WAC 388-466-0140); or
- (c) You, without good cause, refuse to meet refugee employment and training requirements (WAC 388-466-0150).

(10) Will my spouse be eligible for RCA, if he/she arrives in the U.S. after me?

When your spouse arrives in the United States, DSHS determines his/her eligibility for RCA and/or other income assistance programs. Your spouse may be eligible for up to eight months of RCA based on his/her date of arrival into the United States. If you live together you and your spouse are part of the same assistance unit and your spouse's eligibility for RCA is determined based on your and your spouse's combined income and resources (WAC 388-466-0140).

(11) Can I get additional money in an emergency?

If you have an emergency and need a cash payment to get or keep your housing or utilities, you may apply for the DSHS program called additional requirements for emergent needs (AREN). To receive AREN, you must meet the requirements in WAC 388-436-0002.

(12) What can I do if I disagree with a decision or action that has been taken by DSHS on my case?

If you disagree with a decision or action taken on your case by the department, you have the right to request a review of your case or a fair hearing (WAC 388-02-0090). Your request must be made within ninety days of the decision or action.

[Statutory Authority: RCW 74.08.090, 74.08A.320, 02-04-057, § 388-466-0120, filed 1/30/02, effective 2/1/02.]

(2007 Ed.)

WAC 388-466-0130 Refugee medical assistance (RMA). (1) Who can apply for refugee medical assistance?

Any individual can apply for refugee medical assistance (RMA) and have eligibility determined by the department of social and health services (DSHS).

(2) Who is eligible for refugee medical assistance?

(a) You are eligible for RMA if you meet all of the following conditions:

(i) Immigration status requirements of WAC 388-466-0005;

(ii) Income and resource requirements of WAC 388-466-0140;

(iii) Monthly income standards up to two hundred percent of the federal poverty level (FPL). Spenddown is available for applicants whose income exceeds two hundred percent of FPL (see WAC 388-519-0110); and

(iv) Provide the name of the voluntary agency (VOLAG) which helped bring you to this country, so that DSHS can promptly notify the agency (or sponsor) about your application for RMA.

(b) You are eligible for RMA if you meet one of the following conditions:

(i) Receive refugee cash assistance (RCA) and are not eligible for Medicaid or children's health insurance program (CHIP); or

(ii) Choose not to apply for or receive RCA and are not eligible for Medicaid or CHIP, but still meet RMA eligibility requirements.

(3) Who is not eligible for refugee medical assistance?

You are not eligible to receive RMA if you are:

- (a) Already eligible for Medicaid or CHIP;
- (b) A full-time student in an institution of higher education unless the educational activity is part of a department-approved individual responsibility plan (IRP);
- (c) A nonrefugee spouse of a refugee.

(4) If I have already received a cash assistance grant from voluntary agency (VOLAG), will it affect my eligibility for RMA?

No. A cash assistance payment provided to you by your VOLAG is not counted in determining eligibility for RMA.

(5) If I get a job after I have applied but before I have been approved for RMA, will my new income be counted in determining my eligibility?

No. Your RMA eligibility is determined on the basis of your income and resources on the date of the application.

(6) Will my sponsor's income and resources be considered in determining my eligibility for RMA?

Your sponsor's income and resources are not considered in determining your eligibility for RMA unless your sponsor is a member of your assistance unit.

(7) How do I find out if I am eligible for RMA?

DSHS will send you a letter in both English and your primary language informing you about your eligibility. DSHS will also let you know in writing every time there are any changes or actions taken on your case.

(8) Will RMA cover my medical expenses that occurred after I arrived in the U.S. but before I applied for RMA?

You may be eligible for RMA coverage of your medical expenses for three months prior to the first day of the month

of your application. Eligibility determination will be made according to Medicaid rules.

(9) If I am an asylee, what date will be used as an entry date?

If you are an asylee, your entry date will be the date that your asylum status is granted. For example, if you entered the United States on December 1, 1999 as a tourist, then applied for asylum on April 1, 2000, interviewed with the asylum office on July 1, 2000 and granted asylum on September 1, 2000, your date of entry is September 1, 2000. On September 1, 2000 you may be eligible for refugee medical assistance.

(10) When does my RMA end?

Your refugee medical assistance will end on the last day of the eighth month from the month of your entry into the United States. Start counting the eight months from the first day of the month of your entry into the U.S. For example, if you entered the U.S. on May 28, 2000, your last month is December 2000.

(11) What happens if my earned income goes above the income standards?

(a) If you are getting RMA, your medical eligibility will not be affected by the amount of your earnings;

(b) If you were getting Medicaid and it was terminated because of your earnings, we will transfer you to RMA for the rest of your RMA eligibility period. You will not need to apply.

(12) Will my spouse also be eligible for RMA, if he/she arrives into the U.S. after me?

When your spouse arrives in the U.S., we will determine his/her eligibility for Medicaid and other medical programs. Your spouse may be eligible for RMA; if so, he/she would have a maximum of eight months of RMA starting on the first day of the month of his/her arrival.

(13) What do I do if I disagree with a decision or action that has been taken by DSHS on my case?

If you disagree with the decision or action taken on your case by department you have the right to request a review of your case or request a fair hearing (see WAC 388-02-0090). Your request must be made within ninety days of the decision or action).

(14) What happens to my medical coverage after my eligibility period is over?

We will determine your eligibility for other medical programs. You may have to complete an application for another program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-010, § 388-466-0130, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.08A.320, 00-21-065, § 388-466-0130, filed 10/16/00, effective 11/1/00.]

WAC 388-466-0140 Income and resources for refugee assistance eligibility. (1) How does DSHS count my income and resources when determining my eligibility for refugee cash assistance?

We determine your eligibility for RCA using the TANF rules about income and resources in chapters 388-450 and 388-470 WAC, except we do not count a onetime resettlement cash payment provided to you by your voluntary agency (VOLAG).

[Title 388 WAC—p. 864]

(2) How does DSHS count my income and resources when determining my eligibility for refugee medical assistance?

We determine your eligibility for RMA using the TANF rules about income and resources in chapters 388-450 and 388-470 WAC, except as it stated below:

(a) Your monthly income can be up to two hundred percent of the federal poverty level (FPL);

(b) A onetime resettlement cash payment provided to you by your VOLAG is not counted in determining your eligibility for RMA;

(c) Your RMA eligibility is determined on the basis of your income and resources on the date of your application (WAC 388-466-0130).

[Statutory Authority: RCW 74.08.090, 74.08A.320, 02-04-057, § 388-466-0140, filed 1/30/02, effective 2/1/02.]

WAC 388-466-0150 Refugee employment and training services. (1) What are refugee employment and training services?

Refugee employment and training services provided to eligible refugees may include information and referral, employment oriented case management, job development, job placement, job retention, wage progression, skills training, on-the-job training, counseling and orientation, English as a second language, and vocational English training.

(2) Am I required to participate in refugee employment and training services?

If you are receiving refugee cash assistance (RCA) you are required to participate in refugee employment and training services, unless you are exempt.

(3) How do I know if I am exempt from mandatory employment and training requirements?

(a) You may be exempt from participation in employment and training requirements if:

(i) You are needed in the home to personally provide care for your child under three months of age (see WAC 388-310-0300);

(ii) You are sixty years of age or older.

(b) You can not be exempt from work and training requirements solely because of an inability to communicate in English.

(4) If I am required to participate, what do I have to do?

You are required to:

(a) Register with your employment service provider;

(b) Accept and participate in all employment opportunities, training or referrals, determined appropriate by the department.

(5) What happens if I do not follow these requirements?

If you refuse without good reason to cooperate with the requirements, you are subject to the following penalties:

(a) If you are applying for refugee cash and medical assistance, you will be ineligible for thirty days from the date of your refusal to accept work or training opportunity; or

(b) If you are already receiving refugee cash and medical assistance, your cash benefits will be subject to financial penalties.

(c) The department will notify your voluntary agency (VOLAG) if financial penalties take place.

(2007 Ed.)

(6) What are the penalties to my grant?

The penalties to your grant are:

(a) If the assistance unit includes other individuals as well as yourself, the cash grant is reduced by the sanctioned refugee's amount for three months after the first occurrence. For the second occurrence the financial penalty continues for the remainder of the sanctioned refugee's eight-month eligibility period.

(b) If you are the only person in the assistance unit your cash grant is terminated for three months after the first occurrence. For the second occurrence, your grant is terminated for the remainder of your eight-month eligibility period.

(7) How can I avoid the penalties?

You can avoid the penalties, if you accept employment or training before the last day of the month in which your cash grant is closed.

(8) What is considered a good reason for not being able to follow the requirements?

You have a good reason for not following the requirements if it was not possible for you to stay on the job or to follow through on a required activity due to an event outside of your control. See WAC 388-310-1600(3) for examples.

[Statutory Authority: RCW 74.08.090. 00-22-085, § 388-466-0150, filed 10/31/00, effective 12/1/00.]

Chapter 388-468 WAC RESIDENCY

WAC

388-468-0005 Residency.

WAC 388-468-0005 Residency. Subsections (1) through (4) applies to cash, the Basic Food program, and medical programs.

(1) A resident is a person who:

(a) Currently lives in Washington and intends to continue living here permanently or for an indefinite period of time; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) A child under age eighteen is a resident of the state where the child's primary custodian lives.

(4) With the exception of subsection (5) of this section, a client can temporarily be out of the state for more than one month. If so, the client must supply the department with adequate information to demonstrate the intent to continue to reside in the state of Washington.

(5) Basic Food program assistance units who are not categorically eligible do not meet residency requirements if they stay out of the state more than one calendar month.

(6) A client may not receive comparable benefits from another state for the cash and Basic Food programs.

(7) A former resident of the state can apply for the GA-U program while living in another state if:

(a) The person:

(i) Plans to return to this state;

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(2007 Ed.)

(b) In addition to the conditions in subsection (7)(a)(i)(ii), and (iii) being met, the absence must be:

(i) Enforced and beyond the person's control; or

(ii) Essential to the person's welfare and is due to physical or social needs.

(c) See WAC 388-406-0035, 388-406-0040, and 388-406-0045 for time limits on processing applications.

(8) Residency is not a requirement for detoxification services.

(9) A person is not a resident when the person enters Washington state only for medical care. This person is not eligible for any medical program. The only exception is described in subsection (10) of this section.

(10) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency before entering the facility. The person is considered a resident if they intend to remain permanently or for an indefinite period unless placed in the nursing facility by another state.

(11) For purposes of medical programs, a client's residence is the state:

(a) Paying a state Supplemental Security Income (SSI) payment; or

(b) Paying federal payments for foster or adoption assistance; or

(c) Where the noninstitutionalized individual lives when Medicaid eligibility is based on blindness or disability; or

(d) Where the parent or legal guardian, if appointed, for an institutionalized:

(i) Minor child; or

(ii) Client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one.

(e) Where a client is residing if the person becomes incapable of determining residential intent after reaching twenty-one years of age; or

(f) Making a placement in an out-of-state institution; or

(g) For any other institutionalized individual, the state of residence is the state where the individual is living with the intent to remain there permanently or for an indefinite period.

(12) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

[Statutory Authority: RCW 74.08.090. 03-20-060, § 388-468-0005, filed 9/26/03, effective 10/27/03. Statutory Authority: RCW 74.04.050, 74.04.-055, 74.04.057 and 74.08.090. 98-16-044, § 388-468-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-470 WAC RESOURCES

WAC

388-470-0005	How do resources affect my eligibility for cash assistance, medical assistance, and Basic Food?
388-470-0012	Does the department look at the resources of people who are not getting benefits?
388-470-0026	Excluded resources for family medical programs.
388-470-0045	How do my resources count toward the resource limits for cash assistance and family medical programs?
388-470-0055	How do my resources count toward the resource limit for Basic Food?
388-470-0060	How does the department decide how much of my sponsor's resources affect my eligibility for cash, medical, and food assistance benefits?

- 388-470-0070 How vehicles are counted toward the resource limit for cash assistance and family medical programs.
- 388-470-0075 How is my vehicle counted for the Washington Basic Food program?

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

- 388-470-0010 How to determine who owns a resource. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0010, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-470-0015 Availability of resources. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-507-0730.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-470-0020 Excluded resources. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-470-0025 Excluded resources for cash assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0025, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0025, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-470-0030 Excluding a home as a resource. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0030, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-470-0035 Excluded resources for food assistance. [Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-470-0035, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0035, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-470-0040 Additional excluded resources for SSI-related medical assistance. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-511-1160.] Repealed by 04-09-003, filed 4/7/04, effective 6/1/04. Statutory Authority: RCW 74.04.050, 74.08.090. Later promulgation, see chapter 388-475 WAC.
- 388-470-0050 Resources that count. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0050, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-470-0065 Individual development accounts for TANF recipients. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0065, filed 7/31/98, effective 9/1/98.] Repealed by 03-05-015, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510.
- 388-470-0080 Compensatory award or related settlement lump sum payments. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0080, filed 7/31/98, effective 9/1/98.] Repealed by 99-23-083, filed 11/16/99, effective 1/1/00. Statutory Authority: RCW 74.08.090 and 74.04.510.

WAC 388-470-0005 How do resources affect my eligibility for cash assistance, medical assistance, and Basic Food? (1) The following definitions apply to this chapter:

(a) **"We"** means the department of social and health services.

(b) **"You"** means a person applying for or getting benefits from the department.

(c) **"Fair market value (FMV)"** means the price at which you could reasonably sell the resource.

(d) **"Equity value"** means the FMV minus any amount you owe on the resource.

(e) **"Community property"** means a resource in the name of the husband, wife, or both.

(f) **"Separate property"** means a resource of a married person that one of the spouses:

(i) Had possession of and paid for before they were married;

(ii) Acquired and paid for entirely out of income from separate property; or

(iii) Received as a gift or inheritance.

(2) We count a resource to decide if your assistance unit (AU) is eligible for cash assistance, family medical programs, or Basic Food when:

(a) It is a resource we must count under WAC 388-470-0045 and 388-470-0055;

(b) You own the resource. We consider you to own a resource if:

(i) Your name is on the title to the property; or

(ii) You have property that doesn't have a title; and

(c) You have control over the resource, which means the resource is actually available to you; and

(d) You could legally sell the resource or convert it into cash within twenty days.

(3) For cash assistance and family medical programs, you must try to make your resources available even if it will take you more than twenty days to do so, unless:

(a) There is a legal barrier; or

(b) You must petition the court to release part or all of a resource.

(4) When you apply for assistance, we count your resources as of:

(a) The date of your interview, if you are required to have an interview; or

(b) The date of your application, if you are not required to have an interview; or

(c) The first day of the month of application, for medical assistance.

(5) If your total countable resources are over the resource limit in subsection (6) through (13) of this section, you are not eligible for benefits.

(6) For cash assistance and applicants for family medical programs, we use the equity value as the value of your resources.

(a) Applicants can have countable resources up to one thousand dollars.

(b) Recipients of cash assistance can have an additional three thousand dollars in a savings account.

(7) Recipients of family medical programs do not have a resource limit.

(8) We do not count your resources for children's medical or pregnancy medical benefits.

(9) For SSI-related medical assistance, see chapter 388-475 WAC.

(10) For clients receiving institutional or waived services, see chapters 388-513 and 388-515 WAC.

(11) If your household consists of more than one medical assistance unit (MAU), as described in WAC 388-408-0055, we look at the resources for each MAU separately.

(12) If your AU is categorically eligible (CE) as described in WAC 388-414-0001, you do not have a resource limit for Basic Food.

(13) If your AU is not CE under WAC 388-414-0001, your AU may have countable resources up to the following amount and be eligible for Basic Food:

(a) Three thousand dollars if your AU has either an elderly or disabled individual; or

(b) Two thousand dollars for all other AUs.

(14) If you own a countable resource with someone who is not in your AU, we count the portion of the resource that you own. If we cannot determine how much of the resource is yours:

(a) For cash assistance, we count an equal portion of the resource that belongs to each person who owns it.

(b) For medical assistance and Basic Food, we count the entire amount unless you can prove that the entire amount is not available to you.

(15) We assume that you have control of community property and you can legally sell the property or convert it to cash unless you can show that you do not.

(16) We may not consider an item to be separate property if you used both separate and community funds to buy or improve it.

(17) We do not count the resources of victims of family violence when:

(a) The resource is owned jointly with members of the former household; or

(b) Availability of the resource depends on an agreement of the joint owner; or

(c) Making the resource available would place the client at risk of harm.

(18) You may give us proof about a resource anytime, including when we ask for it or if you disagree with a decision we made, about:

(a) Who owns a resource;

(b) Who has legal control of the resource;

(c) The value of a resource;

(d) The availability of a resource; or

(e) The portion of a property you or another person owns.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 03-05-015, § 388-470-0005, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0012 Does the department look at the resources of people who are not getting benefits? Yes we do. We count the resources of certain people who live in your home, even if they are not getting assistance. Their resources count as part of your resources.

(1) For cash assistance, we count the resources of ineligible, disqualified, or financially responsible people as defined in WAC 388-450-0100.

(2) For Basic Food, we count the resources of ineligible assistance unit (AU) members as defined in WAC 388-408-0035.

(2007 Ed.)

(3) For family and SSI-related medical assistance, we count the resources of financially responsible people as defined in WAC 388-408-0055.

(4) For long term care services, we count the resources of financially responsible people as defined in WAC 388-506-0620.

(5) For cash assistance, medical assistance, and Basic Food, we also count the resources of an immigrant's sponsor as described in WAC 388-470-0060.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 03-05-015, § 388-470-0012, filed 2/7/03, effective 3/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-09-053, § 388-470-0012, filed 4/19/99, effective 5/20/99.]

WAC 388-470-0026 Excluded resources for family medical programs. "Continuously eligible" means, for the purposes of this chapter, there has not been a break of a calendar month or more in a client's eligibility since the date the client received resources in an amount that would cause the client to exceed the resource limit of a family medical program.

(1) The department does not count any increase in a client's resources received while a client:

(a) Is eligible for and receiving coverage under a family medical program; and

(b) Remains continuously eligible for a family medical program.

(2) The department does not count the resource increase for a client:

(a) Who meets the requirement of subsection (1)(a) of this section;

(b) Whose family medical program is terminated; and

(c) Who is later found eligible for all months since the termination, which may include a retroactive period of up to three months.

(3) The department counts the resource increase when the client is ineligible for a family medical program for a full calendar month or more except as described in subsection (2) of this section.

(4) When determining the eligibility of a Holocaust survivor for a family medical program, the department does not count the recoveries of:

(a) Insurance proceeds; and

(b) Other assets.

(5) For the purposes of this section, a family medical program includes the medical extension benefits as described in WAC 388-523-0100.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-470-0026, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 2000 2nd sp.s. c 1 § 210(12). 01-18-006, § 388-470-0026, filed 8/22/01, effective 9/22/01.]

WAC 388-470-0045 How do my resources count toward the resource limits for cash assistance and family medical programs? (1) We count the following resources toward your assistance unit's resource limits for cash assistance and family medical programs to decide if you are eligible for benefits under WAC 388-470-0005:

(a) Liquid resources not specifically excluded in subsection (2) below. These are resources that are easily changed into cash. Some examples of liquid resources are:

[Title 388 WAC—p. 867]

- (i) Cash on hand;
- (ii) Money in checking or savings accounts;
- (iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;
- (iv) Available retirement funds or pension benefits, less any withdrawal penalty;
- (v) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;
- (vi) Available trusts or trust accounts; or
- (vii) Lump sum payments as described in chapter 388-455 WAC.

(b) The cash surrender value (CSV) of whole life insurance policies.

(c) The CSV over fifteen hundred dollars of revocable burial insurance policies or funeral agreements.

(d) The amount of a child's irrevocable educational trust fund that is over four thousand dollars per child.

(e) Funds withdrawn from an individual development account (IDA) if they were removed for a purpose other than those specified in RCW 74.08A.220.

(f) Any real property like a home, land or buildings not specifically excluded in subsection (3) below.

(g) The equity value of vehicles as described in WAC 388-470-0070.

(h) Personal property that is not:

- (i) A household good;
- (ii) Needed for self-employment; or
- (iii) Of "great sentimental value," due to personal attachment or hobby interest.

(i) Resources of a sponsor as described in WAC 388-470-0060.

(j) For cash assistance only, sales contracts.

(2) The following types of liquid resources do not count when we determine your eligibility:

- (a) Bona fide loans, including student loans;
- (b) Basic Food benefits;
- (c) Income tax refunds in the month of receipt;
- (d) Earned income tax credit (EITC) in the month received and the following month;
- (e) Advance earned income tax credit payments;
- (f) Individual development accounts (IDAs) established under RCW 74.08A.220;

(g) Retroactive cash benefits or TANF/SFA benefits resulting from a court order modifying a decision of the department;

(h) Underpayments received under chapter 388-410 WAC;

(i) Educational benefits that are excluded as income under WAC 388-450-0035;

(j) The income and resources of an SSI recipient;

(k) A bank account jointly owned with an SSI recipient if SSA already counted the money for SSI purposes;

(l) Foster care payments provided under Title IV-E and/or state foster care maintenance payments;

(m) Adoption support payments;

(n) Self-employment accounts receivable that the client has billed to the customer but has been unable to collect; and

(o) Resources specifically excluded by federal law.

(3) The following types of real property do not count when we determine your eligibility:

(a) Your home and the surrounding property that you, your spouse, or your dependents live in;

(b) A house you do not live in, if you plan on returning to the home and you are out of the home because of:

- (i) Employment;
- (ii) Training for future employment;
- (iii) Illness; or
- (iv) Natural disaster or casualty.

(c) Property that:

- (i) You are making a good faith effort to sell;
- (ii) You intend to build a home on, if you do not already own a home;

- (iii) Produces income consistent with its fair market value, even if used only on a seasonal basis; or

- (iv) A household member needs for employment or self-employment. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(d) Indian lands held jointly with the Tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs.

(4) If you deposit excluded liquid resources into a bank account with countable liquid resources, we do not count the excluded liquid resources for six months from the date of deposit.

(5) If you sell your home, you have ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If you do not reinvest within ninety days, we will determine whether there is good cause to allow more time. Some examples of good cause are:

- (i) Closing on your new home is taking longer than anticipated;

- (ii) You are unable to find a new home that you can afford;

- (iii) Someone in your household is receiving emergent medical care; or

- (iv) Your children are in school and moving would require them to change schools.

(b) If you have good cause, we will give you more time based on your circumstances.

(c) If you do not have good cause, we count the money you got from the sale as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 03-05-015, § 388-470-0045, filed 2/7/03, effective 3/1/03; 99-16-024, § 388-470-0045, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-470-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0055 How do my resources count toward the resource limit for Basic Food? (1) If your AU is not categorically eligible (CE) for Basic Food under WAC 388-414-0001, we count the following resources toward your AU's resource limit for Basic Food to decide if you are eligible for benefits under WAC 388-470-0005:

(a) Liquid resources. These are resources that are easily changed into cash. Some examples of liquid resources are:

- (i) Cash on hand;
- (ii) Money in checking or savings accounts;

(iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;

(iv) Keogh plans that do not involve a contractual agreement with someone outside of the assistance unit, less any withdrawal penalty;

(v) Individual Retirement Accounts (IRAs) less any withdrawal penalty;

(vi) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(vii) Available trusts or trust accounts; or

(viii) Lump sum payments. A lump sum payment is money owed to you from a past period of time that you get but do not expect to get on a continuing basis.

(b) Nonliquid resources, personal property, and real property not specifically excluded in subsection (2) below.

(c) Vehicles as described in WAC 388-470-0075.

(d) The resources of a sponsor as described in WAC 388-470-0060.

(2) The following resources do not count toward your resource limit:

(a) Your home and the surrounding property that you, your spouse, or your dependents live in;

(b) A house you do not live in, if you plan on returning to the home and you are out of the home because of:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Natural disaster or casualty.

(c) Property that:

(i) You are making a good faith effort to sell;

(ii) You intend to build a home on, if you do not already own a home;

(iii) Produces income consistent with its fair market value, even if used only on a seasonal basis;

(iv) Is essential to the employment or self-employment of a household member. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing; or

(v) Is essential for the maintenance or use of an income-producing vehicle; or

(vi) Has an equity value equal to or less than half of the resource limit as described in WAC 388-470-0005.

(d) Household goods

(e) Personal effects;

(f) Life insurance policies, including policies with cash surrender value (CSV);

(g) One burial plot per household member;

(h) One funeral agreement per household member, up to fifteen hundred dollars;

(i) Pension plans or retirement funds not specifically counted in subsection (1) above;

(j) Sales contracts, if the contract is producing income consistent with its fair market value;

(k) Government payments issued for the restoration of a home damaged in a disaster;

(l) Indian lands held jointly with the Tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs;

(m) Nonliquid resources that have a lien placed against them;

(2007 Ed.)

(n) Earned Income Tax Credits (EITC):

(i) For twelve months, if you were a Basic Food recipient when you got the EITC and you remain on Basic Food for all twelve months; or

(ii) The month you get it and the month after, if you were not getting Basic Food when you got the EITC.

(o) Energy assistance payments or allowances;

(p) The resources of a household member who gets SSI, TANF/SFA, or GA benefits; and

(q) Resources specifically excluded by federal law.

(3) If you deposit excluded liquid resources into a bank account with countable liquid resources, we do not count the excluded liquid resources for six months from the date of deposit.

(4) If you sell your home, you have ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If you do not reinvest within ninety days, we will determine whether there is good cause to allow more time. Some examples of good cause are:

(i) Closing on your new home is taking longer than anticipated;

(ii) You are unable to find a new home that you can afford;

(iii) Someone in your household is receiving emergent medical care; or

(iv) Your children are in school and moving would require them to change schools.

(b) If you have good cause, we will give you more time based on your circumstances.

(c) If you do not have good cause, we count the money you got from the sale as a resource.

[Statutory Authority: RCW 74.08.090 and 74.04.510, 03-05-015, § 388-470-0055, filed 2/7/03, effective 3/1/03; 99-16-024, § 388-470-0055, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-470-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0060 How does the department decide how much of my sponsor's resources affect my eligibility for cash, medical, and food assistance benefits?

(1) If you are a sponsored immigrant as defined in WAC 388-450-0155, and you are not exempt from deeming under WAC 388-450-0156, we count part of your sponsor's resources as available to you.

(2) We decide the amount of your sponsor's resources to count by:

(a) Totaling the countable resources of the sponsor and the sponsor's spouse (if the spouse signed the affidavit of support) under chapter 388-470 WAC;

(b) Subtracting fifteen hundred dollars; and

(c) Counting the remaining amount as a resource that is available to you.

(3) If you can show that your sponsor has sponsored other people as well, we divide the result by the total number of people who they sponsored.

(4) We continue to count your sponsor's resources when we determine your eligibility for benefits until you are exempt from deeming under WAC 388-450-0156.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.04.510 and Title 7, Chapter II, Part 273 of the Code of Federal Regulations. 01-21-026, § 388-

470-0060, filed 10/9/01, effective 11/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0060, filed 7/31/98, effective 9/1/98. Formerly WAC 388-510-1030.]

WAC 388-470-0070 How vehicles are counted toward the resource limit for cash assistance and family medical programs. (1) A vehicle is any device for carrying persons and objects by land, water, or air.

(2) The entire value of a licensed vehicle needed to transport a physically disabled assistance unit member is excluded.

(3) The equity value of one vehicle up to five thousand dollars is excluded when the vehicle is used by the assistance unit or household as a means of transportation. Each separate medical assistance unit is allowed this exclusion.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-470-0070, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610.]

WAC 388-470-0075 How is my vehicle counted for the Washington Basic Food program? This rule applies to the Washington Basic Food program only.

(1) A vehicle is a motorized device that the client can use as a regular means of transportation.

(2) If you own a licensed vehicle we (the department) do not count its entire value if the vehicle:

(a) Has an equity value (fair market value (FMV) minus what you owe on the vehicle) of one thousand five hundred dollars or less.

(b) Is used over fifty percent of the time to make income. This includes vehicles such as a taxi, truck, or fishing boat. If you are a self-employed farmer or fisher and your self-employment ends, we still exclude your vehicle for one year from the date you end your self-employment.

(c) Is used to make income each year that is consistent with its FMV, even if used on a seasonal basis.

(d) Is needed for long-distance travel, other than daily commuting, for the employment of an assistance unit (AU).

(e) Is used as your AU's home.

(f) Is used to carry fuel for heating or water for home use when this is the primary source of fuel or water for your AU.

(g) Is needed to transport a physically disabled AU member, no matter if the disability is permanent or temporary.

(3) For licensed vehicles we did not exclude in subsection (2) above, we subtract four thousand six hundred fifty dollars from the vehicle's FMV and count the remaining amount toward the resource limit for:

(a) One vehicle for each adult AU member no matter how it is used; and

(b) Any vehicle an AU member under age eighteen uses to drive to work, school, training, or to look for work.

(4) If you have other licensed vehicles, we count the larger value of the following toward your AU's resource limit:

(a) FMV greater than four thousand six hundred fifty dollars; or

(b) Equity value (FMV minus what is owed on the vehicle).

(5) If you are a tribal member and drive an unlicensed vehicle on a reservation that does not require vehicle licens-

ing, we count or exclude your vehicle as if it was a licensed vehicle.

(6) For all other unlicensed vehicles we count the equity value towards your AU's resource limit unless the vehicle is:

(a) Used to make income each year that is consistent with its FMV, even if used on a seasonal basis; or

(b) Work-related equipment needed for employment or self-employment of a member of your AU.

(7) We do not add the equity values of different vehicles together to perform the equity test. We look at each vehicle separately. If a vehicle passes the equity test, we do not count it towards the resource maximum.

(8) After we determine the countable value of each vehicle, we add those values to your other countable resources to see if your resources are below your resource limit.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 02-23-028, § 388-470-0075, filed 11/12/02, effective 12/1/02; 01-16-134, § 388-470-0075, filed 7/31/01, effective 11/1/01; 01-15-078, § 388-470-0075, filed 7/17/01, effective 8/1/01; 99-16-024, § 388-470-0075, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0075, filed 7/31/98, effective 9/1/98.]

Chapter 388-472 WAC

RIGHTS AND RESPONSIBILITIES

WAC

388-472-0005	What are my rights and responsibilities?
388-472-0010	What are necessary supplemental accommodation services?
388-472-0020	How does the department decide if I am eligible for NSA services?
388-472-0030	How can I get NSA services?
388-472-0040	What are the department's responsibilities in giving NSA services to me?
388-472-0050	What if I don't accept or follow through the program requirements because I'm not able to or I don't understand them?

WAC 388-472-0005 What are my rights and responsibilities? For the purposes of this chapter, "we" and "us" refer to the department and "you" refers to the applicant or recipient.

(1) If you apply for or get cash, food or medical assistance benefits you have the right to:

(a) Have your rights and responsibilities explained to you and given to you in writing;

(b) Be treated politely and fairly no matter what your race, color, political beliefs, national origin, religion, age, gender, disability or birthplace;

(c) Request benefits by giving us an application form using any method listed under WAC 388-406-0010. You can ask for and get a receipt when you give us an application or other documents;

(d) Have your application processed as soon as possible. Unless your application is delayed under WAC 388-406-0040, we process your application for benefits within thirty days, except:

(i) If you are eligible for expedited services under WAC 388-406-0015, you get food assistance within five days. If we deny you expedited services, you have a right to ask that the decision be reviewed by the department within two working days from the date we denied your application;

(ii) If you are pregnant and otherwise eligible, you get medical within fifteen working days.

(iii) General assistance (GAU), alcohol or drug addiction treatment (ADATSA), or medical assistance may take up to forty-five days; and

(iv) Medical assistance requiring a disability decision may take up to sixty days.

(e) Be given at least ten days to give us information needed to determine your eligibility and be given more time if you ask for it. If we do not have the information needed to decide your eligibility, then we may deny your request for benefits;

(f) Have the information you give us kept private. We may share some facts with other agencies for efficient management of federal and state programs;

(g) Ask us not to collect child support or medical support if you fear the noncustodial parent may harm you, your children, or the children in your care;

(h) Ask for extra money to help pay for temporary emergency shelter costs, such as an eviction or a utility shutoff, if you get TANF;

(i) Get a written notice, in most cases, at least ten days before we make changes to lower or stop your benefits;

(j) Ask for a fair hearing if you disagree with a decision we make. You can also ask a supervisor or administrator to review our decision or action without affecting your right to a fair hearing;

(k) Have interpreter or translator services given to you at no cost and without delay;

(l) Refuse to speak to a fraud investigator. You do not have to let an investigator into your home. You may ask the investigator to come back at another time. Such a request will not affect your eligibility for benefits; and

(m) Get help from us to register to vote.

(2) If you get cash, food, or medical assistance, you are responsible to:

(a) Tell us if you are pregnant, in need of immediate medical care, experiencing an emergency such as having no money for food, or facing an eviction so we can process your request for benefits as soon as possible;

(b) Report the following expenses so we can decide if you can get more food assistance:

(i) Shelter costs;

(ii) Child or dependent care costs;

(iii) Child support that is legally obligated;

(iv) Medical expenses; and

(v) Self-employment expenses.

(c) Report changes as required under WAC 388-418-0005 and 388-418-0007. If you get:

(i) Cash or food assistance, changes must be reported within ten days from the date you learn of the change; or

(ii) Medical assistance, changes must be reported within twenty days from the date you learn of the change.

(d) Give us the information needed to determine eligibility;

(e) Give us proof of information when needed. If you have trouble getting proof, we help you get the proof or contact other persons or agencies for it;

(f) Cooperate in the collection of child support or medical support unless you fear the noncustodial parent may harm you, your children, or the children in your care;

(g) Apply for and get any benefits from other agencies or programs prior to getting cash assistance from us;

(2007 Ed.)

(h) Complete reports and reviews when asked;

(i) Look for, get, and keep a job or participate in other activities if required for cash or food assistance;

(j) Give your medical identification card or letter of eligibility from us to your medical care provider; and

(k) Cooperate with the quality control review process.

(3) If you are eligible for necessary supplemental accommodation (NSA) services under chapter 388-472 WAC, we help you comply with the requirements of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 02-14-023, § 388-472-0005, filed 6/21/02, effective 7/1/02; 01-10-104, § 388-472-0005, filed 5/1/01, effective 6/1/01. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-17-025, § 388-472-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-472-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0430, 388-504-0440, 388-504-0450 and 388-505-0560.]

WAC 388-472-0010 What are necessary supplemental accommodation services? Necessary supplemental accommodation (NSA) services are services provided to you if you have a mental, neurological, physical or sensory impairment or other problems that prevent you from getting program benefits in the same way that an unimpaired person would get them.

NSA services include but are not limited to:

(1) Arranging for or providing help to complete and submit forms to us;

(2) Helping you give or get the information we need to decide or continue eligibility;

(3) Helping you request continuing benefits;

(4) If you miss an appointment or deadline, contacting you about the reason before we reduce or end your benefits;

(5) Explaining to you the reduction in or ending of your benefits (see WAC 388-418-0020);

(6) If we know you have a person who helps you with your applications, notifying them when we need information or when we are about to reduce or end your benefits;

(7) Assisting you with requests for fair hearings;

(8) Providing protective payments if needed; and

(9) On request, reviewing our decision to terminate, suspend or reduce your benefits.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.055, 74.04.057, 04-14-037, § 388-472-0010, filed 6/29/04, effective 7/30/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0010, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0020 How does the department decide if I am eligible for NSA services? When you, as head of household, apply for benefits either in person or by phone, we screen you to decide if you meet NSA requirements. We explain NSA services to you during the screening.

(1) We identify you as NSA if you:

(a) Say you need NSA services in order to have equal access to our programs and services;

(b) Have or claim to have a mental impairment;

(c) Have a developmental disability;

(d) Are disabled by alcohol or drug addiction;

(e) Are unable to read or write in any language; or

(f) Are a minor not residing with your parents.

(2) We identify you as NSA if we observe you to have cognitive limitations, whether or not you have a disability,

which may prevent you from understanding the nature of NSA services or affect your ability to access our programs. Cognitive limitations are limitations in your ability to communicate, understand, remember, process information, exercise judgement and make decisions, perform routine tasks or relate appropriately with others.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0020, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0030 How can I get NSA services? (1)

After we screen you for NSA eligibility and initially identify your case as NSA, we mark your case file with a uniform NSA identifier.

(2) After you are initially identified as NSA, we complete an assessment to confirm your NSA designation.

(3) If the assessment confirms your NSA designation, we develop an accommodation plan that specifies the services we will provide to you to improve your access to our programs and services.

(4) If you are designated as NSA according to WAC 388-472-0020 (1) and (2), we include all the NSA services listed in WAC 388-472-0010 in your accommodation plan.

(5) Based on your request or a change in your needs, the NSA designation and the accommodation plan may be assessed and changed.

(6) Even if you are eligible to receive NSA services you may refuse NSA services.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0030, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0040 What are the department's responsibilities in giving NSA services to me? (1) All of our staff are continually responsible to identify you as possibly NSA eligible and assist you with NSA services.

(2) We provide a grace period to continue your financial, food or medical assistance when:

(a) We stop a benefit because we are unable to tell if you continue to qualify; and

(b) You provide proof you still qualify for the benefit within the twenty days right after the benefit stops. We restore lost benefits as follows:

(i) We reopen your medical assistance from the first of the month; and

(ii) We recalculate your cash and food assistance and issue you the correct amount without taking away any benefits as long as you were eligible to receive them.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0040, filed 5/1/01, effective 6/1/01.]

WAC 388-472-0050 What if I don't accept or follow through the program requirements because I'm not able to or I don't understand them? (1) We consider how your limitation or impairment affects your ability to accept and follow through on all program requirements. This can include, but is not limited to, your actions in failing to:

- (a) Follow through with medical treatment;
- (b) Follow through with referrals to other agencies;
- (c) Provide timely income reports;
- (d) Maintain employment;

(e) Participate in food assistance employment and training; or

(f) Participate in the WorkFirst program.

(2) If we decide your limitation was the cause of your refusal to accept or failure to follow through on these requirements, we will find that you have good cause and we will not take any adverse action.

(3) Following a finding of good cause not to have followed through with the requirement, we will review your accommodation plan to assure that all services necessary to enable you to meet the program requirements are being provided to you.

(4) If we are unable to accommodate your condition so that you are able to participate in program requirements, we will waive program requirements.

(5) If participation in program requirements is not waived, you must cooperate with program requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 01-10-104, § 388-472-0050, filed 5/1/01, effective 6/1/01.]

Chapter 388-473 WAC

ONGOING ADDITIONAL REQUIREMENTS

WAC

388-473-0010	What are ongoing additional requirements and how do I qualify?
388-473-0020	When do we authorize meals as an ongoing additional requirement?
388-473-0040	Food for service animals as an ongoing additional requirement.
388-473-0050	Telephone services as an ongoing additional requirement.
388-473-0060	Laundry as an ongoing additional requirement.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-473-0030	Home-delivered meals as an ongoing additional requirement. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0030, filed 7/17/00, effective 9/1/00.] Repealed by 05-19-059, filed 9/16/05, effective 10/17/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090.
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WAC 388-473-0010 What are ongoing additional requirements and how do I qualify? "Ongoing additional requirement" means a need beyond essential food, clothing, and shelter needs and is necessary to help you continue living independently.

(1) We may authorize ongoing additional requirement benefits if you are active in one of the following programs:

(a) Temporary assistance for needy families (TANF), or tribal TANF;

(b) State family assistance (SFA);

(c) Refugee cash;

(d) General assistance cash; or

(e) Supplemental Security Income (SSI).

(2) You apply for an ongoing additional requirement benefit by notifying staff who maintain your cash or medical assistance that you need additional help to live independently.

(3) We authorize ongoing additional requirement benefits only when we determine the item is essential to you. We make the decision based on proof you provide of:

(a) The circumstances that create the need; and

(b) How the need affects your health, safety and ability to continue to live independently.

(4) We authorize ongoing additional requirement benefits by increasing your monthly cash assistance benefit.

(5) We use the following review cycle table to decide when to review your need for the additional benefit(s).

REVIEW CYCLE	
Program	Frequency (Months)
TANF/RCA	6 Months
GA	12 Months
SSI	24 Months
All	Any time need or circumstances are expected to change
All	Any time need or circumstances are expected to change.

(6) Monthly payment standards for ongoing additional requirements are described under WAC 388-478-0050.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-19-059, § 388-473-0010, filed 9/16/05, effective 10/17/05; 01-01-070, § 388-473-0010, filed 12/12/00, effective 2/1/01; 00-15-053, § 388-473-0010, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0020 When do we authorize meals as an ongoing additional requirement? (1) We authorize additional requirement benefits for meals when we decide all of the following conditions are true:

(a) You meet the criteria in WAC 388-473-0020;

(b) You are physically or mentally impaired in your ability to prepare meals; and

(c) Getting help with meals would meet your nutrition or health needs and is not available to you through another federal or state source; such as the community options program entry system (COPES), Medicaid personal care (MPC), or informal support, such as a relative or volunteer.

(2) When we decide to provide meals as an additional requirement, we choose whether to authorize this benefit as restaurant meals or home-delivered meals.

(3) We authorize restaurant meals when:

(a) You are unable to prepare some of your meals;

(b) You have some physical ability to leave your home; and

(c) Home-delivered meals are not available or would be more expensive.

(4) We authorize home-delivered meals when:

(a) You are unable to prepare any of your meals;

(b) You are physically limited in your ability to leave your home; and

(c) Home-delivered meals are available.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-19-059, § 388-473-0020, filed 9/16/05, effective 10/17/05; 00-15-053, § 388-473-0020, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0040 Food for service animals as an ongoing additional requirement. (1) A "service animal" is one that has been trained at a recognized school or training facility to provide you with assistance that is necessary for your health and safety, and that supports your ability to continue to live independently.

(2007 Ed.)

(2) We authorize benefits for food for a service animal if we decide the animal assists you in your daily living as described in WAC 388-473-0040(1).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0040, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0050 Telephone services as an ongoing additional requirement. We authorize benefits for telephone services when we decide:

(1) Without a telephone, your life would be endangered, you could not live independently, or you would require a more expensive type of personal care; and

(2) You have applied for the Washington telephone assistance program (WTAP) through your local telephone company.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0050, filed 7/17/00, effective 9/1/00.]

WAC 388-473-0060 Laundry as an ongoing additional requirement. We authorize benefits for laundry when we decide:

(1) You are not physically able to do your own laundry; or

(2) You do not have laundry facilities that are accessible to you due to your physical limitations.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-053, § 388-473-0060, filed 7/17/00, effective 9/1/00.]

Chapter 388-474 WAC

SUPPLEMENTAL SECURITY INCOME

WAC

388-474-0001	What is Supplemental Security Income (SSI) and who can get it?
388-474-0005	What medical coverage does a Supplemental Security Income client, essential person, and an ineligible spouse get?
388-474-0010	How does being a Supplemental Security Income (SSI) client affect your cash assistance eligibility?
388-474-0012	What is a state supplemental payment and who can get it?
388-474-0015	What happens to my categorically needy (CN) medical coverage when my Supplemental Security Income (SSI) cash payment is terminated?
388-474-0020	What can a general assistance-unemployable (GA-U) client expect when Supplemental Security Income (SSI) benefits begin?

WAC 388-474-0001 What is Supplemental Security Income (SSI) and who can get it? (1) SSI is a federal cash benefit program administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

(2) You can get SSI if you have limited income and resources and if you are:

(a) Aged (sixty-five and older);

(b) Blind; or

(c) Disabled.

(3) The SSI program replaced state programs for aged, blind and disabled persons beginning in January 1974. If you received state assistance in December 1973 and you became eligible for SSI in January 1974, you are called a grandfathered client by the state and a mandatory income level (MIL) client by SSI. You must continue to meet the definition of blind or disabled that was in effect under the state plan in

December 1973. These definitions can be found in the SSA program operations manual system (POMS), see <http://policy.ssa.gov/poms.nsf>.

(4) If you are needed in the home to care for an eligible person, you are called an essential person. You are also called a grandfathered client.

(5) If you are an essential person you must have lived continuously with the eligible person since January 1974.

(6) If you are an SSI recipient and you have a spouse who does not qualify for SSI in their own right, you may be eligible for a state supplemental payment for your spouse (also referred to as an ineligible spouse).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0001, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055. 01-06-042, § 388-474-0001, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0005 What medical coverage does a Supplemental Security Income client, essential person, and an ineligible spouse get? (1) If you are an SSI client you automatically get categorically needy (CN) medical coverage (WAC 388-505-0110) unless you:

(a) Refuse to provide private medical insurance information; or

(b) Refuse to assign the right to recover insurance funds to the department (WAC 388-505-0540).

(2) If you are an essential person as described in WAC 388-474-0001 you get CN medical coverage as long as you continue to live with the SSI client.

(3) If you are an ineligible spouse you are not considered an SSI recipient. You must have your medical assistance determined separately.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0005, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0010 How does being a Supplemental Security Income (SSI) client affect your cash assistance eligibility? (1) If you are married to an SSI recipient but do not get SSI in your own right, you are called an "ineligible spouse."

(2) If you are an ineligible spouse you cannot get the SSI state supplement when you are:

(a) The caretaker relative of a child who receives TANF or SFA; and

(b) Required to be included in the TANF or SFA assistance unit with the child (see WAC 388-408-0015; or

(c) Receiving refugee assistance.

(3) If you are an ineligible spouse and get an SSI state supplement (WAC 388-474-0012), you cannot get general assistance (GA).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0010, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.08.090, 74.04.057, 74.04.050. 01-19-023, § 388-474-0010, filed 9/12/01, effective 11/1/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0012 What is a state supplemental payment and who can get it? (1) The state supplemental payment (SSP) is a state-funded cash assistance program for certain clients who the Social Security Administration determines are eligible for Supplemental Security Income (SSI).

(2) You can get an SSP if:

(a) You are a grandfathered SSI recipient under WAC 388-474-0001;

(b) You are an individual with an ineligible spouse under WAC 388-474-0001;

(c) You receive SSI because you are age sixty-five or older under WAC 388-474-0001;

(d) You receive SSI because you are blind under WAC 388-474-0001;

(e) You are determined eligible for SSP by the division of developmental disabilities; or

(f) You are eligible for and receive SSI as a foster child receiving specific services through children's administration behavior rehabilitation services (BRS) for part or all of a month, and not eligible for foster care reimbursement under Title IV-E of the Social Security Act.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 05-07-031, § 388-474-0012, filed 3/9/05, effective 4/9/05; 03-21-125, § 388-474-0012, filed 10/20/03, effective 11/1/03; 03-03-114, § 388-474-0012, filed 1/21/03, effective 2/23/03.]

WAC 388-474-0015 What happens to my categorically needy (CN) medical coverage when my Supplemental Security Income (SSI) cash payment is terminated? (1) Your CN medical coverage (WAC 388-505-0110) continues after an SSI cash payment ends when:

(a) Countable income exceeds the SSI income standard due solely to the annual cost-of-living adjustment (COLA); or

(b) A timely request for a hearing has been filed. CN medical coverage is continued until Social Security Administration (SSA) makes a final decision on the hearing request and on any subsequent timely appeals.

(2) If your SSI ends your CN medical coverage continues for a period of up to one hundred twenty days while the department reviews your eligibility for other cash or medical programs.

(3) If you are a terminated SSI or SSI-related client, the department will review your disability status when:

(a) You present new medical evidence;

(b) Your medical condition changes significantly; or

(c) Your termination from SSI was not based on a review of current medical evidence.

(4) Children terminated from SSI due to loss of disabled status may be eligible for medical benefits under WAC 388-505-0210.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-20-070, § 388-474-0015, filed 9/30/02, effective 10/31/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0015, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-524-2405.]

WAC 388-474-0020 What can a general assistance-unemployable (GA-U) client expect when Supplemental Security Income (SSI) benefits begin? You can only get assistance to meet your basic needs from one government

source at a time (WAC 388-448-0210). If you are a GA-U client who begins setting SSI, you should know that:

(1) If you got advance, emergency or retroactive SSI cash assistance for any period where you got GA-U, you must repay the department the amount of GA-U paid to you for the matching time period.

(2) When you apply for GA-U you must sign DSHS 18-235(X), interim assistance reimbursement agreement (IARA) to get GA-U assistance.

(3) You cannot use your GA-U money to replace money deducted from your SSI check to repay an SSI overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.04.630. 02-11-033, § 388-474-0020, filed 5/7/02, effective 6/7/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0020, filed 7/31/98, effective 9/1/98.]

Chapter 388-475 WAC

SSI-RELATED MEDICAL AND (HWD) PROGRAM

WAC

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WAC 388-475-0050 SSI-related medical—General information. (1) The department provides medical benefits under the categorically needy (CN) and medically needy (MN) SSI-related programs for SSI-related people, meaning those who meet at least one of the federal SSI program criteria as being:

- (a) Age sixty-five or older;
- (b) Blind with:
 - (i) Central visual acuity of 20/200 or less in the better eye with the use of a correcting lens; or

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(ii) A field of vision limitation so the widest diameter of the visual field subtends an angle no greater than twenty degrees.

(c) Disabled:

(i) "Disabled" means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which:

(A) Can be expected to result in death; or

(B) Has lasted or can be expected to last for a continuous period of not less than twelve months; or

(C) In the case of a child seventeen years of age or younger, if the child suffers from any medically determinable physical or mental impairment of comparable severity.

(ii) Decisions on SSI-related disability are subject to the authority of:

(A) Federal statutes and regulations codified at 42 USC Sec 1382c and 20 CFR, parts 404 and 416, as amended; and

(B) Controlling federal court decisions, which define the OASDI and SSI disability standard and determination process.

(2) A denial of Title II or Title XVI federal benefits by SSA solely due to failure to meet the blindness or disability criteria is binding on the department unless the applicant's:

(a) Denial is under appeal in the reconsideration stage in SSA's administrative hearing process, or SSA's appeals council; or

(b) Medical condition has changed since the SSA denial was issued.

(3) The department considers a client who meets the special requirements for SSI status under Sections 1619(a) or 1619(b) of the Social Security Act as an SSI recipient. Such a client is eligible for CN medical coverage under WAC 388-474-0005.

(4) Individuals referred to in subsection (1) must also meet appropriate eligibility criteria found in the following WAC and EA-Z Manual sections:

(a) For all programs:

(i) WAC 388-408-0055, Medical assistance units;

(ii) WAC 388-416-0015, Categorically needy and WAC 388-416-0020, Medically needy certification periods;

(iii) Program specific requirements in chapter 388-475 WAC;

(iv) WAC 388-490-0005, Verification;

(v) WAC 388-503-0505, General eligibility requirements for medical programs;

(vi) WAC 388-505-0540, Assignment of rights and cooperation;

(vii) Chapter 388-561 WAC, Trusts, annuities and life estates.

(b) For LTC programs:

(i) Chapter 388-513 WAC, Long-term care services

(ii) Chapter 388-515 WAC, Waiver services.

(c) For MN, chapter 388-519 WAC, Spenddown;

(d) For HWD, program specific requirements in chapter 388-475 WAC.

(5) Aliens who qualify for Medicaid benefits, but are determined ineligible because of alien status may be eligible for programs as specified in WAC 388-438-0110.

(6) The department pays for a client's medical care outside of Washington according to WAC 388-501-0180.

(7) The department follows income and resource methodologies of the Supplemental Security Income (SSI) program defined in federal law when determining eligibility for SSI-related medical or Medicare Cost Savings programs unless the department adopts rules that are less restrictive than those of the SSI program.

(8) Refer to WAC 388-418-0025 for effects of changes on medical assistance for redetermination of eligibility.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0050, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0100 SSI-related medical—Categorically needy (CN) medical eligibility. (1) Categorically needy (CN) coverage is available for an SSI-related client who:

(a) Meets the criteria in WAC 388-475-0050, SSI-related medical—General information; or

(b) Meets the criteria for the state-funded general assistance - expedited Medicaid disability (GA-X) program by meeting the:

(i) Requirements of the cash program in WAC 388-400-0025 and 388-478-0030; or

(ii) SSI-related disability standards but who cannot get the SSI cash grant due solely to immigration status or sponsor deeming issues.

(2) To be eligible for SSI-related CN medical programs, a person must also have:

(a) Countable income and resources at or below the SSI-related CN medical monthly standard (refer to WAC 388-478-0080) or be eligible for an SSI cash grant but choose not to receive it; or

(b) Countable resources at or below the SSI resource standard and income above the SSI-related CN medical monthly standard, but the countable income falls below that standard after applying special income disregards as described in WAC 388-475-880; or

(c) Met requirements for long-term care (LTC) CN income and resource requirements that are found in chapters 388-513 and 388-515 WAC if wanting LTC or waiver services.

(3) An ineligible spouse of an SSI recipient is not eligible for noninstitutional SSI-related CN medical benefits. If an ineligible spouse of an SSI recipient has dependent children in the home, eligibility may be determined for family medical programs.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0100, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0150 SSI-related medical—Medically needy (MN) medical eligibility. (1) Medically needy (MN) medical coverage is available for any of the following:

(a) A person who is SSI-related and not eligible for CN medical coverage because they have countable income that is above the CN income standard (or for long-term care (LTC) clients, above the special income limit (SIL));

(i) Their countable income is at or below MN standards, leaving them with no spenddown requirement; or

(ii) Their countable income is above MN standards requiring them to spenddown their excess income (see subsection (4) below). See WAC 388-475-0500 through 388-475-0800 for rules on determining countable income, and

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WAC 388-478-0080 for program standards or chapter 388-513 WAC for institutional standards.

(b) An SSI-related ineligible spouse of an SSI recipient;

(c) An adult who meets SSI program criteria but is not eligible for the SSI cash grant due to immigration status or sponsor deeming. See WAC 388-424-0010 for limits on eligibility for aliens;

(d) A person who meets the MN LTC services requirements of chapter 388-513 WAC and WAC 388-515-1540;

(e) A person who lives in an alternate living facility and meets the requirements of WAC 388-513-1305; or

(f) A person who meets resource requirements as described in chapter 388-475 WAC, elects and is certified for hospice services per chapter 388-551 WAC.

(2) Clients whose countable resources are above the SSI resource standards are not eligible for MN noninstitutional medical benefits. See WAC 388-475-0200 through 388-475-0550 to determine countable resources.

(3) Clients who qualify for services under long term care have different criteria and may spend down excess resources to become eligible for LTC institutional or waiver medical benefits. Refer to WAC 388-513-1315 and 388-513-1395.

(4) A client with income over the medically needy income limit (MNIL) may become eligible for MN coverage when they have incurred medical expenses that are equal to the excess income. This is the process of meeting spend-down. Refer to chapter 388-519 WAC for spenddown information.

(5) A client may be eligible for medical coverage for up to three months immediately prior to the month of application, if the client:

(a) Met all eligibility requirements for the months being considered; and

(b) Received medical services covered by Medicaid during that time.

(6) A client eligible for MN without a spenddown is certified for up to twelve months. For an MN client with spenddown, refer to WAC 388-519-0110. For a long-term care MN client, refer to WAC 388-513-1305 and 388-513-1315.

(7) A client must reapply for each certification period. There is no continuous eligibility for MN. Although each additional certification period requires a new application, if the medical benefits have been closed less than thirty days, an eligibility review form may be used to reapply.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0150, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0200 SSI-related medical—Definition of resources. (1) A resource is any cash, other personal property, or real property that an applicant, recipient or other financially responsible person:

(a) Owns;

(b) Has the right, authority, or power to convert to cash (if not already cash); and

(c) Has the legal right to use for his/her support and maintenance.

(2) The value of a resource may change. However, the property (personal or real) still remains a resource.

(3) Some assets are not resources. Any asset that does not meet the criteria in subsection (1) above is not a resource.

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(4) When an SSI-related client owns a bank account or time deposit jointly with others who are also SSI-related clients, we consider the funds as being available to the SSI-related individuals in equal shares, unless sufficient evidence to the contrary is provided.

(5) When an SSI-related client owns a bank account or time deposit jointly with others who are not SSI-related, we consider all funds in the joint account as available to the client unless sufficient evidence to the contrary is provided.

(6) When an SSI-related client jointly owns either real or personal property other than bank accounts or time deposits, the department considers that the client owns and has available only his or her fractional interest in the property unless sufficient evidence to the contrary is provided.

(7) A resource is countable toward the resource limit only if it is available and is not excluded.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0200, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0250 SSI-related medical—Ownership and availability of resources. (1) Personal or real property is available to the client if the client, client's spouse or other financially responsible person:

- (a) Owns the property;
- (b) Has the authority to convert the property into cash;
- (c) Can expect to convert the property to cash within twenty working days; and
- (d) May legally use the property for his/her support.

(2) A resource is considered available on the first day of the month following the month of receipt unless a rule about a specific type of resource provides for a different time period.

(3) A resource, which ordinarily cannot be converted to cash within twenty working days, is considered unavailable as long as a reasonable effort is being made to convert the resource to cash.

(4) A client may provide evidence showing that a resource is unavailable. A resource is not counted if a client shows sufficient evidence that the resource is unavailable.

(5) We do not count the resources of victims of family violence, as defined in WAC 388-452-0010, when:

- (a) The resource is owned jointly with members of the former household;
- (b) Availability of the resource depends on an agreement of the joint owner; or
- (c) Making the resource available would place the client at risk of harm.

(6) The value of a resource is its fair market value minus encumbrances.

(7) Refer to WAC 388-470-0060 to consider additional resources when an alien has a sponsor.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0250, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0300 SSI-related medical—Resources eligibility. (1) A client must be resource eligible on the first moment of the first day of the month, and is then eligible for the entire month. If the total of the client's countable resources is above the resource standard on the first moment of the first day of the month, the client is ineligible for noninstitutional medical benefits for that entire month regardless of

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resource status at the time of application during that month. For long-term care eligibility see chapter 388-513 WAC.

(2) An excluded resource converted to another excluded resource remains excluded.

(3) Cash received from the sale of an excluded resource becomes a countable resource the first of the month following conversion unless the cash is;

- (a) Used to replace the excluded resource; or
- (b) Invested in another excluded resource in the same month or within the longer time allowed for home sales under WAC 388-475-0350; or
- (c) Spent.

(4) The unspent portion of a nonrecurring lump sum payment is counted as a resource on the first of the month following its receipt with the following exception: The unspent portion of any Title II (SSA) or Title XVI (SSI) retroactive payment is excluded as a resource for six months following the month of receipt. These exclusions apply to lump sums received by the client, client's spouse or other any other person who is financially responsible for the client.

(5) Clients applying for SSI-related medical coverage for long-term care (LTC) services must meet different resource rules. See chapter 388-513 WAC for LTC rules.

(6) The transfer of a resource without adequate consideration does not affect medical program eligibility except for LTC and waiver services programs. In those programs, the transfer may make a client ineligible for medical benefits for a period of time. See WAC 388-513-1364 through 388-513-1366 for LTC rules.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-002, § 388-475-0300, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0350 SSI-related medical—Property and contracts excluded as resources. (1) The department does not count the following resources when determining eligibility for SSI-related medical assistance:

- (a) A client's household goods and personal effects;
- (b) One home (which can be any shelter), including the land on which the dwelling is located and all contiguous property and related out-buildings in which the client has ownership interest, when:

- (i) The client uses the home as his or her primary residence; or
- (ii) The client's spouse lives in the home; or
- (iii) The client does not currently live in the home but the client or his/her representative has stated the client intends to return to the home; or
- (iv) A relative, who is financially or medically dependent on the client, lives in the home and the client, client's representative, or dependent relative has provided a written statement to that effect.

(c) The value of ownership interest in jointly owned real property is an excluded resource for as long as sale of the property would cause undue hardship to a co-owner due to loss of housing. Undue hardship would result if the co-owner:

- (i) Uses the property as his or her principal place of residence;
- (ii) Would have to move if the property were sold; and
- (iii) Has no other readily available housing.

(2) Cash proceeds from the sale of the home described in subsection (1)(b) above are not considered if the client uses

them to purchase another home by the end of the third month after receiving the proceeds from the sale.

(3) An installment contract from the sale of the home described in subsection (1)(b) above is not a resource as long as the person plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home, and does so within three full calendar months after the month of receiving such down payment or installment payment.

(4) The value of sales contracts is excluded when the:

(a) Current market value of the contract is zero,

(b) Contract cannot be sold, or

(c) Current market value of the sales contract combined with other resources does not exceed the resource limits.

(5) Sales contracts executed before December 1, 1993, are exempt resources as long as they are not transferred to someone other than a spouse.

(6) A sales contract for the sale of the client's principal place of residence executed between December 1, 1993 and May 31, 2004 is considered an exempt resource unless it has been transferred to someone other than a spouse and it:

(a) Provides interest income within the prevailing interest rate at the time of the sale;

(b) Requires the repayment of a principal amount equal to the fair market value of the property; and

(c) The term of the contract does not exceed thirty years.

(7) A sales contract executed on or after June 1, 2004 on a home that was the principal place of residence for the client at the time of institutionalization is considered exempt as long as it is not transferred to someone other than a spouse and it:

(a) Provides interest income within the prevailing interest rate at the time of the sale;

(b) Requires the repayment of a principal amount equal to the fair market value of the property within the anticipated life expectancy of the client; and

(c) The term of the contract does not exceed thirty years.

(8) Payments received on sales contracts of the home described in subsection (1)(b) above are treated as follows:

(a) The interest portion of the payment is treated as unearned income in the month of receipt of the payment;

(b) The principal portion of the payment is treated as an excluded resource if reinvested in the purchase of a new home within three months after the month of receipt;

(c) If the principal portion of the payment is not reinvested in the purchase of a new home within three months after the month of receipt, that portion of the payment is considered a liquid resource as of the date of receipt.

(9) Payments received on sales contracts described in subsection (4) are treated as follows:

(a) The principal portion of the payment on the contract is treated as a resource and counted toward the resource limit to the extent retained at the first moment of the month following the month of receipt of the payment; and

(b) The interest portion is treated as unearned income the month of receipt of the payment.

(10) For sales contracts that meet the criteria in subsections (5), (6), or (7) but do not meet the criteria in subsections (3) or (4), both the principal and interest portions of the payment are treated as unearned income in the month of receipt.

(11) Property essential to self-support is not considered a resource within certain limits. The department places property essential to self-support in several categories:

(a) Real and personal property used in a trade or business (income-producing property), such as:

(i) Land,

(ii) Buildings,

(iii) Equipment,

(iv) Supplies,

(v) Motor vehicles, and

(vi) Tools.

(b) Nonbusiness income-producing property, such as:

(i) Houses or apartments for rent, or

(ii) Land, other than home property.

(c) Property used to produce goods or services essential to an individual's daily activities, such as land used to produce vegetables or livestock, which is only used for personal consumption in the individual's household. This includes personal property necessary to perform daily functions including vehicles such as boats for subsistence fishing and garden tractors for subsistence farming, but does not include other vehicles such as those that qualify as automobiles (cars, trucks).

(12) The department will exclude an individual's equity in real and personal property used in a trade or business (income producing property listed in subsection (11)(a) above) regardless of value as long as it is currently in use in the trade or business and remains used in the trade or business.

(13) The department excludes up to six thousand dollars of an individual's equity in nonbusiness income-producing property listed in subsection (11)(b) above, if it produces a net annual income to the individual of at least six percent of the excluded equity.

(a) If a person's equity in the property is over six thousand dollars, only the amount over six thousand dollars is counted toward the resource limit, as long as the net annual income requirement of six percent is met on the excluded equity.

(b) If the six percent requirement is not met due to circumstances beyond the person's control, and there is a reasonable expectation that the activities will again meet the six percent rule, the same exclusions as in subsection (13)(a) above apply.

(c) If a person has more than one piece of property in this category, each is looked at to see if it meets the six percent return and the total equities of all those properties are added to see if the total is over six thousand dollars. If the total is over the six thousand dollars limit, the amount exceeding the limit is counted toward the resource limit.

(d) The equity in each property that does not meet the six percent annual net income limit is counted toward the resource limit, with the exception of property that represents the authority granted by a governmental agency to engage in an income-producing activity if it is:

(i) Used in a trade or business or nonbusiness income-producing activity; or

(ii) Not used due to circumstances beyond the individual's control, e.g., illness, and there is a reasonable expectation that the use will resume.

(14) Property used to produce goods or services essential to an individual's daily activities is excluded if the individual's equity in the property does not exceed six thousand dollars.

(15) Personal property used by an individual for work is not counted, regardless of value, while in current use, or if the required use for work is reasonably expected to resume.

(16) Interests in trust or in restricted Indian land owned by an individual who is of Indian descent from a federally recognized Indian tribe or held by the spouse or widow/er of that individual, is not counted if permission of the other individuals, the tribe, or an agency of the federal government must be received in order to dispose of the land.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0350, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0400 SSI-related medical—Vehicles excluded as resources. (1) For SSI-related medical programs, a vehicle is defined as anything used for transportation. In addition to cars and trucks, a vehicle can include boats, snowmobiles, and animal-drawn vehicles.

(2) One vehicle is excluded regardless of its value, if it is used to provide transportation for the individual or a member of the individual's household:

- (a) For employment;
- (b) For the treatment of a specific or regular medical problem;
- (c) For transportation of or modified for operation by a handicapped person; or
- (d) Because of climate, terrain, distance, or similar factors to perform essential daily activities.

(3) If no vehicle is excluded under subsection (2), the department excludes up to five thousand dollars of the current fair market value of one vehicle as a resource. If the current fair market value of the vehicle exceeds five thousand dollars, the excess is counted toward the resource limit.

(4) A vehicle used as the client's primary residence is excluded as the home, and does not count as the one excluded vehicle.

(5) All other vehicles, except those excluded under WAC 388-475-0350 (11) through (14), are treated as nonliquid resources and the equity value is counted toward the resource limit.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0400, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0450 SSI-related medical—Life insurance excluded as a resource. (1) The department excludes life insurance policies that do not have or cannot accrue a cash surrender value (CSV) in determining whether owned policies exceed the life insurance exclusion limits for resources and in determining burial fund exclusion limits.

(2) Policies owned by each spouse are evaluated and counted separately.

(3) If the total face value of all policies with a CSV potential that a person owns on the same insured is equal to or less than fifteen hundred dollars, the resource is excluded.

(4) If the total face value of all policies with a CSV potential that a person owns on the same insured is more than fifteen hundred dollars, the total CSV of the policies is counted toward the resource limit, unless the client design-

ates such policies as burial funds. If they are designated as burial funds, they must be evaluated under the burial fund exclusion described in WAC 388-475-0500.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0450, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0500 SSI-related medical—Burial funds, contracts and spaces excluded as resources. (1) For the purposes of this section, burial funds are funds set aside and clearly designated solely for burial and related expenses and kept separate from all other resources not intended for burial. These include:

- (a) Revocable burial contracts;
- (b) Revocable burial trusts;
- (c) Installment contracts for purchase of a burial space on which payments are still owing;
- (d) Other revocable burial arrangements. The designation is effective the first day of the month in which the person intended the funds to be set aside for burial.

(2) The following burial funds are excluded as resources for the client and spouse up to fifteen hundred dollars each when set aside solely for the expenses of burial or cremation and expenses related to the burial or cremation, and the funds are either:

- (a) An installment contract for purchase of a burial space that is not yet paid in full; or
- (b) In a revocable burial contract, burial trust, cash accounts, or other financial instrument with a definite cash value.

(3) Interest earned in burial funds and appreciation in the value of excluded burial arrangements in subsection (2)(a) and (b) above are excluded from resources and are not counted as income if left to accumulate and become part of the separate burial fund.

(4) The fifteen hundred dollar exclusion for burial funds described in subsection (2) above is reduced by:

- (a) The face value of life insurance with CSV excluded in WAC 388-475-0450; and
- (b) Amounts in an irrevocable burial trust, or other irrevocable arrangement available to meet burial expenses, or burial space purchase agreement installment contracts on which money is still owing. If these reductions bring the balance of the available exclusion to zero, no additional funds can be excluded as burial funds.

(5) An irrevocable burial account, burial trust, or other irrevocable burial arrangement, set aside solely for burial and related expenses is not considered a resource. The amount set aside must be reasonably related to the anticipated death-related expenses in order to be excluded.

(6) A client's burial funds are no longer excluded when they are mixed with other resources that are not related to burial.

(7) When excluded burial funds are spent for other purposes, the spent amount is added to other countable resources and any amount exceeding the resource limit is considered available income on the first of the month it is used. The amount remaining in the burial fund remains excluded.

(8) Burial space and accessories for the client and any member of the client's immediate family described in subsection (9) of this section are excluded. Burial space and accessories include:

- (a) Conventional gravesites;
- (b) Crypts, niches, and mausoleums;
- (c) Urns, caskets and other repositories customarily used for the remains of deceased persons;
- (d) Necessary and reasonable improvements to the burial space including, but not limited to:
 - (i) Vaults and burial containers;
 - (ii) Headstones, markers and plaques;
 - (iii) Arrangements for the opening and closing of the gravesite; and
 - (iv) Contracts for care and maintenance of the gravesite.
- (e) A burial space purchase agreement that is currently paid for and owned by the client is also defined as a burial space. The entire value of the purchase agreement is excluded; as well as any interest accrued, which is left to accumulate as part of the value of the agreement. The value of this agreement does not reduce the amount of burial fund exclusion available to the client.
- (9) Immediate family, for the purposes of subsection (8) of this section includes the client's:
 - (a) Spouse;
 - (b) Parents and adoptive parents;
 - (c) Minor and adult children, including adoptive and stepchildren;
 - (d) Siblings (brothers and sisters), including adoptive and stepsiblings;
 - (e) Spouses of any of the above.

None of the family members listed above, need to be dependent on or living with the client, to be considered immediate family members.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-003, § 388-475-0500, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0550 SSI-related medical—All other excluded resources. All resources described in this section are excluded resources for SSI-related medical programs. Unless otherwise stated, interest earned on the resource amount is counted as unearned income.

- (1) Resources necessary for a client who is blind or disabled to fulfill a department approved self-sufficiency plan.
- (2) Retroactive payments from SSI or RSDI, including benefits a client receives under the interim assistance reimbursement agreement with the Social Security Administration, are excluded for nine months following the month of receipt. This exclusion applies to:
 - (a) Payments received by the client, spouse, or any other person financially responsible for the client;
 - (b) SSI payments for benefits due for the month(s) before the month of continuing payment;
 - (c) RSDI payments for benefits due for a month that is two or more months before the month of continuing payment; and
 - (d) Proceeds from these payments as long as they are held as cash, or in a checking or savings account. The funds may be commingled with other funds, but must remain identifiable from the other funds for this exclusion to apply. This exclusion does not apply once the payments have been converted to any other type of resource.
- (3) All resources specifically excluded by federal law, such as those described in subsections (4) through (11) as long as such funds are identifiable.

(4) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

(5) Payments made to Native Americans as listed in 20 CFR 416.1182, Appendix to subpart K, section IV, paragraphs (b) and (c), and in 20 CFR 416.1236.

(6) The following Native American/Alaska Native funds are excluded resources:

(a) Resources received from a Native Corporation under the Alaska Native Claims Settlement Act, including:

(i) Shares of stock held in a regional or village corporation;

(ii) Cash or dividends on stock received from the Native Corporation up to two thousand dollars per person per year;

(iii) Stock issued by a native corporation as a dividend or distribution on stock;

(iv) A partnership interest;

(v) Land or an interest in land; and

(vi) An interest in a settlement trust.

(b) All funds contained in a restricted Individual Indian Money (IIM) account.

(7) Restitution payment and any interest earned from this payment to persons of Japanese or Aleut ancestry who were relocated and interned during war time under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act.

(8) Funds received from the Agent Orange Settlement Fund or any other funds established to settle Agent Orange liability claims.

(9) Payments or interest accrued on payments received under the Radiation Exposure Compensation Act received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(10) Payments from:

(a) The Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV).

(b) The Victims of Nazi Persecution Act of 1994 to survivors of the Holocaust.

(c) Susan Walker vs. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds.

(d) Ricky Ray Hemophilia Relief Fund Act of 1998 P.L. 105-369.

(11) The unspent social insurance payments received due to wage credits granted under sections 500 through 506 of the Austrian General Social Insurance Act.

(12) Earned income tax credit refunds and payments are excluded as resources for nine months after the month of receipt.

(13) Payments from a state administered victim's compensation program for a period of nine calendar months after the month of receipt.

(14) Cash or in-kind items received as a settlement for the purpose of repairing or replacing a specific excluded resource are excluded:

(a) For nine months. This includes relocation assistance provided by state or local government.

(b) Up to a maximum of thirty months, when:

(i) The client intends to repair or replace the excluded resource; and

(ii) Circumstances beyond the control of the settlement recipient prevented the repair or replacement of the excluded

resource within the first or second nine months of receipt of the settlement.

(c) For an indefinite period, if the settlement is from federal relocation assistance.

(d) Permanently, if the settlement is assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States, or is comparable assistance received from a state or local government or from a disaster assistance organization. Interest earned on this assistance is also excluded from resources. Any cash or in-kind items received as a settlement and excluded under this subsection are considered as available resources when not used within the allowable time periods.

(15) Insurance proceeds or other assets recovered by a Holocaust survivor as defined in WAC 388-470-0026(4).

(16) Pension funds owned by an ineligible spouse. Pension funds are defined as funds held in a(n):

(a) Individual retirement account (IRA) as described by the IRS code; or

(b) Work-related pension plan (including plans for self-employed individuals, known as Keogh plans).

(17) Cash payments received from a medical or social service agency to pay for medical or social services are excluded for one calendar month following the month of receipt.

(18) SSA- or DVR-approved plans for achieving self-support (PASS) accounts, allowing blind or disabled individuals to set aside resources necessary for the achievement of the plan's goals, are excluded.

(19) Food and nutrition programs with federal involvement. This includes Washington Basic Food, school reduced and free meals and milk programs and WIC.

(20) Gifts to, or for the benefit of, a person under eighteen years old who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of that Code, as follows:

(a) In-kind gifts that are not converted to cash; or

(b) Cash gifts up to a total of two thousand dollars in a calendar year.

(21) Veteran's payments made to, or on behalf of, natural children of Vietnam veterans regardless of their age or marital status, for any disability resulting from spina bifida suffered by these children.

(22) The following are among assets that are not considered resources and as such are neither excluded nor counted:

(a) Home energy assistance/support and maintenance assistance;

(b) Retroactive in-home supportive services payments to ineligible spouses and parents; and

(c) Gifts of domestic travel tickets. For a more complete list please see POMS @ <http://policy.ssa.gov/poms.nsf/lnx/0501130050>.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500, and Social Security Act as amended by P.L. 108-203, 06-04-046, § 388-475-0550, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090, 04-09-004, § 388-475-0550, filed 4/7/04, effective 6/1/04.]

(2007 Ed.)

WAC 388-475-0600 SSI-related medical—Definition of income. (1) Income is anything an individual receives in cash or in-kind that can be used to meet his/her needs for food, clothing, or shelter. Income can be earned or unearned.

(2) Some receipts are not income because they do not meet the definition of income above, including:

(a) Cash or in-kind assistance from federal, state, or local government programs whose purpose is to provide medical care or services;

(b) Some in-kind payments that are not food, clothing or shelter coming from nongovernmental programs whose purposes are to provide medical care or medical services;

(c) Payments for repair or replacement of an exempt resource;

(d) Refunds or rebates for money already paid;

(e) Receipts from sale of a resource; and

(f) Replacement of income already received. See 20 CFR 416.1103 for a more complete list of receipts that are not income.

(3) Earned income includes the following types of payments:

(a) Gross wages and salaries, including garnished amounts;

(b) Commissions and bonuses;

(c) Severance pay;

(d) Other special payments received because of employment;

(e) Net earnings from self-employment (WAC 388-475-0840 describes net earnings);

(f) Self-employment income of tribal members unless the income is specifically exempted by treaty;

(g) Payments for services performed in a sheltered workshop or work activities center;

(h) Royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered; or

(i) In-kind payments made in lieu of cash wages, including the value of food, clothing or shelter.

(4) Unearned income is all income that is not earned income. Some types of unearned income are:

(a) Annuities, pensions, and other periodic payments;

(b) Alimony and support payments;

(c) Dividends and interest;

(d) Royalties (except for royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered which would be earned income);

(e) Capital gains;

(f) Rents;

(g) Benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient;

(h) Gifts;

(i) Inheritances; or

(j) Prizes and awards.

(5) Some items which may be withheld from income, but the department considers as received income are:

(a) Federal, state, or local income taxes;

(b) Health or life insurance premiums;

(c) SMI premiums;

(d) Union dues;

- (e) Penalty deductions for failure to report changes;
 - (f) Loan payments;
 - (g) Garnishments;
 - (h) Child support payments, court ordered or voluntary (WAC 388-475-0900 has an exception for deemors);
 - (i) Service fees charged on interest-bearing checking accounts;
 - (j) Inheritance taxes;
 - (k) Guardianship fees if presence of a guardian is not a requirement for receiving the income.
- (6) Countable income, for the purposes of this chapter, means all income that is available to the individual:
- (a) If it cannot be excluded, and
 - (b) After deducting all allowable disregards and deductions.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0600, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0650 SSI-related medical—Available income. (1) Income is considered available to a client at the earliest of when it is:

- (a) Received, or
 - (b) Credited to an individual's account, or
 - (c) Set aside for his or her use, or
 - (d) Can be used to meet the client's needs for food, clothing or shelter.
- (2) Anticipated nonrecurring lump sum payments are treated as income in the month received, with the exception of those listed in WAC 388-475-0700(5), and any remainder is considered a resource in the following month.

(3) Reoccurring income is considered available in the month of normal receipt, even if the financial institution posts it before or after the month of normal receipt.

(4) In-kind income received from anyone other than a legally responsible relative is considered available income only if it is earned income.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0650, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0700 SSI-related medical—Income eligibility. (1) In order to be eligible, a client is required do everything necessary to obtain any income to which they are entitled including (but not limited to):

- (a) Annuities,
- (b) Pensions,
- (c) Unemployment compensation,
- (d) Retirement, and
- (e) Disability benefits; even if their receipt makes the client ineligible for department services, unless the client can provide evidence showing good reason for not obtaining the benefits.

The department does not count this income until the client begins to receive it.

(2) Income is budgeted prospectively for all medical programs.

(3) Anticipated nonrecurring lump sum payments other than retroactive SSI/SSDI payments are considered income in the month received, subject to reporting requirements in WAC 388-418-0007(4). Any unspent portion is considered a resource the first of the following month.

[Title 388 WAC—p. 882]

(4) The department follows income and resource methodologies of the Supplemental Security Income (SSI) program defined in federal law when determining eligibility for SSI-related medical or Medicare savings programs unless the department adopts rules that are less restrictive than those of the SSI program.

(5) Exceptions to the SSI income methodology:

(a) Lump sum payments from a retroactive SSDI benefit, when reduced by the amount of SSI received during the period covered by the payment, are not counted as income;

(b) Unspent retroactive lump sum money from SSI or SSDI is excluded as a resource for nine months following receipt of the lump sum; and

(c) Both the principal and interest portions of payments from a sales contract, that meet the definition in WAC 388-475-0350(10), are unearned income.

(6) To be eligible for categorically needy (CN) SSI-related medical coverage, a client's countable income cannot exceed the CN program standard described in:

(a) WAC 388-478-0065 through 388-478-0085 for non-institutional medical unless living in an alternate living facility; or

(b) WAC 388-513-1305(2) for noninstitutional CN benefits while living in an alternate living facility; or

(c) WAC 388-513-1315 for institutional and waiver services medical benefits.

(7) To be eligible for SSI-related medical coverage provided under the medically needy (MN) program, a client must:

(a) Have countable income at or below the MN program standard as described in WAC 388-478-0070; or

(b) Satisfy spenddown requirements described in WAC 388-519-0110;

(c) Meet the requirements for noninstitutional MN benefits while living in an alternate living facility (ALF). See WAC 388-513-1305(3); or

(d) Meet eligibility for the MN waiver program. See WAC 388-515-1540 and 388-515-1550.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500, and Social Security Act as amended by P.L. 108-203. 06-04-046, § 388-475-0700, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-004, § 388-475-0700, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0750 SSI-related medical—Countable unearned income. The department counts unearned income for SSI-related medical programs as follows:

(1) The total amount of benefits to which a client is entitled is available unearned income even when the benefits are:

(a) Reduced through the withholding of a portion of the benefit amount to repay a legal obligation;

(b) Garnished to repay a debt, other legal obligation, or make any other payment such as payment of Medicare premiums.

(2) Payments received on a loan:

(a) Interest paid on the loan amount is considered unearned income; and

(b) Payments on the loan principal are not considered income. However, any amounts retained on the first of the following month are considered a resource.

(2007 Ed.)

(3) Money borrowed by a person, which must be repaid, is not considered income. It is considered a loan. If the money received does not need to be repaid, it is considered a gift.

(4) Rental income received for the use of real or personal property, such as land, housing or machinery is considered unearned income. The countable portion of rental income received is the amount left after deducting necessary expenses of managing and maintaining the property paid in that month or carried over from a previous month. Necessary expenses are those such as:

- (a) Advertising for tenants;
- (b) Property taxes;
- (c) Property insurance;
- (d) Repairs and maintenance on the property; and
- (e) Interest and escrow portions of a mortgage.

NOTE: When a client is in the business of renting properties and actively works the business (over twenty hours per week), the income is counted as earned income.

[Statutory Authority: RCW 74.04.050, 74.08.090, 04-09-004, § 388-475-0750, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0800 SSI-related medical—General income exclusions. The department excludes, or does not consider, the following when determining a client's eligibility for SSI-related medical programs:

(1) The first twenty dollars per month of unearned income. If there is less than twenty dollars of unearned income in a month, the remainder is excluded from earned income in that month.

(a) The twenty-dollar limit is the same, whether applying it for a couple or for a single person.

(b) The disregard does not apply to income paid totally or partially by the federal government or a nongovernmental agency on the basis of an eligible person's needs.

(c) The twenty dollars disregard is applied after all exclusions have been taken from income.

(2) Income that is not reasonably anticipated or is received infrequently or irregularly, whether for a single person or each person in a couple when it is:

(a) Earned and does not exceed a total of thirty dollars per calendar quarter; or

(b) Unearned and does not exceed a total of sixty dollars per calendar quarter;

(c) Increases in a client's burial funds that were established on or after November 1, 1982 if the increases are the result of:

- (i) Interest earned on excluded burial funds; or
- (ii) Appreciation in the value of an excluded burial arrangement that was left to accumulate and become part of separately identified burial funds.

(3) Essential expenses necessary for a client to receive compensation (e.g., necessary legal fees in order to get a settlement);

(4) Receipts, which are not considered income, when they are for:

- (a) Replacement or repair of an exempt resource;
- (b) Prepayment or repayment of medical care paid by a health insurance policy or medical service program; or
- (c) Payments made under a credit life or credit disability policy.

(2007 Ed.)

(5) The fee a guardian or representative payee charges as reimbursement for providing services, when such services are a requirement for the client to receive payment of the income.

(6) Funds representing shared household costs.

(7) Crime victim's compensation.

(8) The value of a common transportation ticket, given as a gift, that is used for transportation and not converted to cash.

(9) Gifts that are not for food, clothing or shelter, and gifts of home produce used for personal consumption.

(10) The department does not consider in-kind income received from someone other than a person legally responsible for the individual unless it is earned. Therefore, the following in-kind payments are not counted when determining eligibility for SSI-related medical programs.

(a) In-kind payments for services paid by a client's employer if:

(i) The service is not provided in the course of an employer's trade or business; or

(ii) It is in the form of food and/or shelter that is:

(A) On the employer's business premises;

(B) For the employer's convenience; and

(C) If shelter, acceptance by the employee is a condition of employment.

(b) In-kind payments made to people in the following categories:

(i) Agricultural employees;

(ii) Domestic employees;

(iii) Members of the uniformed services;

(iv) Persons who work from home to produce specific products for the employer from materials supplied by the employer.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.-500, and Social Security Act as amended by P.L. 108-203, 06-04-046, § 388-475-0800, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090, 04-09-005, § 388-475-0800, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0820 SSI-related medical—Child-related income exclusions. (1) The department excludes an allowance from a person's earned and/or unearned income for a child living in the home when:

(a) The minor child lives with an SSI-related parent; and

(b) The minor child is not receiving a needs-based cash payment such as TANF or SSI; and

(c) The SSI-related parent is single; or

(d) The SSI-related parent lives with a spouse who has no income; and

(e) The individual applying for or receiving SSI-related medical benefits is the adult parent. The maximum allowance is one-half the Federal Benefit Rate (FBR) for each child. The child's countable income, if any, is subtracted from the maximum child's allowance before determining this allowance.

(2) Foster care payments received for a child who is not SSI-eligible and who is living in the household, placed there by a licensed, nonprofit or public child placement or child-care agency are excluded from income regardless of whether the person requesting or receiving SSI-related medical is the adult foster parent or the child who was placed.

[Title 388 WAC—p. 883]

(3) Adoption support payments, received by an adult for a child in the household that are designated for the child's needs, are excluded as income. Adoption support payments that are not specifically designated for the child's needs are not excluded and are considered unearned income to the adult.

(4) Earned income of a person under age twenty-two is excluded if that person is a student.

(5) Child support payments received from an absent parent for a child living in the home are considered the income of the child.

(6) One-third of child support payments received for a child are excluded from the child's income.

(7) Any portion of a grant, scholarship, fellowship, or gift used for tuition, fees and/or other necessary educational expenses at any educational institution is excluded from income for nine months after the month of receipt.

(8) Gifts to, or for the benefit of, a person under eighteen years old who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of that Code, is excluded as follows:

(a) In-kind gifts that are not converted to cash; or

(b) Cash gifts up to a total of two thousand dollars in a calendar year.

(9) Veteran's payments made to, or on behalf of, natural children of Vietnam veterans regardless of their age or marital status, for any disability resulting from spina bifida suffered by these children are excluded from income.

(10) Unless it is specifically contributed to the client, all earned income of an ineligible or nonapplying person under the age of twenty-one who is a student:

(a) Attending a school, college, or university; or

(b) Pursuing a vocational or technical training program designed to prepare the student for gainful employment.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500, and Social Security Act as amended by P.L. 108-203. 06-04-046, § 388-475-0820, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-005, § 388-475-0820, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0840 SSI-related medical—Work- and agency-related income exclusions. The department excludes the following when determining eligibility for SSI-related medical programs:

(1) Work related expenses:

(a) Including child care, that enable an SSI-related client to work;

(b) That allow a blind or disabled client to work and that are directly related to the person's impairment.

(2) First sixty-five dollars plus one-half of the remainder of earned income. This is considered a work allowance/incentive. This deduction does not apply to income already excluded.

(3) Any portion of self-employment income normally allowed as an income deduction by the Internal Revenue Service (IRS).

(4) Veteran's Aid and Attendance, housebound allowance, unusual/unreimbursed medical expenses (UME) paid by the VA to some disabled veterans, their spouses, widows

or parents. For people receiving long-term care services, see chapter 388-513 WAC.

(5) Payments provided in cash or in-kind, to an ineligible or nonapplying spouse, under any government program that provides social services provided to the client, such as chore services or attendant care.

(6) SSA refunds for Medicare buy-in premiums paid by the client when the state also paid the premiums.

(7) Income that causes a client to lose SSI eligibility, due solely to reduction in the SSP.

(8) Department of Veteran's Affairs benefits designated for the veteran's dependent. It is considered income of that dependent.

(9) Tax rebates or special payments excluded under other statutes.

(10) Any public agency refund of taxes paid on real property or on food.

[Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-005, § 388-475-0840, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0860 SSI-related medical—Income exclusions under federal statute or other state laws. The Social Security Act and other federal statutes or state laws list income that the department excludes when determining eligibility for SSI-related medical programs. These exclusions include, but are not limited to:

(1) Income tax refunds;

(2) Federal earned income tax credit (EITC) payments for nine months after the month of receipt;

(3) Compensation provided to volunteers in the Corporation for National and Community Service (CNCS), formerly known as ACTION programs established by the Domestic Volunteer Service Act of 1973. P.L. 93-113;

(4) Assistance to a person (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102 (h)(1) of Pub. L. 95-478 (92 Stat. 1515, 42 U.S.C. 3020a);

(5) Federal, state and local government payments including assistance provided in cash or in-kind under any government program that provides medical or social services;

(6) Certain cash or in-kind payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(7) Value of food provided through a federal or nonprofit food program such as WIC, donated food program, school lunch program;

(8) Assistance based on need, including:

(a) Any federal SSI income or state supplement payment (SSP) based on financial need;

(b) Food stamps;

(c) GA-U;

(d) CEAP;

(e) TANF; and

(f) Bureau of Indian Affairs (BIA) general assistance.

(9) Housing assistance from a federal program such as HUD if paid under:

(a) United States Housing Act of 1937 (section 1437 et seq. of 42 U.S.C.);

(b) National Housing Act (section 1701 et seq. of 12 U.S.C.);

(c) Section 101 of the Housing and Urban Development Act of 1965 (section 1701s of 12 U.S.C., section 1451 of 42 U.S.C.);

(d) Title V of the Housing Act of 1949 (section 1471 et seq. of 42 U.S.C.); or

(e) Section 202(h) of the Housing Act of 1959;

(f) Weatherization provided to low-income homeowners by programs that consider income in the eligibility determinations;

(10) Energy assistance payments including:

(a) Those to prevent fuel cutoffs, and

(b) To promote energy efficiency.

(11) Income from employment and training programs as specified in WAC 388-450-0045.

(12) Foster grandparents program;

(13) Title IV-E and state foster care maintenance payments if the foster child is not included in the assistance unit;

(14) The value of any childcare provided or arranged (or any payment for such care or reimbursement for costs incurred for such care) under the Child Care and Development Block Grant Act, as amended by section 8(b) of P.L. 102-586 (106 Stat. 5035).

(15) Educational assistance as specified in WAC 388-450-0035.

(16) Up to two thousand dollars per year derived from an individual's interest in Indian trust or restricted land.

(17) Native American benefits and payments as specified in WAC 388-450-0040 and other Native American payments excluded by federal statute. For a complete list of these payments, see 20 CFR 416, Subpart K, Appendix, IV.

(18) Payments from *Susan Walker v. Bayer Corporation*, et al., 96-cv-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(19) Payments from Ricky Ray Hemophilia Relief Fund Act of 1998, P.L. 105-369;

(20) Disaster assistance paid under Federal Disaster Relief P.L. 100-387 and Emergency Assistance Act, P.L. 93-288 amended by P.L. 100-707 and for farmers P.L. 100-387;

(21) Payments to certain survivors of the Holocaust as victims of Nazi persecution; payments excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, P.L. 103-286 (108 Stat. 1450);

(22) Payments made under section 500 through 506 of the Austrian General Social Insurance Act;

(23) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(24) Restitution payments and interest earned to Japanese Americans or their survivors, and Aleuts interned during World War II, established by P.L. 100-383;

(25) Payments made from the Agent Orange Settlement Funds or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(26) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(27) Any interest or dividend is excluded as income, except for the community spouse of an institutionalized individual.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500, and Social Security Act as amended by P.L. 108-203. 06-04-046, § 388-475-0860, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.08.090. 04-09-005, § 388-475-0860, filed 4/7/04, effective 6/1/04.]

(2007 Ed.)

WAC 388-475-0880 SSI-related medical—Special income disregards. Portions of your income the department otherwise counts are disregarded when determining eligibility for SSI-related medical programs.

(1) The department disregards the following for SSI-related medical programs:

(a) The cost of living adjustment(s) (COLA) for a client who:

(i) Is currently receiving a Social Security payment;

(ii) Was eligible for and received both SSA and SSI/State Supplement payments (SSP) in the same month for at least one month since April, 1977; and

(iii) Would continue to receive SSI/SSP payments but for the COLA increase(s) to their SSA benefits. This is commonly known as the adjustment for "Pickle people."

(b) Widow(er)'s benefits for a client who:

(i) Was entitled to SSA title II (widow/widower's) benefits in December 1983;

(ii) Was at least fifty years old, but not yet sixty at that time;

(iii) Received title II benefits and SSI in January 1984;

(iv) Would continue to be eligible for SSI/SSP payments if the title II benefits were disregarded; and

(v) Filed an application for Medicaid with the state by July 1, 1988.

(c) Widow, Widower or Surviving Divorced Spouse (title II) benefits for a client who:

(i) Received SSI/SSP benefits the month prior to receipt of title II benefits;

(ii) Would continue to be eligible for SSI/SSP benefits if the title II benefits or the COLA(s) to those benefits were disregarded;

(iii) Is not eligible for Medicare Part A. This client is considered an SSI recipient until becoming entitled to Medicare Part A.

(2) A disabled adult child (DAC) who is ineligible for SSI/SSP solely due to receipt of either Social Security benefits as a disabled adult child of a person with a Social Security account or due to receipt of a COLA to the DAC benefits, may be income eligible for CN medical if disregarding the SSA DAC benefits and COLA brings countable income below the CN standards, and the client:

(a) Is eighteen years of age or older;

(b) Remains related to the SSI program through disability or blindness;

(c) Lost SSI eligibility on or after July 1, 1988 due solely to the receipt of DAC benefits from SSA or a COLA to those benefits; and

(d) Meets the other SSI-related CN medical requirements.

(3) Clients who stop receiving an SSI cash payment due to earnings, but still meet all of the other SSI eligibility rules and have income below the higher limit established by the Social Security Act's Section 1619(b) are eligible for continued CN Medicaid.

(4) TANF income methodology is used to determine countable income for children and pregnant women applying for MN unless the SSI methodology would be more beneficial to the client. For cases using TANF methodology, follow the family medical rules and allow the:

(a) Fifty percent earned income disregard;

(b) Child care and dependent care expenses related to employment; and

(c) Child support actually paid.

[Statutory Authority: RCW 74.04.050, 74.08.090, 04-09-005, § 388-475-0880, filed 4/7/04, effective 6/1/04.]

WAC 388-475-0900 SSI-related medical—Allocating income. The department considers income of financially responsible persons to determine if a portion of that income must be regarded as available to other household members.

(1) When income is allocated from an SSI-related person to other household members, that income is considered as the other members' income.

(2) A portion of the income of a spouse or parent is allocated to the needs of an SSI-related applicant when the spouse or parent is:

(a) Financially responsible for the SSI-related person as described in WAC 388-408-0055 and 388-506-0620. For long-term care programs, see WAC 388-513-1315, 388-513-1330, 388-513-1350; for waiver programs see WAC 388-515-1505 through 388-515-1530;

(b) Living in the same household;

(c) Not receiving SSI; and

(d) Either not related to SSI or is not applying for medical assistance.

(3) Allocations to children are deducted from the nonapplying spouse's unearned income, then from their earned income, before they are deducted from the applicant's income. See WAC 388-475-0820.

(4) If the conditions in subsection (2) are met, the income to be allocated from a parent to an SSI-related minor child applying for medical benefits is the amount remaining after deducting:

(a) All allowable income exclusions and disregards as described in WAC 388-475-750 through WAC 388-475-880;

(b) One-half of the federal benefit rate (FBR) for each SSI ineligible sibling of the SSI related child living in the household, minus any countable income of that child. See WAC 388-478-0055 for FBR amount;

(c) The parent's allowance, either the one person FBR for a single parent or two person FBR for a two-parent household.

(5) A portion of the countable income of a nonapplying spouse remaining after the deductions in subsection (4) may be allocated to the SSI-related spouse as follows for CN medical determinations:

(a) If the income is less than or equal to one-half of the FBR after allowing the income exclusions in subsection (4) of this section, no income is allocated to the client.

(b) If the income is equal to or more than one-half of the FBR after allowing the income exclusions in subsection (4) of this section, all income other than the excluded amounts is allocated to the applying spouse.

(6) Deductions from the income of the nonapplying spouse of an SSI-related applicant for CN medical determinations are:

(a) Income exclusions as described in WAC 388-475-0750 through 388-478-0880;

(b) One-half of the federal benefit rate (FBR) as described in WAC 388-478-0055 for each eligible child in the household, minus the child's countable income.

(7) In determining MN medical eligibility for SSI-related applicants:

(a) If the income of the nonapplying spouse is less than the MNIL (see WAC 388-478-0070) after applying any child allocation, a portion of the applying spouse's countable income is added to the nonapplying spouse's income to raise it to the MNIL for MN;

(b) If the income of the nonapplying spouse is more than the MNIL after applying any child allocation, the entire amount exceeding the MNIL is allocated to the applying spouse.

(8) Only income and resources actually contributed to an alien applicant from their sponsor are counted as income. For allocation of income from an alien sponsor, refer to WAC 388-450-0155.

[Statutory Authority: RCW 74.04.050, 74.08.090, 04-09-005, § 388-475-0900, filed 4/7/04, effective 6/1/04.]

WAC 388-475-1000 Healthcare for workers with disabilities (HWD)—Program description. This section describes the healthcare for workers with disabilities (HWD) program.

(1) The HWD program provides categorically needy (CN) scope of care as described in WAC 388-501-0060.

(2) The department approves HWD coverage for twelve months effective the first of the month in which a person applies and meets program requirements. See WAC 388-475-1100 for "retroactive" coverage for months before the month of application.

(3) A person who is eligible for another Medicaid program may choose not to participate in the HWD program.

(4) A person is not eligible for HWD coverage for a month in which the person received Medicaid benefits under the medically needy (MN) program.

(5) The HWD program does not provide long-term care (LTC) services described in chapters 388-513 and 388-515 WAC. LTC services include institutional, waived, and hospice services. To receive LTC services, a person must qualify and participate in the cost of care according to the rules of those programs.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700, 06-24-036, § 388-475-1000, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II, 02-01-073, § 388-475-1000, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1050 Healthcare for workers with disabilities (HWD)—Program requirements. This section describes requirements a person must meet to be eligible for the healthcare for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must:

(a) Meet the general requirements for a medical program described in WAC 388-503-0505 (3)(a) through (f);

(b) Be age sixteen through sixty-four;

(c) Meet the federal disability requirements described in WAC 388-475-1150;

(d) Have net income at or below two hundred twenty percent of the federal poverty level (FPL) (see WAC 388-478-0075 for FPL amounts for medical programs); and

(e) Be employed full or part time (including self-employment) as described in WAC 388-475-1200.

(2) To determine net income, the department applies the following rules to total gross household income in this order:

(a) Deduct income exclusions described in WAC 388-475-0800, 388-475-0820, 388-475-0840, and 388-475-0860; and

(b) Follow the CN income rules described in:

(i) WAC 388-475-0600, SSI-related medical—Definition of income;

(ii) WAC 388-475-0650, SSI-related medical—Available income;

(iii) WAC 388-475-0700 (1) through (5), SSI-related medical—Income eligibility;

(iv) WAC 388-475-0750, SSI-related medical—Countable unearned income; and

(v) WAC 388-506-0620, SSI-related medical clients.

(3) The HWD program does not require an asset test.

(4) Once approved for HWD coverage, a person must pay his/her monthly premium in the following manner to continue to qualify for the program:

(a) The department calculates the premium for HWD coverage according to WAC 388-475-1250;

(b) If a person does not pay four consecutive monthly premiums, the person is not eligible for HWD coverage for the next four months and must pay all premium amounts owed before HWD coverage can be approved again; and

(c) Once approved for HWD coverage, a person who experiences a job loss can choose to continue HWD coverage through the original twelve months of eligibility, if the following requirements are met:

(i) The job loss results from an involuntary dismissal or health crisis; and

(ii) The person continues to pay the monthly premium.

[Statutory Authority: RCW 74.08.090, 34.05.353 and Section 1902 (a)(10)(A)(ii) of the Social Security Act, 04-15-002, § 388-475-1050, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1050, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1100 Healthcare for workers with disabilities (HWD)—Retroactive coverage. This section describes requirements for retroactive coverage provided under the healthcare for workers with disabilities (HWD) program.

(1) Retroactive coverage refers to the period of up to three months before the month in which a person applies for the HWD program. The department cannot approve HWD coverage for a month that precedes January 1, 2002.

(2) To qualify for retroactive coverage under the HWD program, a person must first:

(a) Meet all program requirements described in WAC 388-475-1050 for each month of the retroactive period; and

(b) Pay the premium amount for each month requested within one hundred twenty days of being billed for such coverage.

(3) If a person does not pay premiums in full as described in subsection (2)(b) for all months requested in the retroactive period, the department denies retroactive coverage and refunds any payment received for those months.

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1100, filed 12/14/01, effective 1/14/02.]

(2007 Ed.)

WAC 388-475-1150 Healthcare for workers with disabilities (HWD)—Disability requirements. This section describes the disability requirements for the two groups of individuals that may qualify for the healthcare for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must meet the requirements of the Social Security Act in section 1902 (a) (10) (A) (ii):

(a) (XV) for the basic coverage group (BCG); or

(b) (XVI) for the medical improvement group (MIG).

(2) The BCG consists of individuals who:

(a) Meet federal disability requirements for the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) program; or

(b) Are determined by the division of disability determination services (DDDS) to meet federal disability requirements for the HWD program.

(3) The MIG consists of individuals who:

(a) Were previously eligible and approved for the HWD program as a member of the BCG; and

(b) Are determined by DDDS to have a medically improved disability. The term "medically improved disability" refers to the particular status granted to persons described in subsection (1)(b).

(4) When completing a disability determination for the HWD program, DDDS will not deny disability status because of employment.

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1150, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1200 Healthcare for workers with disabilities (HWD)—Employment requirements. This section describes the employment requirements for the basic coverage group (BCG) and the medical improvement group (MIG) for the healthcare for workers with disabilities (HWD) program.

(1) For the purpose of the HWD program, employment means a person:

(a) Gets paid for working;

(b) Has earnings that are subject to federal income tax; and

(c) Has payroll taxes taken out of earnings received, unless self-employed.

(2) To qualify for HWD coverage as a member of the BCG, a person must be employed full or part time.

(3) To qualify for HWD coverage as a member of the MIG, a person must be:

(a) Working at least forty hours per month; and

(b) Earning at least the local minimum wage as described under section 6 of the Fair Labor Standards Act (29 U.S.C. 206).

[Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1200, filed 12/14/01, effective 1/14/02.]

WAC 388-475-1250 Healthcare for workers with disabilities (HWD)—Premium payments. This section describes how the department calculates the premium amount a person must pay for healthcare for workers with disabilities (HWD) coverage. This section also describes program

requirements regarding the billing and payment of HWD premiums.

(1) When determining the HWD premium amount, the department counts only the income of the person approved for the program. It does not count the income of another household member.

(2) When determining countable income used to calculate the HWD premium, the department applies the following rules:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the person's needs for food, clothing, and shelter, except as described in WAC 388-475-0600(5), 388-475-0650, and 388-475-0700(1).

(b) Loans and certain other receipts are not considered to be income as described in 20 C.F.R. Sec. 416.1103, e.g., direct payment by anyone of a person's medical insurance premium or a tax refund on income taxes already paid.

(3) The HWD premium amount equals a total of the following (rounded down to the nearest whole dollar):

(a) Fifty percent of unearned income above the medically needy income level (MNIL) described in WAC 388-478-0070; plus

(b) Five percent of total unearned income; plus

(c) Two point five percent of earned income after first deducting sixty-five dollars.

(4) When determining the premium amount, the department will use the current income amount until a change in income is reported and processed.

(5) A change in the premium amount is effective the month after the change in income is reported and processed.

(6) For current and ongoing coverage, the department will bill for HWD premiums during the month following the month in which coverage is approved.

(7) For retroactive coverage, the department will bill the HWD premiums during the month following the month in which coverage is requested and necessary information is received.

(8) If initial coverage for the HWD program is approved in a month that follows the month of application, the first monthly premium includes the costs for both the month of application and any following month(s).

(9) As described in WAC 388-475-1050 (4)(b), the department will close HWD coverage after four consecutive months for which premiums are not paid in full.

(10) If a person makes only a partial payment toward the cost of HWD coverage for any one month, the person remains one full month behind in the payment schedule.

(11) The department first applies payment for current and ongoing coverage to any amount owed for such coverage in an earlier month. Then it applies payment to the current month and then to any unpaid amount for retroactive coverage.

[Statutory Authority: RCW 74.08.090, 34.05.353 and Section 1902 (a)(10)(A)(ii) of the Social Security Act, 04-15-002, § 388-475-1250, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.08.090, Section 1902 (a)(10)(A)(ii) of the Social Security Act, and 2001 c 7 § 209(5), Part II. 02-01-073, § 388-475-1250, filed 12/14/01, effective 1/14/02.]

Chapter 388-476 WAC SOCIAL SECURITY NUMBER

WAC

388-476-0005 Social Security number requirements.

WAC 388-476-0005 Social Security number requirements. (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash, medical, and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) A newborn may receive benefits for up to six months from the date of birth if the household is unable to provide proof of application for an SSN at the time of birth.

(6) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy (CN) medical without meeting the SSN requirement until the baby's first birthday.

(7) There is no SSN requirement for the following programs:

(a) The consolidated emergency assistance program;

(b) The refugee cash and medical assistance program;

(c) The alien emergency medical program;

(d) The state-funded pregnant woman program; and

(e) Detoxification services.

[Statutory Authority: RCW 74.08.090, 03-20-061, § 388-476-0005, filed 9/26/03, effective 10/27/03. Statutory Authority: RCW 74.08.090 and 74.04.510, 99-17-025, § 388-476-0005, filed 8/10/99, effective 10/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-476-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0530.]

Chapter 388-478 WAC STANDARDS FOR PAYMENTS

WAC

388-478-0005 Cash assistance need and payment standards and grant maximum.

388-478-0010 Households with obligations to pay shelter costs.

388-478-0015 Need standards for cash assistance.

388-478-0020 Payment standards for TANF, SFA, GA-S, GA-H and RCA.

388-478-0030 Payment standards for GA-U and ADATSA.

388-478-0035 Maximum earned income limits for TANF and SFA.

388-478-0040 Payment standard for persons in medical institutions.

388-478-0045 Payment standard for persons in certain group living facilities.

388-478-0050	Payment standards for ongoing additional requirements.
388-478-0055	How much do I get from my state supplemental payments (SSP)?
388-478-0057	Year-end adjustments to the SSI state supplement.
388-478-0060	What are the income limits and maximum benefit amounts for Basic Food?
388-478-0065	Income and resource standards for family medical programs.
388-478-0070	Monthly income and countable resource standards for medically needy (MN).
388-478-0075	Medical programs—Monthly income standards based on the federal poverty level (FPL).
388-478-0080	Supplemental Security Income (SSI) standards; SSI-related categorically needy income level (CNIL); and countable resource standards.
388-478-0085	Medicare savings programs—Monthly income standards.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-478-0025	TANF payment standards for recent arrivals to Washington state. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0025, filed 7/31/98, effective 9/1/98.] Repealed by 99-16-024, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.08.090 and 74.04.510.
388-478-0026	Excluded resources for family medical programs. [Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530 and 2000 c 218. 00-21-063, § 388-478-0026, filed 10/16/00, effective 12/1/00.] Repealed by 02-05-004, filed 2/7/02, effective 3/10/02. Statutory Authority: RCW 74.08.090.
388-478-0056	SSI state supplement standards. [Statutory Authority: RCW 74.04.620, 74.04.630. 00-24-056, § 388-478-0056, filed 11/30/00, effective 1/1/01.] Repealed by 01-08-015, filed 3/23/01, effective 5/1/01. Statutory Authority: RCW 74.08.090, 74.04.057.

WAC 388-478-0005 Cash assistance need and payment standards and grant maximum. (1) Need standards for cash assistance programs represent the amount of income required by individuals and families to maintain a minimum and adequate standard of living. Need standards are based on assistance unit size and include basic requirements for food, clothing, shelter, energy costs, transportation, household maintenance and operations, personal maintenance, and necessary incidentals.

(2) Payment standards for assistance units in medical institutions and other facilities are based on the need for clothing, personal maintenance, and necessary incidentals (see WAC 388-478-0040 and 388-478-0045).

(3) Need and payment standards for persons and families who do not reside in medical institutions and other facilities are based on their obligation to pay for shelter.

(a) Eligibility and benefit levels for persons and families who meet the requirements in WAC 388-478-0010 are determined using standards for assistance units with an obligation to pay shelter costs.

(b) Eligibility and benefit levels for all other persons and families are determined using standards for assistance units who have shelter provided at no cost.

(c) For recent arrivals to Washington state who apply for temporary assistance for needy families (TANF), see WAC 388-468-0005.

(4) The monthly grant for an assistance unit containing eight or more persons cannot exceed the grant maximum of one thousand seventy-five dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-05-010, § 388-478-0005, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW

(2007 Ed.)

74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0010 Households with obligations to pay shelter costs. The monthly need and payment standards for cash assistance are based on a determination of assistance unit size and whether the assistance unit has an obligation to pay shelter costs.

Eligibility and benefit level is determined using standards for assistance unit with obligations to pay shelter costs. An assistance unit has an obligation to pay shelter costs if one of the members:

(1) Owns, purchases or rents their place of residence, even if costs are limited to property taxes, fire insurance, sewer, water, or garbage;

(2) Resides in a lower income housing project which is funded under the United States Housing Act of 1937 or Section 236 of the National Housing Act, if the household either pays rent or makes a utility payment instead of a rental payment; or

(3) Is homeless. Homeless households include persons or families who:

(a) Lack a fixed, regular, and adequate nighttime residence; or

(b) Reside in a public or privately operated shelter designed to provide temporary living accommodations; or

(c) Live in temporary lodging provided through a public or privately funded emergency shelter program.

[Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-478-0010, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0015 Need standards for cash assistance. The need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

Assistance Unit Size	Need Standard
1	\$ 989
2	1,251
3	1,545
4	1,823
5	2,101
6	2,379
7	2,749
8	3,043
9	3,336
10 or more	3,630

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard
1	\$ 528
2	668
3	825
4	973
5	1,122
6	1,270
7	1,468
8	1,625
9	1,782
10 or more	1,939

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-05-102, § 388-478-0015, filed 2/14/06, effective 3/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, and 74.08.090. 05-22-077 and 05-23-012, § 388-478-0015, filed 10/31/05 and 11/4/05, effective 1/1/06; 05-01-074, § 388-478-0015, filed 12/9/04, effective 1/9/05. Statutory Authority: RCW 74.04.770, 74.04.050, 74.04.055, 74.04.057, 03-24-059, § 388-478-0015, filed 12/1/03, effective 1/1/04; 03-23-116, § 388-478-0015, filed 11/18/03, effective 12/19/03. Statutory Authority: RCW 74.08.090, 74.04.510, and 74.04.770. 02-23-029, § 388-478-0015, filed 11/12/02, effective 12/1/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.200. 01-11-108, § 388-478-0015, filed 5/21/01, effective 7/1/01. Statutory Authority: RCW 74.04.200. 99-04-056, § 388-478-0015, filed 1/29/99, effective 3/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0020 Payment standards for TANF, SFA, GA-S, GA-H and RCA. (1) The payment standards for temporary assistance for needy families (TANF), state family assistance (SFA), general assistance for pregnant women (GA-S), general assistance for children (GA-H) and refugee cash assistance (RCA) assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	\$349	6	\$ 841
2	440	7	971
3	546	8	1,075
4	642	9	1,180
5	740	10 or more	1,283

(2) The payment standards for TANF, SFA, GA-S, GA-H and RCA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	\$212	6	\$ 511
2	268	7	591
3	332	8	654
4	391	9	718
5	451	10 or more	780

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710.]

WAC 388-478-0030 Payment standards for GA-U and ADATSA. (1) The payment standards for general assistance - unemployable (GA-U) and alcohol and drug addiction treatment and support act (ADATSA) program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard
1	\$ 339
2	428

(2) The payment standards for GA-U and ADATSA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	\$ 206
2	261

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0030, filed 7/31/98, effective 9/1/98.]

[Title 388 WAC—p. 890]

WAC 388-478-0035 Maximum earned income limits for TANF and SFA. To be eligible for temporary assistance for needy families (TANF) or state family assistance (SFA), a family's gross earned income must be below the following levels:

Number of Family Members	Maximum Earned Income Level	Number of Family Members	Maximum Earned Income Level
1	\$ 698	6	\$1,682
2	880	7	1,942
3	1,092	8	2,150
4	1,284	9	2,360
5	1,480	10 or more	2,566

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0040 Payment standard for persons in medical institutions. (1) "Medical institutions" include skilled nursing homes, public nursing homes, general hospitals, tuberculosis hospitals, intermediate care facilities, and psychiatric hospitals approved by the joint commission on accreditation of hospitals (JCAH).

(2) The monthly payment standard for eligible persons in medical institutions is forty-one dollars and sixty-two cents. The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0045 Payment standard for persons in certain group living facilities. (1) A monthly grant payment of thirty-eight dollars and eighty-four cents will be made to eligible persons in the following facilities:

- (a) Congregate care facilities (CCF);
- (b) Adult residential rehabilitation centers/adult residential treatment facilities (AARC/ARTF); and
- (c) Division of developmental disabilities (DDD) group home facilities.

(2) The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0050 Payment standards for ongoing additional requirements. An "ongoing additional requirement" is a continuing need that you have for which you require additional financial benefits in order to continue living independently. The "payment standard" for ongoing additional requirement benefits is the amount of money needed to pay for these items or services. We use the following payment standards for ongoing additional requirements approved under WAC 388-473-0020 through 388-473-0060:

(1) Restaurant meals: \$187.09 per month (or \$6.04 per day with the payment rounded down to the nearest dollar amount);

(2) Laundry: \$11.13 per month;

(3) Service animal food: \$33.66 per month;

(4) Home delivered meals: The amount charged by the agency providing the meals;

(5) Telephone: The local telephone flat rate for the area; or the Washington telephone assistance program (WTAP) rate, whichever is less.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 00-15-052, § 388-478-0050, filed 7/17/00, effective 9/1/00; 98-16-044, § 388-478-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

WAC 388-478-0055 How much do I get from my state supplemental payments (SSP)? (1) The SSP is a payment from the state for certain SSI eligible people (see WAC 388-474-0012).

If you converted to the federal SSI program from state assistance in January 1974, because you were aged, blind, or disabled, and have remained continuously eligible for SSI since January 1974, the department calls you a grandfathered client. Social Security calls you a mandatory income level (MIL) client.

A change in living situation, cost-of-living adjustment (COLA) or federal payment level (FPL) can affect a grandfathered (MIL) client. A grandfathered (MIL) client gets a federal SSI payment and a SSP payment, which totals the higher of one of the following:

(a) The state assistance standard set in December 1973, unless you lived in a medical institution at the time of conversion, plus the federal cost-of-living adjustments (COLA) since then; or

(b) The current payment standard.

(2) The monthly SSP rates for eligible persons under WAC 388-474-0012 and individuals residing in an institution are:

SSP eligible persons	Monthly SSP Rate
Individual (aged 65 and older) - Calendar Year 2005	\$46.00
Individual (blind as determined by SSA) - Calendar Year 2005	\$46.00
Individual with an ineligible spouse - Calendar Year 2005	\$46.00
Grandfathered (MIL)	Varies by individual based on federal requirements. Payments range between \$0.54 and \$199.77.

Medical institution Individual

Monthly SSP Rate
\$23.68

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-16-071, § 388-478-0055, filed 7/28/06, effective 8/28/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090. 06-01-045, § 388-478-0055, filed 12/15/05, effective 1/15/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-07-024, § 388-478-0055, filed 3/8/04, effective 4/8/04; 03-03-114, § 388-478-0055, filed 1/21/03, effective 2/23/03. Statutory Authority: RCW 74.08.090, 74.04.057. 01-19-024, § 388-478-0055, filed 9/12/01, effective 11/1/01; 01-08-015, § 388-478-0055, filed 3/23/01, effective 5/1/01. Statutory Authority: RCW 74.08.090. 00-20-054, § 388-478-0055, filed 9/29/00, effective 11/1/00. Statutory Authority: RCW 74.08.090 and 74.04.057. 00-11-130, § 388-478-0055, filed 5/22/00, effective 7/1/00; 99-18-063, § 388-478-0055, filed 8/30/99, effective 10/1/99. Statutory Authority: RCW 74.08.090 and 74.04.630. 99-04-103, § 388-478-0055, filed 2/3/99, effective 3/6/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1115.]

WAC 388-478-0057 Year-end adjustments to the SSI state supplement. For the purposes of this rule, "we" refers to the department of social and health services. We are required by federal law to maintain the total SSI state supplement payments at the same level each year, without an increase or decrease in total spending. This may result in adjustment to your SSI state supplement benefits at the end of the year.

(1) If there are unexpended funds, you will receive a one-time bonus payment, usually at the end of the calendar year.

(2) When there is a shortage in available funds, your state supplement benefits will be decreased. The decrease will usually be spread out over multiple months to reduce the negative impact on you.

[Statutory Authority: RCW 74.08.090, 74.04.057. 01-22-088, § 388-478-0057, filed 11/5/01, effective 12/6/01.]

WAC 388-478-0060 What are the income limits and maximum benefit amounts for Basic Food? If your assistance unit (AU) meets all other eligibility requirements for Basic Food, your AU must have income at or below the limits in column B and C to get Basic Food, unless you meet one of the exceptions listed below. The maximum monthly food assistance benefit your AU could receive is listed in column D.

EFFECTIVE 10-1-2006				
Column A Number of Eligible AU Members	Column B Maximum Gross Monthly Income	Column C Maximum Net Monthly Income	Column D Maximum Allotment	Column E 165% of Poverty Level
1	\$1062	\$817	\$155	\$1348
2	1430	1100	284	1815
3	1799	1384	408	2283
4	2167	1667	518	2750
5	2535	1950	615	3218
6	2904	2234	738	3685
7	3272	2517	816	4153
8	3640	2800	932	4620
9	4009	3084	1049	5088
10	4378	3368	1166	5556
Each Additional Member	+369	+284	+117	+468

Exceptions:

(1) If your AU is categorically eligible as under WAC 388-414-0001, your AU does not have to meet the gross or net income standards in columns B and C. We do budget your AU's income to decide the amount of Basic Food your AU will receive.

(2) If your AU includes a member who is sixty years of age or older or has a disability, your income must be at or below the limit in column C only.

(3) If you are sixty years of age or older and cannot buy and cook your own meals because of a permanent disability, we will use column E to decide if you can be a separate AU.

(4) If your AU has zero income, your benefits are the maximum allotment in column D, based on the number of eligible members in your AU.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-478-0060, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-478-0060, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-478-0060, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.510, 74.04.510. 03-21-030, § 388-478-0060, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 02-21-050, § 388-478-0060, filed 10/14/02, effective 12/1/02. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 01-21-059, § 388-478-0060, filed 10/16/01, effective 12/1/01. Statutory Authority: RCW 74.04.510, 74.08.090. 00-23-013, § 388-478-0060, filed 11/3/00, effective 12/4/00. Statutory Authority: RCW 74.04.510. 99-24-053, § 388-478-0060, filed 11/29/99, effective 12/30/99. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-478-0060, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.500, 74.04.510, 74.08.090. 99-05-074, § 388-478-0060, filed 2/17/99, effective 3/20/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0060, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0065 Income and resource standards for family medical programs. (1) The categorically needy income level (CNIL) standard for family medical is the same as the grant payment standards for the TANF cash program as stated in WAC 388-478-0020.

(2) The countable resource standards for family medical are the same as those of the TANF/SFA cash program as stated in WAC 388-470-0005.

(3) Each unborn child is counted as a household member when determining household size for:

- (a) Family medical;
- (b) Pregnancy medical; and
- (c) Children's medical.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 05-15-080, § 388-478-0065, filed 7/14/05, effective 8/14/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 673(2) (42 U.S.C. 9902(2)). 01-18-056, § 388-478-0065, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0065, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710 and 388-508-0820.]

WAC 388-478-0070 Monthly income and countable resource standards for medically needy (MN). (1) Beginning January 1, 2006, the medically needy income level (MNIL) is:

- (a) One person \$603
- (b) Two persons \$603
- (c) Three persons \$667
- (d) Four persons \$742

- (e) Five persons \$858
- (f) Six persons \$975
- (g) Seven persons \$1,125
- (h) Eight persons \$1,242
- (i) Nine persons \$1,358
- (j) Ten persons and more \$1,483

(2) The MNIL standard for a person who meets institutional status requirements is in WAC 388-513-1305(3).

(3) Countable resource standards for the MN program is:

- (a) One person \$2,000
- (b) Two persons \$3,000
- (c) For each additional family member add \$50

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). 06-06-013, § 388-478-0070, filed 2/17/06, effective 3/20/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 9902(2). 05-06-090, § 388-478-0070, filed 3/1/05, effective 4/1/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 1396r-5. 02-10-116, § 388-478-0070, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924 (42 U.S.C. 1396r-5). 01-12-073, § 388-478-0070, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, and 74.09.575. 00-10-095, § 388-478-0070, filed 5/2/00, effective 5/2/00; 99-11-054, § 388-478-0070, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710, 388-507-0720, 388-511-1115, 388-518-1820, 388-518-1830, 388-518-1840 and 388-518-1850.]

WAC 388-478-0075 Medical programs—Monthly income standards based on the federal poverty level (FPL). (1) Each year, the federal government publishes new federal poverty level (FPL) income standards in the Federal Register found at <http://aspe.hhs.gov/poverty/index.shtml>. The income standards for the following medical programs change on the first of April every year based on the new FPL:

- (a) Children's health program is one hundred percent of FPL;
- (b) Pregnant women's program up to one hundred eighty-five percent of FPL;
- (c) Children's categorically needy program up to two hundred percent of FPL;
- (d) Healthcare for workers with disabilities (HWD) up to two hundred twenty percent of FPL; and
- (e) The state children's health insurance program (SCHIP) is over two hundred percent of FPL but not over two hundred fifty percent of FPL.

(2) The department uses the FPL income standards to determine:

- (a) The mandatory or optional Medicaid status of an individual; and
 - (b) Premium amount, if any, for a Medicaid child.
- (3) There are no resource limits for the programs under this section.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and 42 U.S.C. 9902(2). 06-16-026, § 388-478-0075, filed 7/24/06, effective 8/24/06. Statutory Authority: RCW 74.08.090, 74.09.415, 74.09.530 and 2005 c 279. 06-03-080, § 388-478-0075, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 9902(2). 05-17-157, § 388-478-0075, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 74.08.090, 74.04.057, 74.04.050, and 74.09.530. 04-15-092, § 388-478-0075, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and 42 U.S.C. 9902(2). 03-15-088, § 388-478-0075, filed 7/17/03, effective

7/17/03. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-478-0075, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.500, 74.09.510, and Section 1902 (a)(10)(A)(ii)(XV) and (XVI) of the Social Security Act. 02-07-090, § 388-478-0075, filed 3/19/02, effective 4/1/02. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 673(2) (42 U.S.C. 9902(2)). 01-18-056, § 388-478-0075, filed 8/30/01, effective 9/30/01; 00-17-085, § 388-478-0075, filed 8/14/00, effective 9/14/00; 99-19-005, § 388-478-0075, filed 9/3/99, effective 10/4/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0075, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0805, 388-508-0810, 388-509-0910, 388-509-0920, 388-509-0940 and 388-509-0960.]

WAC 388-478-0080 Supplemental security income (SSI) standards; SSI-related categorically needy income level (CNIL); and countable resource standards. (1) The SSI payment standards, also known as the federal benefit rate (FBR), beginning January 1, 2006 are:

(a) Living alone (in own home or alternate care, does not include nursing homes or medical situations)

Individual	\$603
Individual with an ineligible spouse	\$603
Couple	\$904

(b) Shared living (in the home of another)

Individual	\$402
Individual with an ineligible spouse	\$402
Couple	\$603

(c) Living in an institution

Individual	\$30
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(2) See WAC 388-478-0055 for the amount of the state supplemental payments (SSP) for SSI recipients.

(3) The SSI-related CNIL standards are:

(a) Single person	\$603
(b) Married couple - both eligible	904
(c) Supplied shelter - single person	402
(d) Supplied shelter couple - both eligible	603

(4) The countable resource standards for SSI and SSI-related CN medical programs are:

(a) One person	\$2,000
(b) A legally married couple	\$3,000

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). 06-06-013, § 388-478-0080, filed 2/17/06, effective 3/20/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 9902(2). 05-06-090, § 388-478-0080, filed 3/1/05, effective 4/1/05; 04-16-107, § 388-478-0080, filed 8/3/04, effective 9/3/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 1396r-5. 02-10-116, § 388-478-0080, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924 (42 U.S.C. 1396r-5). 01-12-073, § 388-478-0080, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, and 74.09.575. 00-10-095, § 388-478-0080, filed 5/2/00, effective 5/2/00; 99-11-054, § 388-478-0080, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0080, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

WAC 388-478-0085 Medicare savings programs—Monthly income standards. (1) The income standards for Medicare Savings Programs change each year based on the

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federal poverty level (FPL) published yearly by the federal government in the Federal Register at <http://aspe.hhs.gov/poverty/index.shtml>. The qualified Medicare beneficiary (QMB) program income standard is up to one hundred percent of the FPL.

(2) The specified low-income Medicare beneficiary (SLMB) program income standard is over one hundred percent of FPL, but not more than one hundred twenty percent of FPL.

(3) The qualified individual (QI-1) program income standard is over one hundred twenty percent of FPL, but not more than one hundred thirty-five percent of FPL.

(4) The qualified disabled working individual (QDWI) program income standard is two hundred percent of FPL.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and 42 U.S.C. 9902(2). 06-16-026, § 388-478-0085, filed 7/24/06, effective 8/24/06; 05-17-157, § 388-478-0085, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). 04-17-076, § 388-478-0085, filed 8/13/04, effective 9/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 673(2) (42 U.S.C. 9902(2)). 01-18-056, § 388-478-0085, filed 8/30/01, effective 9/30/01; 00-17-085, § 388-478-0085, filed 8/14/00, effective 9/14/00; 99-19-005, § 388-478-0085, filed 9/3/99, effective 10/4/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0085, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1715, 388-517-1730, 388-517-1750 and 388-517-1770.]

Chapter 388-480 WAC STRIKERS

WAC

388-480-0001 Does being on strike impact my eligibility for the Washington Basic Food program?

WAC 388-480-0001 Does being on strike impact my eligibility for the Washington Basic Food program? (1) A strike is a work stoppage, slowdown or other interruption of work caused by employees. This includes when a stoppage happens because a collective bargaining agreement has expired.

(2) We do not consider you to be on strike if you:

(a) Are locked out by your employer;

(b) Do not have work available as a result of striking employees;

(c) Are not a member of the bargaining unit on strike and you fear someone may physically hurt you if you cross a picket line; or

(d) Would have been exempt from work registration under WAC 388-444-0015 the day before the strike for any reason other than being employed at least thirty hours per week.

(3) If a person in your assistance unit (AU) is a striker, your AU is not eligible for Basic Food unless:

(a) Your AU met all income requirements the day before the strike; and

(b) You meet all other requirements of the Basic Food program as described in WAC 388-400-0040.

(4) If someone in your AU is on strike, your AU cannot receive a higher amount of Basic Food benefits solely because the person receives less income as a direct result of being on strike. We count the larger of the two following

amounts to determine if your AU is eligible and calculate your benefits:

- (a) The striker's income before they went on strike; or
- (b) The striker's current income.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.-510. 03-22-037, § 388-480-0001, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.04.-510. 00-05-007, § 388-480-0001, filed 2/4/00, effective 3/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-480-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-482 WAC

STUDENT STATUS

WAC

388-482-0005 How does being a student impact my eligibility for the Washington Basic Food program?

WAC 388-482-0005 How does being a student impact my eligibility for the Washington Basic Food program?

- (1) For Basic Food, we consider you a student if you are:
 - (a) Age eighteen through forty-nine;
 - (b) Physically and mentally able to work; and
 - (c) Enrolled in an institution of higher education at least half-time as defined by the institution.
- (2) An institution of higher education is:
 - (a) Any educational institution that requires a high school diploma or general education development certificate (GED);
 - (b) A business, trade, or vocational that requires a high school diploma or GED; or
 - (c) A two-year or four-year college or university that offers a degree but does not require a high school diploma or GED.
- (3) If you are a student, you must meet one of the following conditions to be eligible for Basic Food:
 - (a) Have paid employment of twenty hours per week.
 - (b) Be self-employed, work, and earn at least the amount you would earn working twenty hours at the federal minimum wage;
 - (c) Be participating in a state or federal work study program at the time you applied for Basic Food benefits. For the purpose of being eligible for Basic Food, work study is:
 - (i) Working and receiving money from the work study program; and
 - (ii) Not turning down a work assignment.
 - (d) Be responsible for more than half the care of a dependent person in your assistance unit (AU) who is age five or younger;
 - (e) Be responsible for more than half the care of a dependent person in your AU who is between age six and eleven if we have determined that there is not adequate child care available during the school year to allow you to:
 - (i) Attend class and satisfy the twenty-hour work requirement; or
 - (ii) Take part in a work study program.
 - (f) Be a single parent responsible for the care of your natural, step, or adopted child who is eleven or younger;
 - (g) Be an adult who has the parental responsibility of a child who is age eleven or younger if none of the following people live in the home:
 - (i) The child's parents; or

- (ii) Your spouse.
- (h) Participate in the WorkFirst program under WAC 388-310-0200;
- (i) Receive TANF or SFA benefits;
- (j) Attend an institution of higher education through:
 - (i) The Workforce Investment Act (WIA);
 - (ii) The food stamp employment and training program under chapter 388-444 WAC;
 - (iii) An approved state or local employment and training program; or
 - (iv) Section 236 of the Trade Act of 1974.
- (4) If you are a student and the only reason you are eligible for Basic Food is because you participate in work study, you are only eligible while you work and receive money from work study. If your work study stops during the summer months, you must meet another condition to be an eligible student during this period.
 - (5) If you are a student, your status as a student:
 - (a) Begins the first day of the school term; and
 - (b) Continues through vacations. This includes the summer break if you plan to return to school for the next term.
 - (6) We do not consider you a student if you:
 - (a) Graduate;
 - (b) Are suspended or expelled;
 - (c) Drop out; or
 - (d) Do not intend to register for the next school term other than summer.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.-510. 03-22-037, § 388-482-0005, filed 10/28/03, effective 12/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 99-16-024, § 388-482-0005, filed 7/26/99, effective 9/1/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-482-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-484 WAC

TANF/SFA FIVE YEAR TIME LIMIT

WAC

388-484-0005	There is a five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance.
388-484-0006	TANF/SFA time limit extensions.
388-484-0010	How does the five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance apply to American Indians or Alaskan Natives living in Indian country?

WAC 388-484-0005 There is a five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance. (1) What is the sixty-month time limit?

- (a) You can receive cash assistance for temporary assistance for needy families (TANF), state family assistance (SFA), and general assistance for pregnant women (GA-S) for a lifetime limit of sixty months. The time limit applies to cash assistance provided by any combination of these programs, and whether or not it was received in consecutive months.
- (b) If you receive cash assistance for part of the month, it counts as a whole month against the time limit.
- (c) If you have received cash assistance from another state on or after August 1, 1997, and it was paid for with federal TANF funds, those months will count against your time limit.

(d) The time limit does not apply to diversion cash assistance, support services, food assistance or Medicaid.

(2) When did the sixty-month time limit go into effect?

The sixty-month time limit applies to cash assistance received on or after August 1, 1997 for TANF and SFA. Although the GA-S program no longer exists, the time limit applies to GA-S cash assistance received from May 1, 1999 through July 31, 1999.

(3) Does the time limit apply to me?

The sixty-month time limit applies to you for any month in which you are a parent or other relative as defined in WAC 388-454-0010, or a minor parent emancipated through court order or marriage.

(4) Do any exceptions to the time limits apply to me?

The department does not count months of assistance towards the sixty-month time limit if you are:

(a) An adult caretaker, as described in WAC 388-454-0005 through 388-454-0010, who is not a member of the assistance unit and you are receiving cash assistance on behalf of a child;

(b) An unemancipated pregnant or parenting minor living in a department approved living arrangement as defined by WAC 388-486-0005; or

(c) An American Indian or Native Alaskan adult and you are living in Indian country, as defined under 18 U.S.C. 1151, or an Alaskan Native village and you are receiving TANF, SFA, or GA-S cash assistance during a period when at least fifty percent of the adults living in Indian country or in the village were not employed. See WAC 388-484-0010.

(5) What happens if a member of my assistance unit has received sixty months of TANF, SFA, and GA-S cash benefits?

Once any adult or emancipated minor in the assistance unit has received sixty months of cash assistance, the entire assistance unit becomes ineligible for TANF or SFA cash assistance, unless you are eligible for an extended period of cash assistance called a TANF/SFA time limit extension under WAC 388-484-0006.

(6) What can I do if I disagree with how the department has counted my months of cash assistance?

(a) If you disagree with how we counted your months of cash assistance, you may ask for a hearing within ninety days of the date we sent you a letter telling you how many months we are counting.

(b) You will get continued benefits (the amount you were getting before the change) if:

(i) You have used all sixty months of benefits according to our records; and

(ii) You ask for a hearing within the ten-day notice period, as described in chapter 388-458 WAC.

(c) If you get continued benefits and the administrative law judge (ALJ) agrees with our decision, you may have to pay back the continued benefits after the hearing, as described in chapter 388-410 WAC.

(7) Does the department ever change the number of months that count against my time limit?

We change the number of months we count in the following situations:

(a) You repay an overpayment for a month where you received benefits but were not eligible for any of the benefits

you received. We subtract one month for each month that you completely repay. If you were eligible for some of the benefits you received, we still count that month against your time limit.

(b) We did not close your grant on time when the division of child support (DCS) collected money for you that was over your grant amount two months in a row, as described in WAC 388-422-0030.

(c) An ALJ decides at a fair hearing that we should change the number of months we count.

(d) You start getting worker's compensation payments from the department of labor and industries (L&I) and your L&I benefits have been reduced by the payments we made to you.

(e) You participated in the excess real property (ERP) program in order to get assistance and we collected the funds when your property sold.

(f) Another state gave us incorrect information about the number of months you got cash assistance from them.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW. 06-10-034, § 388-484-0005, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-010, § 388-484-0005, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.04.050, and 78.08A.340. 03-06-046, § 388-484-0005, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-484-0005, filed 5/31/02, effective 6/1/02. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.010, and 42 U.S.C. 608 (a)(7). 01-04-016, § 388-484-0005, filed 1/26/01, effective 2/1/01. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 99-08-050, § 388-484-0005, filed 4/1/99, effective 5/2/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-484-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-484-0006 TANF/SFA time limit extensions. (1) What happens after I receive sixty or more months of TANF/SFA cash assistance?

After you receive sixty or more months of TANF/SFA cash assistance, you may qualify for additional months of cash assistance. We call these additional months of TANF/SFA cash assistance a TANF/SFA time limit extension.

(2) Who is eligible for a TANF/SFA time limit extension?

You are eligible for a TANF/SFA time limit extension if you are on TANF or otherwise eligible for TANF and:

(a) You qualify for one of the exemptions listed in WAC 388-310-0350; or

(b) You:

(i) Are participating satisfactorily in the WorkFirst program (see chapter 388-310 WAC for a description of WorkFirst participation requirements); or

(ii) Meet the family violence option criteria in WAC 388-61-001 and are participating satisfactorily in specialized activities listed in your individual responsibility plan.

(c) You have a temporary situation that prevents you from working or looking for a job. (For example, you may be unable to look for a job while you have health problems or if you are dealing with family violence.) You will receive a time-limited extension if you are participating in activities included in your individual responsibility plan to help your situation.

(d) You are in sanction, but you will be subject to the sanction rules described in WAC 388-310-1600.

(3) Who reviews and approves an extension?

(a) Your case manager or social worker will review your case and determine which extension type will be approved.

(b) This review will not happen until after you have received at least fifty-two months of assistance but before you reach your time limit.

(c) Before you reach your time limit, the department will send you a notice that tells you whether your extension was approved and how to request a fair hearing if you disagree with the decision.

(4) Do my WorkFirst participation requirements change if I receive a TANF/SFA time limit extension?

Your participation requirements do not change. You must still meet all of the WorkFirst participation requirements listed in chapter 388-310 WAC while you receive a TANF/SFA time limit extension.

(5) Do my benefits change if I receive a TANF/SFA time limit extension?

(a) You are still a TANF/SFA recipient and your cash assistance, services, or supports will not change as long as you continue to meet all other TANF/SFA eligibility requirements.

(b) During the TANF/SFA time limit extension, you must continue to meet all other TANF/SFA eligibility requirements. If you no longer meet TANF/SFA eligibility criteria during your extension, your benefits will end.

(6) What happens if I stop participating in WorkFirst activities as required during a TANF/SFA time limit extension?

If you do not participate in the WorkFirst activities required in your individual responsibility plan, and you do not have a good reason under WAC 388-310-1600(4), the department will follow the sanction rules in WAC 388-310-1600.

(7) How long will a TANF/SFA time limit extension last?

(a) We will review your TANF/SFA time limit extension and your case periodically for changes in family circumstances:

(i) If you are extended under WAC 388-484-0006 (2)(a) then we will review your extension at least every twelve months;

(ii) If you are extended under WAC 388-484-0006 (2)(b) then we will review your extension at least every six months;

(iii) If you are extended under WAC 388-484-0006 (2)(c) or (d) then we will review your extension at least every twelve months.

(b) Your TANF/SFA time limit extension may be renewed for as long as you continue to meet the criteria to qualify.

(c) If during the extension period we get proof that your circumstances have changed, we may review your case and change the type of TANF/SFA time limit extension.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and chapter 74.08A RCW. 06-10-034, § 388-484-0006, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 74.08A.-340. 03-24-057, § 388-484-0006, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08A.010(4), 74.08A.340, 74.08.090, 74.04.050. 02-12-068, § 388-484-0006, filed 5/31/02, effective 6/1/02.]

WAC 388-484-0010 How does the five-year (sixty-month) time limit for TANF, SFA and GA-S cash assistance apply to American Indians or Alaskan Natives living in Indian country? (1) If you are American Indian or Alaskan Native, time limits on temporary assistance for needy families (TANF), state family assistance (SFA) and general assistance for pregnant women (from May 1, 1999 to July 31, 1999) do not count under certain circumstances.

If you are an American Indian or Alaskan Native parent or other relative as defined by WAC 388-454-0010, months of cash assistance do not count against the sixty-month lifetime limit if you live in Indian country or an Alaskan Native village where at least fifty percent of Indian adults are not employed.

(2) Do time limits on cash assistance apply if I am not an American Indian or Alaskan Native but I am the parent or other relative of an American Indian or Alaskan Native child?

If you are a non-American Indian or non-Alaskan Native parent or other relative, as defined by WAC 388-454-0010, of an American Indian or Alaskan Native child or children living in a qualifying area of Indian country, your months on assistance will count against your lifetime limit. You may, however, receive more than sixty months of assistance under hardship criteria to be developed by the department.

(3) Where must I live to qualify for the Indian country exemption to time limits?

To qualify for this exemption to TANF time limits, you must live in "Indian country." The department uses the "Indian country" definition in federal law at 18 U.S.C. 1151. Indian country is defined as reservations, dependent Indian communities, and allotments. Dependent Indian communities must be set aside by the federal government for the use of Indians and be under federal superintendence. Near reservation areas (areas or communities adjacent or contiguous to reservations) are not considered Indian country for purposes of this exemption.

(4) Can I live on the reservation or Indian country belonging to a tribe other than my own to qualify for this time limit exemption?

Yes. You do not need to be an American Indian or Alaskan Native of the same tribe as the reservation or other area of Indian country on which you reside.

(5) How does the department determine if at least fifty percent of adults living in Indian country are not employed?

The department uses the most current biennial *Indian Service Population and Labor Force Estimates Report* published by the Bureau of Indian Affairs (BIA), or any successor report, as the default data source to determine if the not employed rates for areas of Indian country are at least fifty percent.

(6) What if a tribe disagrees with the not employed rate published in the BIA Indian Service Population and Labor Force Estimates Report?

A tribe may provide alternative data, based on similar periods to the *Indian Service Population and Labor Force Estimates Report*, to demonstrate that the not employed rate is at least fifty percent.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.010, and 42 U.S.C. 608 (a)(7). 01-04-016, § 388-484-0010, filed 1/26/01, effective 2/1/01.]

Chapter 388-486 WAC

TEEN PARENTS

WAC

388-486-0005	Unmarried pregnant or parenting minors—Required living arrangement.
388-486-0010	Unmarried pregnant or parenting minors—Required school attendance.

WAC 388-486-0005 Unmarried pregnant or parenting minors—Required living arrangement. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) The following definitions apply to terms used in this section:

(a) "Unmarried" means a person who have never been married or whose marriage has been annulled. It does not include a person who has been divorced or widowed.

(b) "Minor" means a person younger than eighteen years of age.

(c) "Legal guardian" means a court-appointed legal guardian or court-appointed permanent custodian.

(d) "Relative" is a person who related to the pregnant or parenting minor as defined under RCW 74.15.020(4).

(3) An unmarried pregnant or parenting minor is not eligible for TANF, SFA or GA-S unless the person:

(a) Has been emancipated by a court; or

(b) Lives in a home approved by the department and has a protective payee.

(4) The home of a minor's parent, legal guardian, or adult relative may be approved unless:

(a) The minor has no living parent, legal guardian, or adult relative that can be located or those persons do not want the minor to live with them;

(b) The minor or the minor's child is being or has been seriously harmed either physically, emotionally or sexually in the home of the parent, legal guardian, or adult relative;

(c) Substantial evidence exists of an act or failure to act by the parent, legal guardian, or adult relative that presents imminent or serious harm to the minor or the minor's child if they lived there; or

(d) The department determines that it is in the best interest of the minor or the minor's child to waive the requirement of living in the home of a parent, legal guardian, or adult relative.

(5) If the home of a minor's parent, legal guardian, or adult relative is not available or suitable, one of the following alternatives may be approved:

(a) A facility or home licensed under chapter 74.15 RCW that provides a supportive and supervised living arrangement requiring residents to learn parenting skills;

(b) A maternity home;

(c) Other adult-supervised living arrangement; or

(d) The minor's current or proposed living arrangement, if the department determines it is appropriate.

(6) A home that includes the other natural parent of the minor's child or unborn child is never approved if:

(a) The minor is under age sixteen; and

(b) The other parent is eighteen or older and meets the age criteria for rape of a child as set forth in RCW 9A.44.073, 9A.44.076, and 9A.44.079.

(7) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-486-0010 Unmarried pregnant or parenting minors—Required school attendance. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) To be eligible for TANF or SFA, an unmarried pregnant or parenting minor who has not completed high school or a general education development (GED) certificate program must participate in educational activities leading to the attainment of a high school diploma or GED.

(3) The minor must meet the standard for satisfactory attendance set by the school or program in which the minor is enrolled.

(4) An unmarried minor is exempt from this rule if the minor has:

(a) Been emancipated by a court; or

(b) A child who is less than twelve weeks old.

(5) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-488 WAC

TRANSFER OF PROPERTY

WAC

388-488-0005	Transfer of property to qualify for cash assistance.
388-488-0010	Transfer of property to qualify for food assistance.

WAC 388-488-0005 Transfer of property to qualify for cash assistance. This rule applies to cash assistance programs only and does not affect Medicaid eligibility for a person who is not institutionalized. For transfer of property for institutional medical see WAC 388-513-1365.

(1) An assistance unit is disqualified from receiving benefits when it transferred or transfers real or personal property for less than its market value in an attempt to qualify for benefits:

(a) Two years prior to the date of application;

(b) During the application process; or

(c) Anytime while receiving benefits.

(2) When an assistance unit transferred property for less than its fair market value in an attempt to qualify for benefits, the disqualification period:

(a) For applicants, begins the first day of the month the property was transferred.

(b) For recipients, begins the first day of the month after the month the property was transferred.

(3) To determine the number of months an assistance unit will be disqualified, divide the uncompensated resource value of the transferred property by the state gross median income. The uncompensated resource value is the equity value minus the amount the client received when transferring a resource.

(4) An assistance unit can provide evidence to clarify the reasons for transferring the property when the department presumes that the assistance unit transferred the property in an attempt to qualify for benefits.

(5) The benefits received by an assistance unit are not affected by the transfer of separate property of a spouse who is not a member of the assistance unit.

(6) An assistance unit's disqualification period is reduced when the client:

(a) Verifies undue hardship will exist if the benefits are denied such as an eviction;

(b) Secures a return of some or all of the transferred property or the equivalent value of the transferred property;

(c) Verifies an unforeseen change in circumstances such as extensive hospitalization; or

(d) Is responsible for and can verify medical expenses.

(7) When a disqualification period has been adjusted and the client is otherwise eligible, benefits will be authorized. Any benefits authorized because of the reason(s) in subsection (6) of this section, are not considered an overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-488-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-518-1820.]

WAC 388-488-0010 Transfer of property to qualify for food assistance. (1) An assistance unit is disqualified from the program when it transfers a resource to qualify or attempt to qualify for benefits:

(a) Three months prior to the month of application; or

(b) Beginning the month the household is approved for benefits.

(2) The length of disqualification depends on the dollar amount the household is over the resource limit. The countable resources transferred are added to the assistance unit's other countable resources. This total is compared to the resource limit. The amount in excess of the resource limit is located on the chart below to determine the length of the disqualification period.

Amount Over the Resource Limit	Disqualification Period
\$ 0 - \$ 249.99	1 month
250 - 999.99	3 months
1,000 - 2,999.99	6 months
3,000 - 4,999.99	9 months
5,000 and over	12 months

(3) The disqualification period begins:

(a) For applicants, the month of application; or

(b) For recipients, the first of the month after the advance notice period expires.

(4) An assistance unit will not be disqualified for transferring the following:

(a) Excluded resources that do not affect eligibility;

(b) Resources sold or traded at or near fair market value (FMV);

(c) Resources transferred between assistance unit members of the same household including ineligible household members; and

(d) Resources transferred for reasons other than to qualify for benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-488-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-489 WAC

TRANSITIONAL FOOD ASSISTANCE

WAC

388-489-0005	Who is eligible for transitional food assistance?
388-489-0010	How is my transitional food assistance benefit calculated?
388-489-0015	How long will my family receive transitional food assistance?
388-489-0020	Am I required to report changes in my household's circumstances while on transitional food assistance?
388-489-0025	Can my transitional food assistance benefits end before the end of my five-month transition period?

WAC 388-489-0005 Who is eligible for transitional food assistance? If your family stops receiving temporary assistance for needy families cash benefits, including benefits from a tribal program, you will be eligible for transitional food assistance for up to five months if you meet all the following eligibility requirements:

(1) Your family was receiving Basic Food at the time we determined you were no longer eligible for temporary assistance for needy families;

(2) After your family stops receiving temporary assistance for needy families, no other member of your Basic Food assistance unit continues to receive temporary assistance for needy families;

(3) Your family did not move out of the state of Washington (WAC 388-468-0005);

(4) Your family was not in sanction status at the time your temporary assistance for needy families grant ended. Sanction status means:

(a) We reduced or stopped your family's temporary assistance for needy families grant payment because a family member is not:

(i) Meeting WorkFirst program requirements (WAC 388-310-1600); or

(ii) Cooperating with the division of child support (WAC 388-422-0100); or

(b) We decided that a member of your family was not eligible for temporary assistance for needy families because the member:

(i) Failed to meet teen parent living arrangement (WAC 388-486-0005) or teen parent school attendance requirements (WAC 388-410-0010); or

(ii) Was convicted of unlawful practices (WAC 388-446-0005) or for receiving temporary assistance for needy families in two or more states at the same time (WAC 388-446-0010); or

(c) If you are receiving temporary assistance for needy families benefits from a tribal program, your family's grant is reduced or stopped for a reason that is the same as one of the reasons listed in (4)(a) or (4)(b) of this section.

(5) At the time your family's temporary assistance for needy families grant ended, your Basic Food assistance unit did not become ineligible because:

(a) You were applying for recertification of your Basic Food benefits and refused to cooperate with the application process; or

(b) All members are ineligible for Basic Food for the reasons stated in WAC 388-489-0025(3).

(6) There is no limit to the number of times your family may leave temporary assistance for needy families and receive transitional food assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-489-0005, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0010 How is my transitional food assistance benefit calculated? (1) We base your transitional food assistance benefit amount on the regular monthly benefit allotment issued to your Basic Food assistance unit for the last month your family received temporary assistance for needy families. We will not count your last temporary assistance for needy families grant payment when we calculate your transitional food assistance benefit amount. For example:

(a) If your Basic Food assistance unit's only income was temporary assistance for needy families, the transitional food assistance benefit will be the amount your household would have received if you had no income.

(b) If your Basic Food benefit was calculated using temporary assistance for needy families plus income from another source, we will count only the income from the other source when calculating the transitional food assistance amount.

(2) We will adjust your transitional food assistance benefits if:

(a) Someone who gets transitional food assistance with you leaves your assistance unit and is found eligible to receive Basic Food in another assistance unit. We will reduce your transitional food assistance based on the number of persons who left your assistance unit and become eligible in another Basic Food assistance unit.

(b) A change to the maximum allotment for Basic Food under WAC 388-478-0060 results in an increase in benefits for Basic Food assistance units.

(c) You got an overpayment of Basic Food benefits and we need to adjust the amount we deduct from your monthly benefits to repay the overpayment as required in WAC 388-410-0033. This includes:

(i) Starting a new monthly deduction;

(ii) Changing the amount of the monthly deduction; and

(iii) Ending the monthly deduction when the amount you owe has been paid off.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-489-0010, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0015 How long will my family receive transitional food assistance? If your Basic Food assistance unit is eligible for transitional food assistance according to WAC 388-489-0005, you will receive transitional food assistance

for up to five months after your family leaves temporary assistance for needy families.

(1) If you stopped getting temporary assistance for needy families from the department, you are eligible for transitional benefits beginning the month after your family received their last grant.

(2) If you stopped receiving tribal TANF benefits, you are eligible for transitional benefits:

(a) With the next monthly issuance after we update your case to show you no longer have tribal TANF income, if the tribal TANF end date is the end of the current month or the end of a prior month; or

(b) On the first of the month following the tribal TANF end date, if the tribal TANF end date is the end of a future month.

(3) If necessary, we will extend or shorten your Basic Food assistance unit's current certification period to match the five-month transition period.

(4) You may choose to end your five-month transition period early by submitting an application for regular Basic Food under WAC 388-489-0020 or by asking us to terminate your benefits.

(5) We send you a notice before the end of your five-month transition period so you can reapply for regular Basic Food benefits and continue to receive benefits without interruption as described in WAC 388-434-0010.

(6) We may terminate your transitional food assistance early for the reasons stated in WAC 388-489-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-489-0015, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0020 Am I required to report changes in my household's circumstances while on transitional food assistance? (1) If you only receive transitional food assistance, you are not required to report any changes in your household circumstances.

(2) If you receive benefits from another cash or medical assistance program, you must meet the reporting requirements for the other program as required by WAC 388-418-0005. Except for changes listed under WAC 388-489-0025, the changes you report for the other program will not affect your family's eligibility for transitional food assistance.

(3) If your family experiences a change in circumstances during your five-month transition period, and you think that you may be eligible for more food assistance, you may submit an application for the regular Basic Food program. Examples of such changes include the loss of income by a person who gets transitional food assistance with you or adding a new person to your household.

(a) If you submit a new application, we will determine your eligibility for Basic Food and allow you to choose if you want to remain on transitional food assistance or receive regular Basic Food benefits.

(b) If you choose to go back on Basic Food and are found eligible, we will start your new benefit amount on the first day of the month after we receive your application for Basic Food. If you have already received transitional food assistance for this month and are eligible for more assistance on the Basic Food program, we will pay you the additional amount.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-489-0020, filed 9/16/05, effective 11/1/05.]

WAC 388-489-0025 Can my transitional food assistance benefits end before the end of my five-month transition period? Your transitional food assistance benefits will end early if:

- (1) Someone who gets transitional food assistance with you applies and is approved for temporary assistance for needy families while still living in your home. You may reapply to have your eligibility for Basic Food determined;
- (2) We learn that you and your family are no longer residing in the state of Washington; or
- (3) **All members** of your household are eligible to get Basic Food for any of the following reasons:
 - (a) Refusal to cooperate with quality assurance (WAC 388-464-0001);
 - (b) Transfer of property to qualify for Basic Food assistance (WAC 388-488-0010);
 - (c) Intentional program violation (WAC 388-466-0015 and 388-446-0020);
 - (d) Fleeing felon or violating a condition of probation or parole (WAC 388-442-0010);
 - (e) Alien status (WAC 388-424-0020 and 388-424-0025);
 - (f) Employment and training requirements (WAC 388-444-0055 and 388-444-0075);
 - (g) Work requirements for able-bodied adults without dependents (WAC 388-444-0030);
 - (h) Student status (WAC 388-482-0005);
 - (i) Living in an institution where residents are not eligible for Basic Food (WAC 388-408-0040); or
 - (j) Deceased.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-489-0025, filed 9/16/05, effective 11/1/05.]

Chapter 388-490 WAC VERIFICATION

WAC

388-490-0005 The department requires proof before authorizing benefits for cash, medical, and Basic Food.

WAC 388-490-0005 The department requires proof before authorizing benefits for cash, medical, and Basic Food. This rule applies to cash, medical, and Basic Food.

(1) When you first apply for benefits, the department may require you to provide proof of things that help us decide if you are eligible for benefits. This is also called "verification." The types of things that need to be proven are different for each program.

(2) After that, we will ask you to give us proof when:

- (a) You report a change;
- (b) We find out that your circumstances have changed;

or

(c) The information we have is questionable, confusing, or outdated.

(3) Whenever we ask for proof, we will give you a notice as described in WAC 388-458-0020.

[Title 388 WAC—p. 900]

(4) You must give us the proof within the time limits described in:

- (a) WAC 388-406-0030 if you are applying for benefits; and
- (b) WAC 388-458-0020 if you currently receive benefits.

(5) We will accept any proof that you can easily get when it reasonably supports your statement or circumstances. The proof you give to us must:

- (a) Clearly relate to what you are trying to prove;
 - (b) Be from a reliable source; and
 - (c) Be accurate, complete, and consistent.
- (6) We cannot make you give us a specific type or form of proof.

(7) If the only type of proof that you can get costs money, we will pay for it.

(8) If the proof that you give to us is questionable or confusing, we may:

(a) Ask you to give us more proof, which may include providing a collateral statement. A "collateral statement" is from someone outside of your residence who knows your situation;

(b) Schedule a visit to come to your home and verify your circumstances; or

(c) Send an investigator from the Division of Fraud Investigations (DFI) to make an unannounced visit to your home to verify your circumstances.

(9) By signing the application, eligibility review, or change of circumstances form, you give us permission to contact other people, agencies, or institutions.

(10) If you do not give us all of the proof that we have asked for, we will determine if you are eligible based on the information that we already have. If we cannot determine that you are eligible based on this information, we will deny or stop your benefits.

(11) For all Medicaid programs, you must provide proof of citizenship and identity as specified at Section 6036 of the Deficit Reduction Act of 2005 (PL 106-171 amending USC 1396b). Exempt from this requirement are recipients of:

- (a) SSI cash benefits; or
- (b) Medicare.

[Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.530, and Public Law 109-171, Section 6036. 07-02-066, § 388-490-0005, filed 12/29/06, effective 1/29/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-21-029, § 388-490-0005, filed 10/7/03, effective 11/1/03. Statutory Authority: RCW 74.08.090 and 74.04.510. 00-08-091, § 388-490-0005, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-490-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0460.]

Chapter 388-492 WAC WASHINGTON COMBINED APPLICATION PROJECT

WAC

388-492-0020	What are WASHCAP food benefits?
388-492-0030	Who can get WASHCAP?
388-492-0040	Can I choose whether I get WASHCAP food benefits or Basic Food benefits?
388-492-0050	How do I apply for WASHCAP?
388-492-0060	How do I get my WASHCAP food benefits?
388-492-0070	How are my WASHCAP food benefits calculated?
388-492-0080	Where do I report changes?
388-492-0090	How often do my WASHCAP food benefits need to be reviewed?

(2007 Ed.)

388-492-0100	How is my eligibility for WASHCAP food benefits reviewed?
388-492-0110	What happens if my WASHCAP food benefits end?
388-492-0120	What happens to my WASHCAP benefits if I am disqualified?
388-492-0130	What can I do if I disagree with a decision the department made about my WASHCAP benefits?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-492-0010	Washington state combined application program (WASHCAP) definitions. [Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510, 02-15-148, § 388-492-0010, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0010, filed 10/16/01, effective 12/1/01.] Repealed by 04-23-026, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090.
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WAC 388-492-0020 What are WASHCAP food benefits? WASHCAP means the Washington State Combined Application program.

(1) WASHCAP is a simplified food benefits program for certain Supplemental Security Income (SSI) recipients. Unless specifically stated in this WAC chapter, WASHCAP food benefits follow all the program requirements of the Basic Food program as described under WAC 388-400-0040.

(2) Social Security Administration (SSA) asks you if you want to get food benefits when you apply for SSI in Washington state.

(3) If you meet the requirements of WAC 388-492-0030, you will get WASHCAP food benefits unless you can choose Basic Food benefits under WAC 388-492-0040.

(4) If you are eligible for WASHCAP food benefits under WAC 388-492-0030, SSA electronically sends us the information we need to open your WASHCAP food benefits.

(5) WASHCAP food benefits begin the first month after the month you are eligible for ongoing SSI.

(6) You do not have to go to your local community services office (CSO) to apply for WASHCAP.

(7) If you want Basic Food benefits before WASHCAP food benefits begin, you can apply at your local CSO, home and community services office (HCS), or SSA.

(8) While you get WASHCAP food benefits, you must report all changes to SSA.

(9) SSA shares the changes you report to them with your WASHCAP worker.

(10) You do not have to report changes to your WASHCAP worker. See WAC 388-492-0080.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 04-23-026, § 388-492-0020, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510, 02-15-148, § 388-492-0020, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0020, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0030 Who can get WASHCAP? (1)

You can get WASHCAP food benefits if:

- (a) You are eligible to receive federal SSI benefits; and
- (b) You are eighteen years of age or older; and
- (c) You live alone, or SSA considers you as a single household; or
- (d) You live with others but buy and cook your food separately from them; and
- (e) You do not have earned income when you apply for SSI; or

(2007 Ed.)

(f) You already get WASHCAP food benefits and become employed and receive earned income for less than three consecutive months; or

(g) You already get WASHCAP and move to an institution for ninety days or less.

(2) You are not eligible for WASHCAP food benefits if:

- (a) You live in an institution;
- (b) You are under age eighteen;
- (c) You live with your spouse;

(d) You are under age twenty-two and you live with your parent(s) who are getting Basic Food benefits;

(e) You begin working after you have been approved for WASHCAP and have earned income for more than three consecutive months;

(f) You live with others and do not buy and cook your food separately from them; or

(g) You are ineligible for Basic Food benefits under WAC 388-400-0040 (13)(b) and (e).

(3) We accept SSA information about your WASHCAP eligibility unless you prove the information is not accurate.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 04-23-026, § 388-492-0030, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510, 02-15-148, § 388-492-0030, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0030, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0040 Can I choose whether I get WASHCAP food benefits or Basic Food benefits? You can choose to have Basic Food benefits instead of WASHCAP food benefits when:

(1) Your nonutility shelter costs as defined in WAC 388-450-0190 (1)(a) through (d) are more than five hundred sixty-seven dollars a month;

(2) Your out-of-pocket medical expenses are more than thirty-five dollars a month; or

(3) You chose to have Basic Food benefits instead of WASHCAP benefits prior to January 1, 2005.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. 273.9 (d)(6)(iii)(b), 06-21-011, § 388-492-0040, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 05-18-036, § 388-492-0040, filed 8/30/05, effective 10/1/05; 05-08-009, § 388-492-0040, filed 3/25/05, effective 4/25/05; 04-23-026, § 388-492-0040, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 03-21-030, § 388-492-0040, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510, 03-01-045, § 388-492-0040, filed 12/10/02, effective 1/10/03; 02-15-148, § 388-492-0040, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0040, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0050 How do I apply for WASHCAP?

(1) You apply for WASHCAP food benefits at Social Security Administration (SSA) when you apply for Supplemental Security Income (SSI).

(2) If you want food benefits, your SSA worker will ask you WASHCAP food eligibility questions when you have your SSI interview.

(3) If you are eligible for WASHCAP food benefits, your benefits will start the first of the month after the month you are eligible for ongoing SSI benefits.

(4) If you need food benefits in five days or less, you must apply for expedited services at:

- (a) Your local community services office (CSO);

[Title 388 WAC—p. 901]

(b) Your local home and community services office (HCS) if you get long-term care services; or

(c) The SSA office if you give them an application for Basic Food expedited services when you apply for SSI. SSA forwards the Basic Food application to the local CSO to process.

(5) If you want Basic Food benefits before you get SSI, you must apply at:

(a) SSA if you give them a Basic Food application when you apply for SSI;

(b) Your local CSO; or

(c) Your local HCS office if you get long-term care services.

(6) If you already receive SSI and want WASHCAP food benefits, you can apply at:

(a) Your SSA office;

(b) Your local CSO;

(c) Your local HCS office if you get long-term care services.

(7) If you get Basic Food benefits, these benefits will continue:

(a) Through the end of your certification period; or

(b) Through the month before your WASHCAP food benefits start.

(8) If your Basic Food benefits end before you are eligible for WASHCAP food benefits, you must reapply to continue these benefits.

(9) If you get Basic Food benefits and you become eligible for WASHCAP food benefits, we will automatically change your Basic Food benefits to WASHCAP food benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0050, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0050, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0050, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0060 How do I get my WASHCAP food benefits? (1) If you are eligible for WASHCAP, you will get your food benefits through electronic benefits transfer (EBT).

(2) The department issues your EBT food benefits according to WAC 388-412-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0060, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0060, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0060, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0070 How are my WASHCAP food benefits calculated? We calculate your food benefits as follows:

(1) We begin with your gross income.

(2) We subtract one hundred thirty-four dollars from your gross income to get your countable income.

(3) We figure your shelter cost based on information we receive from Social Security Administration (SSA), unless you report a change as described under WAC 388-492-0080. If you pay:

(a) Three hundred forty-two dollars or more a month for shelter, we use three hundred fifty-four dollars as your shelter cost; or

(b) Less than three hundred forty-two dollars for shelter, we use one hundred seventy-one dollars as your shelter cost; and

(c) We add the current limited utility allowance under WAC 388-450-0195 to determine your total shelter cost.

(4) We figure your shelter deduction by subtracting one half of your countable income from your shelter cost.

(5) We figure your net income by subtracting your shelter deduction from your countable income and rounding the resulting figure up from fifty cents and down from forty-nine cents to the nearest whole dollar.

(6) We figure your WASHCAP food benefits (allotment) by:

(a) Multiplying your net income by thirty percent and rounding up to the next whole dollar; and

(b) Subtracting the result from the maximum allotment under WAC 388-478-0060.

(c) If you are eligible for WASHCAP, you will get at least ten dollars in food benefits each month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. 273.9 (d)(6)(iii)(b). 06-21-011, § 388-492-0070, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-17-155, § 388-492-0070, filed 8/22/05, effective 10/1/05; 05-08-008, § 388-492-0070, filed 3/25/05, effective 4/25/05; 04-23-026, § 388-492-0070, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-492-0070, filed 10/7/03, effective 12/1/03. Statutory Authority: RCW 74.04.057, 74.04.500, 74.04.510. 03-01-045, § 388-492-0070, filed 12/10/02, effective 1/10/03; 02-15-148, § 388-492-0070, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0070, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0080 Where do I report changes? (1)

You report all changes to Social Security Administration (SSA) according to their reporting requirements. Social Security reports these changes to your WASHCAP worker.

(2) SSA will not accept or report shelter costs changes to WASHCAP until SSA does its redetermination.

(3) You do not have to report any changes to your WASHCAP worker.

(4) You can choose to report the following changes to your WASHCAP worker to see if you will get more food benefits.

(a) A change in your address;

(b) An increase in your shelter costs; or

(c) An increase in your out-of-pocket medical expenses.

(5) If changes are reported to DSHS, proof may be required.

(6) If you report a change that could increase the amount of your food benefits, we will not increase the benefit amount if we have asked for proof and it has not been provided.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0080, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0080, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0080, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0090 How often do my WASHCAP food benefits need to be reviewed? (1) Your eligibility for WASHCAP food benefits must be reviewed at least every twenty-four months.

(2) Your certification period is the amount of time your assistance unit is eligible for WASHCAP food benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0090, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0090, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0090, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0100 How is my eligibility for WASHCAP food benefits reviewed? (1) If Social Security Administration (SSA) reviews your Supplemental Security Income (SSI) eligibility, they will also complete your review for WASHCAP. SSA sends us this information electronically and we will automatically extend your WASHCAP certification period.

(2) If SSA does not review your SSI eligibility, we will mail you a one-page application two months before your WASHCAP benefits end. You must complete and return this application to the WASHCAP unit or your local home and community services office (HCS).

(3) We do WASHCAP reviews by mail. If you bring your WASHCAP application to the local office, we will process the application as follows:

(a) If you get long-term care services, your local HCS office will process your application; or

(b) If you do not get long-term care services, the local office will forward your application to the WASHCAP central unit.

(4) If we get your completed one-page application after your WASHCAP food benefits end, we will reopen your benefits back to the first of the month if:

(a) We get your application form within thirty days from the end of your certification period; and

(b) You are still eligible for WASHCAP food benefits.

(5) If we get your completed one-page application form more than thirty days after your benefits end, your WASHCAP food benefits open the first of the next month after you turn in your application and SSA shows you are eligible for WASHCAP in their system.

(6) If your application is not complete, we will return it to you to complete.

(7) If you want Basic Food benefits while you are waiting for WASHCAP food benefits, you must apply for these benefits at the local CSO or HCS office.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0100, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0100, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0100, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0110 What happens if my WASHCAP food benefits end? (1) If your WASHCAP food benefits end because you did not have the review required under WAC 388-492-0100, you must finish the required review or apply for Basic Food benefits at:

(a) Your local community services office (CSO); or

(b) Your home and community services (HCS) office.

(2) If your WASHCAP benefits end because you are disqualified under WAC 388-400-0040 (13)(b) or (e), you are not eligible for Basic Food benefits and:

(a) If you get medical assistance, we will send your medical assistance case to your local office;

(b) If you are a HCS client, your medical case will remain at HCS.

(2007 Ed.)

(3) If your WASHCAP benefits end for any other reason:

(a) We will send you an application for Basic Food benefits along with:

(i) Information about what you must verify in order to get benefits; and

(ii) The address of your local CSO. If you are an HCS client, your case will remain at your HCS office.

(b) For the local CSO to decide if you are eligible for Basic Food benefits, you must:

(i) Finish the application process for Basic Food benefits under chapter 388-406 WAC; and

(ii) Have an interview for Basic Food benefits under WAC 388-452-0005.

(c) If you get medical assistance, we will send your medical case to the local CSO unless you are an HCS client;

(d) If your WASHCAP benefits closed because SSA ended your SSI, you will still receive the same medical benefits until we decide what medical program you are eligible for under WAC 388-418-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0110, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0110, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0110, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0120 What happens to my WASHCAP benefits if I am disqualified? (1) If you are disqualified from receiving SSI for any reason, you will not be able to get WASHCAP benefits. See WAC 388-492-0030, Who can get WASHCAP?

(2) If you are disqualified from receiving Basic Food for any reason, you will not get WASHCAP food benefits. This includes clients who:

(a) Are ineligible under WAC 388-400-0040 (13)(b) and (e) and 388-442-0010; or

(b) Did not cooperate with quality assurance as required under WAC 388-464-0001.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0120, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0120, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0120, filed 10/16/01, effective 12/1/01.]

WAC 388-492-0130 What can I do if I disagree with a decision the department made about my WASHCAP benefits? (1) If you disagree with a decision about your benefits, you may ask for a fair hearing.

(2) You can ask for a hearing by contacting the WASHCAP central unit, home and community service office or any responsible department or office of administrative hearings employee.

(3) See chapter 388-02 WAC for information on the fair hearing process.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 04-23-026, § 388-492-0130, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.57 [74.04.057], 74.04.500, 74.04.510. 02-15-148, § 388-492-0130, filed 7/22/02, effective 9/1/02; 01-21-058, § 388-492-0130, filed 10/16/01, effective 12/1/01.]

Chapter 388-500 WAC
MEDICAL DEFINITIONS

WAC

388-500-0005 Medical definitions.

WAC 388-500-0005 Medical definitions. Unless defined in this chapter or in other chapters of the *Washington Administrative Code*, use definitions found in the *Webster's New World Dictionary*. This section contains definitions of words and phrases the department uses in rules for medical programs. Definitions of words used for both medical and financial programs are defined under WAC 388-22-030.

"Assignment of rights" means the client gives the state the right to payment and support for medical care from a third party.

"Base period" means the time period used in the limited casualty program which corresponds with the months considered for eligibility.

"Beneficiary" means an eligible person who receives:

- *A federal cash Title XVI benefit; and/or
- *State supplement under Title XVI; or
- *Benefits under Title XVIII of the Social Security Act.

"Benefit period" means the time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for Medicare payments.

"Cabulance" means a vehicle for hire designed and used to transport a physically restricted person.

"Carrier" means:

- *An organization contracting with the federal government to process claims under Part B of Medicare; or
- *A health insurance plan contracting with the department.

"Categorical assistance unit (CAU)" means one or more family members whose eligibility for medical care is determined separately or together based on categorical relatedness.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-503-0310, chapter 388-517 WAC and WAC 388-523-2305.

"Children's health program" means a state-funded medical program for children under age eighteen:

- *Whose family income does not exceed one hundred percent of the federal poverty level; and
- *Who are not otherwise eligible under Title XIX of the Social Security Act.

"Coinsurance-Medicare" means the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges.

"Community services office (CSO)" means an office of the department which administers social and health services at the community level.

"Couple" means, for the purposes of an SSI-related client, an SSI-related client living with a person of the opposite sex and both presenting themselves to the community as husband and wife. The department shall consider the income and resources of such couple as if the couple were married except when determining institutional eligibility.

"Deductible-Medicare" means an initial specified amount that is the responsibility of the client.

"Part A of Medicare-inpatient hospital deductible" means an initial amount of the medical care cost in each benefit period which Medicare does not pay.

"Part B of Medicare-physician deductible" means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.

"Delayed certification" means department approval of a person's eligibility for medicaid made after the established application processing time limits.

"Department" means the state department of social and health services.

"Early and periodic screening, diagnosis and treatment (EPSDT)" also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid or the children's health program.

"Electronic fund transfers (EFT)" means automatic bank deposits to a client's or provider's account.

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- *Placing the patient's health in serious jeopardy;
- *Serious impairment to bodily functions; or
- *Serious dysfunction of any bodily organ or part.

"Emergency medical expense requirement" means a specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

"Essential spouse" see "spouse."

"Extended care patient" means a recently hospitalized Medicare patient needing relatively short-term skilled nursing and rehabilitative care in a skilled nursing facility.

"Garnishment" means withholding an amount from earned or unearned income to satisfy a debt or legal obligation.

"Grandfathered client" means:

- *A noninstitutionalized person who meets all current requirements for Medicaid eligibility except the criteria for blindness or disability; and

*Was eligible for Medicaid in December 1973 as blind or disabled whether or not the person was receiving cash assistance in December 1973; and

*Continues to meet the criteria for blindness or disability and other conditions of eligibility used under the Medicaid plan in December 1973; and

*An institutionalized person who was eligible for Medicaid in December 1973 or any part of that month, as an inpatient of a medical institution or resident of an intermediate care facility that was participating in the Medicaid program and for each consecutive month after December 1973 who:

*Continues to meet the requirements for Medicaid eligibility that were in effect under the state's plan in December 1973 for institutionalized persons; and

*Remains institutionalized.

"Health maintenance organization (HMO)" means an entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis.

"Healthy kids," see **"EPSDT."**

"Home health agency" means an agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

"Hospital" means an institution licensed as a hospital by the department of health.

"Income for an SSI-related client," means the receipt by an individual of any property or service which the client can apply either directly, by sale, or conversion to meet the client's basic needs for food, clothing, and shelter.

***"Earned income"** means gross wages for services rendered and/or net earnings from self-employment.

***"Unearned income"** means all other income.

"Institution" means an establishment which furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally retarded.

***"Institution-public"** means an institution, including a correctional institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

***"Institution for mental diseases"** means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.

***"Institution for the mentally retarded or a person with related conditions"** means an institution that:

*Is primarily for the diagnosis, treatment or rehabilitation of the mentally retarded or a person with related conditions; and

*Provides, in a protected residential setting, on-going care, twenty-four hour supervision, evaluation, and planning to help each person function at the greatest ability.

***"Institution for tuberculosis"** means an institution for the diagnosis, treatment, and care of a person with tuberculosis.

***"Medical institution"** means an institution:

*Organized to provide medical care, including nursing and convalescent care;

*With the necessary professional personnel, equipment and facilities to manage the health needs of the patient on a continuing basis in accordance with acceptable standards;

*Authorized under state law to provide medical care; and

*Staffed by professional personnel. Services include adequate physician and nursing care.

"Intermediary" means an organization having an agreement with the federal government to process Medicare claims under Part A.

"Legal dependent" means a person for whom another person is required by law to provide support.

"Limited casualty program (LCP)" means a medical care program for medically needy, as defined under WAC 388-503-0320 and for medically indigent, as defined under WAC 388-503-0370.

"Medicaid" means the federal aid Title XIX program under which medical care is provided to persons eligible for:

*Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or

*Medically needy program as defined in WAC 388-503-0320.

"Medical assistance." See **"Medicaid."**

"Medical assistance administration (MAA)" means the unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs.

"Medical assistance unit (MAU)" means one or more family members whose eligibility for medical care is determined separately or together based on financial responsibility.

"Medical care services" means the limited scope of care financed by state funds and provided to general assistance (GAU) and ADATSA clients.

"Medical consultant" means a physician employed by the department.

"Medical facility" see **"Institution."**

"Medically indigent (MI)" means a state-funded medical program for a person who has an emergency medical condition requiring hospital-based services.

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Medically needy (MN)" is the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"Medicare" means the federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

***"Part A"** covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

***"Part B"** is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech

pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

"Medicare assignment" means the method by which the provider receives payment for services under Part B of Medicare.

"Month of application" means the calendar month a person files the application for medical care. When the application is for the medically needy program, at the person's request and if the application is filed in the last ten days of that month, the month of application may be the following month.

"Nursing facility" means any institution or facility the department [of health] licenses as a nursing facility, or a nursing facility unit of a licensed hospital, that the:

*Department certifies; and

*Facility and the department agree the facility may provide skilled nursing facility care.

"Outpatient" means a nonhospitalized patient receiving care in a hospital outpatient or hospital emergency department, or away from a hospital such as in a physician's office, the patient's own home, or a nursing facility.

"Patient transportation" means client transportation to and from covered medical services under the federal Medicaid and state medical care programs.

"Physician" means a doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

"Professional activity study (PAS)" means a compilation of inpatient hospital data, conducted by the commission of professional and hospital activities, to determine the average length of hospital stay for patients.

"Professional review organization for Washington (PRO-W)" means the state level organization responsible for determining whether health care activities:

*Are medically necessary;

*Meet professionally acceptable standards of health care; and

*Are appropriately provided in an outpatient or institutional setting for beneficiaries of Medicare and clients of Medicaid and maternal and child health.

"Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law to:

*Artificially replace a missing portion of the body;

*Prevent or correct physical deformity or malfunction;

or

*Support a weak or deformed portion of the body.

"Provider" or **"provider of service"** means an institution, agency, or person:

*Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and

*Is eligible to receive payment from the department.

"Resources for an SSI-related client," means cash or other liquid assets or any real or personal property that an individual or spouse, if any, owns and could convert to cash to be used for support or maintenance.

*If an individual can reduce a liquid asset to cash, it is a resource.

*If an individual cannot reduce an asset to cash, it is not considered an available resource.

*Liquid means properties that are in cash or are financial instruments which are convertible to cash such as, but not limited to, cash, savings, checking accounts, stocks, mutual fund shares, mortgage, or a promissory note.

*Nonliquid means all other property both real and personal evaluated at the price the item can reasonably be expected to sell for on the open market.

"Retroactive period" means the three calendar months before the month of application.

"Spell of illness" see **"benefit period."**

"Spendedown" means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department.

"Spouse" means:

***"Community spouse"** means a person living in the community and married to an institutionalized person or to a person receiving services from a home and community-based waived program as described under chapter 388-515 WAC.

***"Eligible spouse"** means an aged, blind or disabled husband or wife of an SSI-eligible person, with whom such a person lives.

***"Essential spouse"** means, a husband or wife whose needs were taken into account in determining old age assistance (OAA), aid to the blind (AB), or disability assistance (DA) client for December 1973, who continues to live in the home and to be the spouse of such client.

***"Ineligible spouse"** means the husband or wife of an SSI-eligible person, who lives with the SSI-eligible person and who has not applied or is not eligible to receive SSI.

***"Institutionalized spouse"** means a married person in an institution or receiving services from a home or community-based waived program.

***"Nonapplying spouse"** means an SSI-eligible person's husband or wife, who has not applied for assistance.

"SSI-related" means an aged, blind or disabled person not receiving an SSI cash grant.

"Supplemental security income (SSI) program, Title XVI" means the federal grant program for aged, blind, and disabled established by section 301 of the Social Security amendments of 1972, and subsequent amendments, and administered by the Social Security Administration (SSA).

"Supplementary payment (SSP)" means the state money payment to persons receiving benefits under Title XVI, or who would, but for the person's income, be eligible for such benefits, as assistance based on need in supplementation of SSI benefits. This payment includes:

***"Mandatory state supplement"** means the state money payment to a person who, for December 1973, was a client receiving cash assistance under the department's former programs of old age assistance, aid to the blind and disability assistance; and

***"Optional state supplement"** means the elective state money payment to a person eligible for SSI benefits or who, except for the level of the person's income, would be eligible for SSI benefits.

"Third party" means any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

"Title XIX" is the portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

"Transfer" means any act or omission to act when title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person; including delivery of personal property, bills of sale, deeds, mortgages, pledges, or any other instrument conveying or relinquishing an interest in property. Transfer of title to a resource occurs by:

*An intentional act or transfer; or

*Failure to act to preserve title to the resource.

"Value-fair market for an SSI-related person" means the current value of a resource at the price for which the resource can reasonably be expected to sell on the open market.

"Value of compensation received" means, for SSI-related medical eligibility, the gross amount paid or agreed to be paid by the purchaser of a resource.

"Value-uncompensated" means, for SSI-related medical eligibility, the fair market value of a resource, minus the amount of compensation received in exchange for the resource.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-500-0005, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-500-0005, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-500-0005, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-80-005, 388-82-006, 388-92-005 and 388-93-005.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

Chapter 388-501 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

388-501-0050	Healthcare general coverage.
388-501-0060	Healthcare coverage—Scope of covered categories of service.
388-501-0065	Healthcare coverage—Description of covered categories of service.
388-501-0100	Subrogation.
388-501-0125	Advance directives.
388-501-0135	Patient review and restriction (PRR).
388-501-0160	Exception to rule—Request for a noncovered healthcare service.
388-501-0165	Medical and dental coverage—Fee-for-service (FFS) prior authorization—Determination process for payment.
388-501-0169	Healthcare coverage—Limitation extension.
388-501-0175	Medical care provided in bordering cities.
388-501-0180	Out-of-state medical care.
388-501-0200	Third-party resources.
388-501-0213	Case management services.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-501-0105	Applicability. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0105, filed 5/3/94, effective 6/3/94. Formerly WAC 388-80-002.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
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388-501-0110 Purpose of the medical care program. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0110, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-81-005, 388-81-025, 388-99-005 and 388-100-005.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.

388-501-0130 Administrative controls. [Statutory Authority: RCW 74.08.090 and 74.09.290. 96-06-041 (Order 3949), § 388-501-0130, filed 3/1/96, effective 4/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0130, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-015.] Repealed by 00-23-014, filed 11/3/00, effective 12/4/00. Statutory Authority: RCW 74.08.090, 43.20B.675.

388-501-0140 Fraud. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0140, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-446-0001.

388-501-0150 Confidential records. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-035.] Repealed by 00-14-047, filed 6/30/00, effective 7/31/00.

388-501-0170 Third party resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0170, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-010 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0540.

388-501-0190 Maternity care distressed area. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0190, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-070.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-501-0300 Limits on scope of medical program services. [Statutory Authority: RCW 74.08.090. 01-12-072, § 388-501-0300, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. 00-23-052, amended and recodified as § 388-501-0300, filed 11/13/00, effective 12/14/00. Statutory Authority: RCW 74.08.090. 93-16-037 (Order 3599), § 388-86-200, filed 7/28/93, effective 8/28/93; 93-11-086 (Order 3536), § 388-86-200, filed 5/19/93, effective 6/19/93.] Repealed by 06-24-036, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700.

WAC 388-501-0050 Healthcare general coverage.

The following rules, WAC 388-501-0050 through 388-501-0065, describe the healthcare services available to a client on a fee-for-service basis or as an enrollee in a managed care organization (MCO)(defined in WAC 388-538-050). Non-covered services are described in WAC 388-501-0070.

(1) Service categories listed in WAC 388-501-0060 do not represent a contract for services.

(2) The client must be eligible for the covered service on the date the service is performed or provided.

(3) The department pays only for medical or dental services, equipment, or supplies that are:

(a) Within the scope of the client's medical program;

(b) Covered - see subsection (5);

(c) Medically necessary;

(d) Ordered or prescribed by a healthcare provider meeting the requirements of chapter 388-502 WAC; and

(e) Furnished by a provider according to the requirements of chapter 388-502 WAC.

(4) The department's fee-for-service program pays only for services furnished by enrolled providers who meet the requirements of chapter 388-502 WAC.

(5) The department does not pay for any service, treatment, equipment, drug, or supply requiring prior authorization from the department, if prior authorization was not obtained before the service was provided.

(6) Covered services

(a) Covered services are either:

(i) "Federally mandated" - means the state of Washington is required by federal regulation (42 CFR 440.210 and 220) to cover the service for Medicaid clients; or

(ii) "State-option" - means the state of Washington is not federally mandated to cover the service but has chosen to do so at its own discretion.

(b) The department may limit the scope, amount, duration, and/or frequency of covered services. Limitation extensions are authorized according to WAC 388-501-0169.

(7) Noncovered services

(a) The department does not pay for any service, equipment, or supply:

(i) That federal or state law or regulations prohibit the department from covering;

(ii) Listed as noncovered in WAC 388-501-0070 or in any other program rule. The department evaluates a request for a noncovered service only if an exception to rule is requested according to the provisions in WAC 388-501-0160.

(b) When Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) applies, a noncovered service, equipment, or supply will be evaluated according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-534-0100 for EPSDT rules).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0050, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 01-12-070, § 388-501-0050, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0050, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0060 Healthcare coverage—Scope of covered categories of service. (1) This rule provides a list (see subsection (5)) of medical, dental, mental health, and substance abuse categories of service covered by the department under categorically needy (CN) Medicaid, medically needy (MN) Medicaid, Alien Emergency Medical (AEM), and medical care services (MCS) programs. MCS means the limited scope of care financed by state funds and provided to general assistance and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program clients.

(2) Not all categories of service listed in this section are covered under every medical program, nor do they represent a contract for services. Services are subject to the exclusions, limitations, and eligibility requirements contained in department rules.

(3) Services covered under each listed category:

(a) Are determined by the department after considering available evidence relevant to the service or equipment to:

(i) Determine efficacy, effectiveness, and safety;

(ii) Determine impact on health outcomes;

(iii) Identify indications for use;

(iv) Compare alternative technologies; and

(v) Identify sources of credible evidence that use and report evidence-based information.

(b) May require prior authorization (see WAC 388-501-0165), or expedited authorization when allowed by the department.

(c) Are paid for by the department and subject to review both before and after payment is made. The department or the client's managed care organization may deny or recover payment for such services, equipment, and supplies based on these reviews.

(4) The department does not pay for covered services, equipment, or supplies that:

(a) Require prior authorization from the department, if prior authorization was not obtained before the service was provided;

(b) Are provided by providers who are not contracted with the department as required under chapter 388-502 WAC;

(c) Are included in a department waiver program identified in chapter 388-515 WAC; or

(d) Are covered by a third-party payer (see WAC 388-501-0200), including Medicare, if the third-party payer has not made a determination on the claim or has not been billed by the provider.

(5) **Scope of covered service categories.** The following table lists the department's covered categories of healthcare services.

- Under the four program columns (CN, MN, MCS, and AEM), the letter "C" means a service category is covered for that program, subject to any limitations listed in the specific medical assistance program WAC and department issuances.

- The letter "N" means a service category is not covered under that program.

- The letter "E" means the service category is available only if it is necessary to treat the client's emergency medical condition and may require prior authorization from the department.

- Refer to WAC 388-501-0065 for a description of each service category and for the specific program WAC containing the limitations and exclusions to services.

Service Categories	CN*	MN	MCS	AEM
(a) Adult day health	C	C	N	E
(b) Ambulance (ground and air)	C	C	C	E
(c) Blood processing/administration	C	C	C	E
(d) Dental services	C	C	C	E
(e) Detoxification	C	C	C	E
(f) Diagnostic services (lab & x-ray)	C	C	C	E
(g) Family planning services	C	C	C	E
(h) Healthcare professional services	C	C	C	E
(i) Hearing care (audiology/hearing exams/aids)	C	C	C	E
(j) Home health services	C	C	C	E
(k) Hospice services	C	C	N	E

(l) Hospital services - inpatient/outpatient	C	C	C	E
(m) Intermediate care facility/services for mentally retarded	C	C	C	E
(n) Maternity care and delivery services	C	C	N	E
(o) Medical equipment, durable (DME)	C	C	C	E
(p) Medical equipment, nondurable (MSE)	C	C	C	E
(q) Medical nutrition services	C	C	C	E
(r) Mental health services	C	C	C	E
(s) Nursing facility services	C	C	C	E
(t) Organ transplants	C	C	C	N
(u) Out-of-state services	C	C	N	E
(v) Oxygen/respiratory services	C	C	C	E
(w) Personal care services	C	C	N	N
(x) Prescription drugs	C	C	C	E
(y) Private duty nursing	C	C	N	E
(z) Prosthetic/orthotic devices	C	C	C	E
(aa) School medical services	C	C	N	N
(bb) Substance abuse services	C	C	C	E
(cc) Therapy - occupational/physical/speech	C	C	C	E
(dd) Vision care (exams/lenses)	C	C	C	E

*Clients enrolled in the State Children's Health Insurance Program and the Children's Health Program receive CN scope of medical care.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0060, filed 11/30/06, effective 1/1/07.]

WAC 388-501-0065 Healthcare coverage—Description of covered categories of service. This rule provides a brief description of the medical, dental, mental health, and substance abuse service categories listed in the table in WAC 388-501-0060. The description of services under each category is not intended to be all inclusive.

(1) For categorically needy (CN), medically needy (MN), and medical care services (MCS), refer to the WAC citations listed in the following descriptions for specific details regarding each service category. For Alien Emergency Medical (AEM) services, refer to WAC 388-438-0110.

(2) The following service categories are subject to the exclusions, limitations, and eligibility requirements contained in department rules:

(a) **Adult day health**—Skilled nursing services, counseling, therapy (physical, occupational, speech, or audiology), personal care services, social services, general therapeutic activities, health education, nutritional meals and

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snacks, supervision, and protection. [WAC 388-71-0702 through 388-71-0776]

(b) **Ambulance**—Emergency medical transportation and ambulance transportation for nonemergency medical needs. [WAC 388-546-0001 through 388-546-4000]

(c) **Blood processing/administration**—Blood and/or blood derivatives, including synthetic factors, plasma expanders, and their administration. [WAC 388-550-1400 and 388-550-1500]

(d) **Dental services**—Diagnosis and treatment of dental problems including emergency treatment and preventive care. [Chapters 388-535 and 388-535A WAC]

(e) **Detoxification**—Inpatient treatment performed by a certified detoxification center or in an inpatient hospital setting. [WAC 388-800-0020 through 388-800-0035; and 388-550-1100]

(f) **Diagnostic services**—Clinical testing and imaging services. [WAC 388-531-0100; 388-550-1400 and 388-550-1500]

(g) **Family planning services**—Gynecological exams; contraceptives, drugs, and supplies, including prescriptions; sterilization; screening and treatment of sexually transmitted diseases; and educational services. [WAC 388-532-530]

(h) **Healthcare professional services**—Office visits, emergency room, nursing facility, home-based, and hospital-based care; surgery, anesthesia, pathology, radiology, and laboratory services; obstetric services; kidney dialysis and renal disease services; osteopathic care, podiatry services, psychiatry, and pulmonary/respiratory services; and allergen immunotherapy. [Chapter 388-531 WAC]

(i) **Hearing care**—Audiology; diagnostic evaluations; hearing exams and testing; and hearing aids. [WAC 388-544-1200 and 388-544-1300; 388-545-700; and 388-531-0100]

(j) **Home health services**—Intermittent, short-term skilled nursing care, physical therapy, speech therapy, home infusion therapy, and health aide services, provided in the home. [WAC 388-551-2000 through 388-551-2220]

(k) **Hospice services**—Physician services, skilled nursing care, medical social services, counseling services for client and family, drugs, medications (including biologicals), medical equipment and supplies needed for palliative care, home health aide, homemaker, personal care services, medical transportation, respite care, and brief inpatient care. This benefit also includes services rendered in a hospice care center and pediatric palliative care services. [WAC 388-551-1210 through 388-551-1850]

(l) **Hospital services—Inpatient/outpatient**—Emergency room; hospital room and board (includes nursing care); inpatient services, supplies, equipment, and prescription drugs; surgery, anesthesia; diagnostic testing, laboratory work, blood/blood derivatives; radiation and imaging treatment and diagnostic services; and outpatient or day surgery, and obstetrical services. [Chapter 388-550 WAC]

(m) **Intermediate care facility/services for mentally retarded**—Habilitative training, health-related care, supervision, and residential care. [Chapter 388-835 WAC]

(n) **Maternity care and delivery services**—Community health nurse visits, nutrition visits, behavioral health visits, midwife services, maternity and infant case management services, and community health worker visits. [WAC 388-533-0330]

(o) **Medical equipment, durable (DME)**—Wheelchairs, hospital beds, respiratory equipment; prosthetic and orthotic devices; casts, splints, crutches, trusses, and braces. [WAC 388-543-1100]

(p) **Medical equipment, nondurable (MSE)**—Antiseptics, germicides, bandages, dressings, tape, blood monitoring/testing supplies, braces, belts, supporting devices, decubitus care products, ostomy supplies, pregnancy test kits, syringes, needles, transcutaneous electrical nerve stimulators (TENS) supplies, and urological supplies. [WAC 388-543-2800]

(q) **Medical nutrition services**—Enteral and parenteral nutrition, including supplies. [Chapters 388-553 and 388-554 WAC]

(r) **Mental health services**—Inpatient and outpatient psychiatric services and community mental health services. [Chapter 388-865 WAC]

(s) **Nursing facility services**—Nursing, therapies, dietary, and daily care services. [Chapter 388-97 WAC]

(t) **Organ transplants**—Solid organs, e.g., heart, kidney, liver, lung, pancreas, and small bowel; bone marrow and peripheral stem cell; skin grafts; and corneal transplants. [WAC 388-550-1900 and 388-550-2000, and 388-556-0400]

(u) **Out-of-state services**—Emergency services; prior authorized care. Services provided in bordering cities are treated as if they were provided in state. [WAC 388-501-0175 and 388-501-0180; 388-531-1100; and 388-556-0500]

(v) **Oxygen/respiratory services**—Oxygen, oxygen equipment and supplies; oxygen and respiratory therapy, equipment, and supplies. [Chapter 388-552 WAC]

(w) **Personal care services**—Assistance with activities of daily living (e.g., bathing, dressing, eating, managing medications) and routine household chores (e.g., meal preparation, housework, essential shopping, transportation to medical services). [WAC 388-106-0010, [388-106-]0300, [388-106-]0400, [388-106-]0500, [388-106-]0600, [388-106-]0700, [388-106-]0720 and [388-106-]0900]

(x) **Prescription drugs**—Outpatient drugs (including in nursing facilities), both generic and brand name; drug devices and supplies; some over-the-counter drugs; oral, topical, injectable drugs; vaccines, immunizations, and biologicals; and family planning drugs, devices, and supplies. [WAC 388-530-1100] Additional coverage for medications and prescriptions is addressed in specific program WAC sections.

(y) **Private duty nursing**—Continuous skilled nursing services provided in the home, including client assessment, administration of treatment, and monitoring of medical equipment and client care for clients seventeen years of age and under. [WAC 388-551-3000.] For benefits for clients eighteen years of age and older, see WAC 388-106-1000 through 388-106-1055.

(z) **Prosthetic/orthotic devices**—Artificial limbs and other external body parts; devices that prevent, support, or correct a physical deformity or malfunction. [WAC 388-543-1100]

(aa) **School medical services**—Medical services provided in schools to children with disabilities under the Individuals with Disabilities Education Act (IDEA). [Chapter 388-537 WAC]

(bb) **Substance abuse services**—Chemical dependency assessment, case management services, and treatment ser-

vices. [WAC 388-533-0701 through 388-533-0730; 388-556-0100 and 388-556-0400; and 388-800-0020]

(cc) **Therapy—Occupational/physical/speech**—Evaluations, assessments, and treatment. [WAC 388-545-300, 388-545-500, and 388-545-700]

(dd) **Vision care**—Eye exams, refractions, frames, lenses, ocular prosthetics, and surgery. [WAC 388-544-0250 through 388-544-0550]

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0065, filed 11/30/06, effective 1/1/07.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 388-501-0100 Subrogation. (1) For the purpose of this section, "**liable third party**" means:

(a) The tort-feasor or insurer of the tort-feasor, or both; and

(b) Any person who is liable to provide coverage for the illness or injuries for which the medical assistance administration (MAA) is providing assistance or residential care. That liability must be based on any contract or insurance purchased by the client or any other person.

(2) As a condition of medical care eligibility, a client must assign to the state any right the client may have to receive payment from any other third party. An eligible client who receives health care items or services from the state under medical care programs under chapter 74.09 RCW and who has a right to payment from any other third party for those items or services, subrogates that right of payment to the state. This applies except as provided in subsection (3) of this section.

(3) To the extent authorized by a contract executed under RCW 74.09.522, a managed health care plan has the rights and remedies of the department as provided in RCW 43.20B.060 and 70.09.180.

(4) MAA is not responsible to pay for medical care for a client whose personal injuries are caused by the negligence or wrongdoing of another. However, MAA may provide the medical care required as a result of an injury to the client if both of the following apply:

(a) The client is otherwise eligible for medical care; and

(b) No other liable third party has been identified at the time the claim is filed.

(5) The department may pursue its right to recover the value of medical care provided to an eligible client from any liable third party as a subrogee, assignee, or by enforcement of its public assistance lien as provided under RCW 43.20B.-040 through 43.20B.070.

(6) Recovery pursuant to the subrogation rights, assignment, or enforcement of the lien granted to the department is not reduced, prorated, or applied to only a portion of a judgment, award, or settlement. The secretary of the department or the secretary's designee must consent in writing to any discharge or compromise of any settlement or judgment of a lien created under RCW 42.20B.060. The department considers the compromise or discharge of a medical care lien only as authorized by federal regulation at 42 CFR 433.139.

(7) The doctrine of equitable subrogation does not apply to defeat, reduce, or prorate any recovery made by the department that is based on its assignment, lien, or subrogation rights.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-501-0100, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0125 Advance directives. In this section "advance directive" means a written instruction, recognized under state law, relating to the provision of health care when an individual is incapacitated.

(1) All agencies, health maintenance organizations (HMOs), and facilities including hospitals, critical access hospitals, skilled nursing and nursing facilities, and providers of in-home care services that serve medical assistance clients eighteen years of age or older must have written policies and procedures concerning advance directives.

(2) The agencies, HMOs, and facilities must give the following information to each adult client, in writing and orally, and in a language the client understands:

(a) A statement about the client's right to:

- (i) Make decisions concerning the client's medical care;
- (ii) Accept or refuse surgical or medical treatment;
- (iii) Execute an advance directive;
- (iv) Revoke an advance directive at any time;

(b) The written policies of the agency, HMO, or facility concerning advance directives, including any policy that would preclude it from honoring the client's advance directive; and

(c) The client's rights under state law.

(3) The agencies, HMOs, and facilities must provide the information described in subsection (2) of this section to adult clients as follows:

(a) Hospitals at the time the client is admitted as an inpatient;

(b) Nursing facilities at the time the client is admitted as a resident;

(c) Providers of in-home care services before the client comes under the care of the provider or at the time of the first home visit so long as it is provided prior to care being rendered;

(d) Hospice programs at the time the client initially receives hospice care from the program; and

(e) HMOs at the time the client enrolls with the organization.

(4) If the client is incapacitated at the time of admittance or enrollment and is unable to receive information or articulate whether or not the client has executed an advance directive, the agencies, HMOs, and facilities:

(a) May give information about advance directives to the person authorized by RCW 7.70.065 to make decisions regarding the client's health care;

(b) Must document in the client's file that the client was unable to communicate whether an advance directive exists if no one comes forward with a previously executed advance directive; and

(c) Must give the information described in subsection (2) to the client once the client is no longer incapacitated.

(5) The agencies, HMOs, and facilities must:

(a) Review each client's medical record prior to admittance or enrollment to determine if the client has an advance directive;

(b) Honor the directive or follow the process explained in subsection (6); and

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(c) Not refuse, put conditions on care, or otherwise discriminate against a client based on whether or not the client has executed an advance directive.

(6) If an agency, HMO, or facility has a policy or practice that would keep it from honoring a client's advance directive, the facility or organization must:

(a) Tell the client prior to admission or enrollment or when the client executes the directive;

(b) Provide the client with a statement clarifying the differences between institution-wide conscience objections and those that may be raised by individual physicians and explaining the range of medical conditions or procedures affected;

(c) Prepare and keep a written plan of intended actions according to the requirements in RCW 70.122.060 if the client still chooses to retain the facility or organization; and

(d) Make a good faith effort to transfer the client to another health care practitioner who will honor the directive if the client chooses not to retain the facility or organization.

(7) A health care practitioner may refuse to implement a directive, and may not be discriminated against by the facility or organization for refusing to withhold or withdraw life-sustaining treatment.

(8) The agencies, HMOs, and facilities must document, in a prominent place in each client's medical record, whether or not the client has executed an advance directive.

(9) The agencies, HMOs, and facilities must educate staff and the community on issues concerning advance directives.

(10) The agencies, HMOs, and facilities must comply with state and federal laws and regulations concerning advance directives, including but not limited to: 42 USC 1396a, subsection (w); 42 CFR 417.436; 42 CFR 489 Subpart I; and chapter 70.122 RCW.

[Statutory Authority: RCW 74.08.090, 74.09.035. 00-19-050, § 388-501-0125, filed 9/14/00, effective 10/15/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0125, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-017.]

WAC 388-501-0135 Patient review and restriction (PRR). (1) **Patient review and restriction (PRR)** is a health and safety program for medical assistance fee-for-service clients and managed care organization (MCO) enrollees needing help with using medical services appropriately. PRR is authorized under federal Medicaid law by 42 USC 1396n (a)(2) and 42 CFR 431.54.

(2) **Definitions.** The following definitions apply to this section only:

"Appropriate use" means use of health care services that are adapted to or appropriate for a client's or enrollee's medical needs.

"Assigned provider" means a department-enrolled or MCO contracted medical provider who agrees to be assigned as a primary provider and coordinator of services for a medical assistance client or MCO enrollee in the PRR program. Assigned providers can include a primary care provider (PCP), a pharmacy, a narcotic prescriber, and, for nonemergency medical services, a hospital.

"At-risk" means a medical history that may include one or more of the following:

- Indicators of forging or altering prescriptions;

- Seeking and/or obtaining medical services at a frequency or amount that is not medically necessary;
- Indicators of potentially life-threatening events or life-threatening conditions that required or may require medical intervention;
- A client's or enrollee's medical assistance identification card reportedly used by an unauthorized person(s) or for an unauthorized purpose(s); or
- Other behaviors or practices that could jeopardize a client's or enrollee's medical treatment or health.

"Conflicting" means drugs and or health care services that are incompatible and/or unsuitable for use together because of undesirable chemical or physiological effects.

"Contraindicated" means to indicate or show that a medical treatment or procedure is inadvisable or not recommended or warranted.

"Duplicative" applies to the use of the same or similar drugs and health care services without due justification. Example: A client (or MCO enrollee) receives health care services from two or more providers for the same or similar condition(s) in an overlapping time frame, or the client receives two or more similarly acting drugs in an overlapping time frame, which could result in a harmful drug interaction or an adverse reaction.

"Managed care organization" or **"MCO"** means an organization having a certificate of authority or certificate of registration from the office of insurance commissioner, that contracts with the department under a comprehensive risk contract to provide prepaid health care services to eligible medical assistance clients under the department's managed care programs.

"MCO enrollee" means a medical assistance client enrolled in, and receiving medical services from, a department-contracted managed care organization (MCO).

"Narcotic prescriber" means any of the following health care professionals who, within their scope of professional practice, are licensed to prescribe and administer controlled substances (see chapter 69.50 RCW, Uniform Controlled Substance Act) for a legitimate medical purpose:

- A physician under chapter 18.71 RCW;
- A physician assistant under chapter 18.71A RCW;
- An osteopathic physician under chapter 18.57 RCW;
- An osteopathic physician assistant under chapter 18.57A RCW; and
- An advanced registered nurse practitioner under chapter 18.79 RCW.

"Primary care provider" or **"PCP"** means a person licensed or certified under title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health care services to a client or an MCO enrollee, initiates referrals for specialty and ancillary care, and maintains the client's or enrollee's continuity of care.

(3) Restrictions under the PRR program:

(a) Do not apply to a client eligible for a family planning only program; and

(b) Do apply to a fee-for-service client or an MCO enrollee currently assigned to the PRR program.

(4) The prior authorization process described in WAC 388-530-1250 may be required for a fee-for-service client:

(a) Prior to or during a PRR review; or

(b) Currently placed in the PRR program.

(5) **Clients selected for PRR review.** The department or MCO selects a fee-for-service client or MCO enrollee for PRR review when either or both of the following occur:

(a) A utilization review report indicates the client or enrollee has utilized health care services as described in subsection (6) of this section; or

(b) Medical providers, social service agencies, or other concerned parties have provided direct referrals.

(6) **PRR review for placement in the PRR program.**

When the department or MCO selects a client or enrollee for PRR review, the department or MCO staff, with clinical oversight, reviews a client's or enrollee's medical and/or billing history to determine if the client or enrollee has utilized medical services at a frequency or amount that is not medically necessary (42 CFR 431.54(e)). The utilization guidelines in subsection (7) of this section establish that a client or enrollee has utilized medical services at a frequency or amount that is not medically necessary when:

(a) There is a history of medical services that are duplicative, excessive, or contraindicated;

(b) There is a history of conflicting health care services, drugs, or supplies that are not within acceptable medical practice; or

(c) The medical history shows indicators of "at-risk" utilization patterns.

(7) **Utilization guidelines for PRR placement.** Department and MCO staff use the following utilization guidelines to determine PRR placement and may place a client or enrollee in the PRR program when medical and/or billing histories document any of the following:

(a) Any two or more of the following conditions occurred in a period of ninety calendar days. The client or enrollee:

(i) Received services from four or more different providers, including physicians, advanced registered nurse practitioners (ARNPs), and physician assistants (PAs);

(ii) Had prescriptions filled by four or more different pharmacies;

(iii) Received ten or more prescriptions;

(iv) Had prescriptions written by four or more different prescribers;

(v) Received similar services from two or more providers in the same day; or

(vi) Had ten or more office visits.

(b) Any one of the following occurred within a period of ninety calendar days. The client or enrollee has:

(i) Made two or more emergency department visits;

(ii) A medical history that indicates "at-risk" utilization patterns;

(iii) Made repeated and documented efforts to seek health care services that are not medically necessary; or

(iv) Been counseled at least once by a health care provider, or a department or MCO staff member, with clinical oversight, about the appropriate use of health care services.

(c) The client or enrollee received prescriptions for controlled substances from two or more different prescribers in any month.

(8) **PRR review outcomes.** As a result of the PRR review, department or MCO staff may:

(a) Determine no action is needed and close the client's or enrollee's file;

(b) Send the client or enrollee and, if applicable, the client's or enrollee's authorized representative, a letter of concern with information on specific findings and notice of potential placement in the PRR program; or

(c) Determine that the utilization guidelines for PRR placement establish that the client or enrollee has utilized medical services at an amount or frequency that is not medically necessary and take one or more of the following actions. The department or MCO staff:

(i) Refers the client or enrollee for education on appropriate use of health care services;

(ii) Refers the client or enrollee to other support services or agencies; or

(iii) Places the client or enrollee into the PRR program for an initial restriction period of twenty-four months.

(9) **PRR program placement.** When a fee-for-service client or MCO enrollee is initially placed in the PRR program, the department or the MCO sends the client or enrollee and, if applicable, the client's or enrollee's authorized representative, a written notice of the PRR placement that:

(a) Informs the client or the enrollee of the reason for the PRR program placement.

(b) Restricts the client or enrollee for twenty-four months to one or more of the following types of providers when obtaining health care services:

(i) Primary care physician (PCP) (as defined in subsection (2) of this section);

(ii) Pharmacy;

(iii) Narcotic prescriber;

(iv) Hospital (for nonemergency medical services); or

(v) Another qualified provider-type, as determined by department or MCO program staff on a case-by-case basis.

(c) Directs the client or enrollee to respond to the department or the MCO within ten days of the date of the written notice:

(i) To select providers, subject to department or MCO approval;

(ii) To submit additional medical information, justifying the client's or enrollee's use of medical services; or

(iii) To request assistance, if needed, from the department or MCO program staff.

(d) Informs the client or enrollee of hearing rights (see subsection (14) of this section).

(e) Informs the client or enrollee that if a response is not received within ten days of the date of the notice, the client or enrollee will be assigned providers.

(f) Informs the client or enrollee of the rules that support the decision.

(10) **Selection and role of assigned provider.** A fee-for-service client and an MCO enrollee may be afforded a limited choice of providers for the types of services that are to be restricted (see subsection (9)(a) of this section for a list of provider-types that the department may assign).

(a) For a fee-for-service client placed in the PRR program, the assigned:

(i) Provider(s) must be located in the client's local geographic area and/or reasonably accessible to the client.

(ii) Department-enrolled primary care provider (PCP) supervises and coordinates health care services for the client,

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including providing continuity of care and referrals to specialists when necessary. The PCP must be one of the following:

(A) A physician who meets the criteria under WAC 388-502-0020 and 388-502-0030;

(B) An advanced registered nurse practitioner (ARNP) who meets the criteria under WAC 388-502-0020 and 388-502-0030; or

(C) A licensed physician assistant (PA), practicing with a sponsored supervising physician.

(iii) Narcotic prescriber prescribes all controlled substances for the client.

(iv) Pharmacy fills all prescriptions for the client.

(v) Hospital provides all nonemergency and outpatient hospital care for the client.

(b) For an MCO enrollee placed in the PRR program, the assigned PCP, narcotic prescriber, pharmacy, and hospital must be:

(i) Available within the enrollee's selected MCO; and

(ii) Located in the enrollee's local geographic area and/or reasonably accessible to the enrollee.

(c) A client or enrollee placed in the PRR program cannot change assigned providers for twelve months after the assignments are made, unless:

(i) The client or enrollee moves to a residence outside the provider's geographic area;

(ii) The provider moves out of the client's or enrollee's local geographic area and is no longer reasonably accessible to the client or enrollee;

(iii) The provider refuses to continue to serve the client or enrollee;

(iv) The client or enrollee did not select the provider. The client or enrollee may request to change an assigned provider once within thirty calendar days of the initial assignment;

(v) The enrollee's assigned provider no longer participates with the MCO. In this case, the enrollee may select a new provider from the list of available providers in the MCO or transfer enrollment of all family members to the new department-contracted MCO that the established provider has joined;

(vi) The provider has been suspended or disqualified from participating as a department-enrolled or MCO-contracted provider; or

(vii) The provider's business license has been suspended or revoked by the licensing authority;

(d) When an assigned prescribing provider no longer contracts with the department:

(i) All prescriptions from the provider are invalid thirty days following the date the contract ends;

(ii) All prescriptions from the provider are subject to applicable pharmacy rules in chapter 388-530 WAC or appropriate MCO rules; and

(iii) The client or enrollee must choose or be assigned another provider according to the requirements in this section.

(11) **PRR restriction periods.** The length of time for a fee-for-service client's or MCO enrollee's:

(a) Initial restriction period of PRR placement is:

(i) A minimum of twenty-four consecutive months; or

(ii) If the client or enrollee is not eligible for a medical assistance program for any month(s) during the span of the twenty-four consecutive months of PRR placement, the restriction period is for the duration of the client's or enrollee's medical assistance program eligibility plus any subsequent period of eligibility up to but not exceeding twenty-four months;

(b) Second restriction period of PRR placement is:

(i) An additional thirty-six consecutive months; or

(ii) If the client or enrollee is not eligible for a medical assistance program for any month(s) during the span of the thirty-six consecutive months, the restriction period is for the duration of the client's or enrollee's eligibility for a medical assistance program plus any subsequent period of eligibility up to but not exceeding thirty-six months; and

(c) Third restriction period and each subsequent period of PRR placement is:

(i) An additional seventy-two consecutive months; or

(ii) If the client or enrollee is not eligible for a medical assistance program for any month(s) during the span of the seventy-two consecutive months, the restriction period is for the duration of the client's or enrollee's eligibility for a medical assistance program plus any subsequent period of eligibility up to but not exceeding each seventy-two month placement.

(12) Department review of a PRR restriction period assignment. The department reviews a fee-for-service client's or MCO enrollee's use of health care services prior to the end of each assigned PRR restriction period described in subsection (11) of this section using the utilization guidelines in subsection (7) of this section.

(a) The department assigns the next PRR restriction period if the utilization guidelines for PRR placement in subsection (7) apply to the client or enrollee.

(b) When the department assigns a subsequent PRR restriction period, the department sends the client or enrollee and, if applicable, the client's or enrollee's authorized representative, a written notice that informs the client or enrollee:

(i) Of the reason for the subsequent PRR program placement;

(ii) Of the period of time of the subsequent PRR placement;

(iii) That the current providers assigned to the client or enrollee continue to be assigned to the client during the subsequent PRR restriction period;

(iv) That all PRR program rules continue to apply;

(v) Of hearing rights (see subsection (14) of this section); and

(vi) Of the rules that support the decision.

(c) The department may lift any assigned PRR restriction period if the client or enrollee:

(i) Successfully completes a treatment program that is provided by a chemical dependency service provider certified by the department under chapter 388-805 WAC;

(ii) Submits documentation of completion of the approved treatment program to the department; and

(iii) Maintains appropriate use of health care services within the utilization guidelines described in subsection (7) for six months after the date the treatment ends.

(d) A client or enrollee who is placed in the PRR program after being removed from any PRR restriction period

will be placed at the next PRR restriction period described in subsections (11)(b) and (c) of this section.

(e) A client or enrollee will remain placed in the PRR program regardless of change in eligibility program type or change in address.

(13) Client financial responsibility. This subsection takes precedence over WAC 388-502-0160. A fee-for-service client or MCO enrollee placed in the PRR program may be billed by a provider and held financially responsible for health care services when the client or enrollee obtains none-emergency services and the provider who renders the services is not assigned or referred under the PRR program.

(14) Right to hearing. A fee-for-service client or MCO enrollee who believes the department or MCO has taken action erroneously may request a hearing.

(a) A client or enrollee must request the hearing within ninety days after the client or enrollee receives the written notice of restriction. Chapter 388-538 WAC does not apply to the department's or MCO's decision to place an enrollee in the PRR program.

(b) The department conducts a hearing according to chapter 388-02 WAC. Definitions for the terms "hearing," "initial order," and "final order" used in this subsection are found in WAC 388-02-0010.

(c) A client or enrollee who requests a hearing within ten calendar days from the date of the written notice of an initial restriction period of PRR placement under subsection (11)(a) of this section will not be placed in the PRR program until the date an initial order is issued that supports the client's or enrollee's placement in the PRR program.

(d) A client or enrollee who requests a hearing after ten days from the date of the written notice under subsection (11)(a) of this section will remain placed in the PRR program unless a final administrative order is entered that orders their removal from restriction.

(e) A client or enrollee who requests a hearing within ninety days from the date of receiving the written notice under subsection (11)(b) or (c) of this section and who has already been assigned providers will remain placed in the PRR program unless a final administrative order is entered that orders the client's or enrollee's removal from restriction.

(f) An administrative law judge (ALJ) may rule that the client or enrollee be placed in the PRR program prior to the date the record is closed and prior to the date the initial order is issued based on a showing of just cause (a showing of just cause means it has been demonstrated that there is a legitimate cause to justify the action taken) to protect the health and safety of the client or enrollee.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.04.055, and 42 C.F.R. 431.54. 06-14-062, § 388-501-0135, filed 6/30/06, effective 7/31/06. Statutory Authority: RCW 74.08.090, 74.04.055, and 42 C.F.R. Subpart B 431.51, 431.54 (e) and (3), and 456.1. 04-01-099, § 388-501-0135, filed 12/16/03, effective 1/16/04. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-501-0135, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-501-0135, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.522. 97-03-038, § 388-501-0135, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0135, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-100.]

WAC 388-501-0160 Exception to rule—Request for a noncovered healthcare service. A client and/or the client's

provider may request the department to pay for a noncovered healthcare service. This is called an exception to rule.

(1) The department cannot approve an exception to rule if the requested service is excluded under state statute.

(2) The item or service(s) for which an exception is requested must be of a type and nature which falls within accepted standards and precepts of good medical practice;

(3) All exception requests must represent cost-effective utilization of medical assistance program funds as determined by the department;

(4) A request for an exception to rule must be submitted to the department in writing within ninety days of the date of the written notification denying authorization for the noncovered service. For the department to consider the exception to rule request:

(a) The client and/or the client's healthcare provider must submit sufficient client-specific information and documentation to health and recovery services administration's medical director or designee which demonstrate the client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s).

(b) The client's healthcare professional must certify that medical treatment or items of service which are covered under the client's medical assistance program and which, under accepted standards of medical practice, are indicated as appropriate for the treatment of the illness or condition, have been found to be:

(i) Medically ineffective in the treatment of the client's condition; or

(ii) Inappropriate for that specific client.

(5) Within fifteen business days of receiving the request, the department sends written notification to the provider and the client:

(a) Approving the exception to rule request;

(b) Denying the exception to rule request; or

(c) Requesting additional information.

(i) The additional information must be received by the department within thirty days of the date the information was requested.

(ii) The department approves or denies the exception to rule request within five business days of receiving the additional information.

(iii) If the requested information is insufficient or not provided within thirty days, the department denies the exception to rule request.

(6) The HRSA medical director or designee evaluates and considers requests on a case-by-case basis. The HRSA medical director has final authority to approve or deny a request for exception to rule.

(7) Clients do not have a right to a fair hearing on exception to rule decisions.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0160, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035, 00-03-035, § 388-501-0160, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-030.]

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WAC 388-501-0165 Medical and dental coverage—Fee-for-service (FFS) prior authorization—Determination process for payment. (1) This section applies to fee-for-service (FFS) requests for medical or dental services and medical equipment that:

(a) Are identified as covered services or EPSDT services; and

(b) Require prior authorization by the department.

(2) The following definitions and those found in WAC 388-500-0005 apply to this section:

"Controlled studies"—Studies in which defined groups are compared with each other to reduce bias.

"Credible evidence"—Type I-IV evidence or evidence-based information from any of the following sources:

- Clinical guidelines
- Government sources
- Independent medical evaluation (IME)
- Independent review organization (IRO)
- Independent technology assessment organizations
- Medical and hospital associations
- Policies of other health plans
- Regulating agencies (e.g., Federal Drug Administration or Department of Health)
- Treating provider
- Treatment pathways

"Evidence-based"—The ordered and explicit use of the best evidence available (see "hierarchy of evidence" in subsection (6)(a) of this section) when making health care decisions.

"Health outcome"—Changes in health status (mortality and morbidity) which result from the provision of health care services.

"Institutional review board (IRB)"—A board or committee responsible for reviewing research protocols and determining whether:

(1) The rights and welfare of human subjects are adequately protected;

(2) The risks to individuals are minimized and are not unreasonable;

(3) The risks to individuals are outweighed by the potential benefit to them or by the knowledge to be gained; and

(4) The proposed study design and methods are adequate and appropriate in the light of stated study objectives.

"Independent review organization (IRO)"—A panel of medical and benefit experts intended to provide unbiased, independent, clinical, evidence-based reviews of adverse decisions.

"Independent medical evaluation (IME)"—An objective medical examination of the client to establish the medical facts.

"Provider"—The individual who is responsible for diagnosing, prescribing, and providing medical, dental, or mental health services to department clients.

(3) The department authorizes, on a case-by-case basis, requests described in subsection (1) when the department determines the service or equipment is medically necessary as defined in WAC 388-500-0005. The process the department uses to assess medical necessity is based on:

(a) The evaluation of submitted and obtainable medical, dental, or mental health evidence as described in subsections (4) and (5) of this section; and

(b) The application of the evidence-based rating process described in subsection (6) of this section.

(4) The department reviews available evidence relevant to a medical, dental, or mental health service or equipment to:

- (a) Determine its efficacy, effectiveness, and safety;
- (b) Determine its impact on health outcomes;
- (c) Identify indications for use;
- (d) Evaluate pertinent client information;
- (e) Compare to alternative technologies; and
- (f) Identify sources of credible evidence that use and report evidence-based information.

(5) The department considers and evaluates all available clinical information and credible evidence relevant to the client's condition. At the time of request, the provider responsible for the client's diagnosis and/or treatment must submit credible evidence specifically related to the client's condition, including but not limited to:

- (a) A client-specific physiological description of the disease, injury, impairment, or other ailment;
- (b) Pertinent laboratory findings;
- (c) Pertinent X-ray and/or imaging reports;
- (d) Individual patient records pertinent to the case or request;
- (e) Photographs and/or videos when requested by the department; and
- (f) Objective medical/dental/mental health information such as medically/dentally acceptable clinical findings and diagnoses resulting from physical or mental examinations.

(6) The department uses the following processes to determine whether a requested service described in subsection (1) is medically necessary:

(a) **Hierarchy of evidence—How defined.** The department uses a hierarchy of evidence to determine the weight given to available data. The weight of medical evidence depends on objective indicators of its validity and reliability including the nature and source of the evidence, the empirical characteristics of the studies or trials upon which the evidence is based, and the consistency of the outcome with comparable studies. The hierarchy (in descending order with Type I given the greatest weight) is:

(i) Type I: Meta-analysis done with multiple, well-designed controlled studies;

(ii) Type II: One or more well-designed experimental studies;

(iii) Type III: Well-designed, quasi-experimental studies such as nonrandomized controlled, single group pre-post, cohort, time series, or matched case-controlled studies;

(iv) Type IV: Well-designed, nonexperimental studies, such as comparative and correlation descriptive, and case studies (uncontrolled); and

(v) Type V: Credible evidence submitted by the provider.

(b) **Hierarchy of evidence—How classified.** Based on the quality of available evidence, the department determines if the requested service is effective and safe for the client by classifying it as an "A," "B," "C," or "D" level of evidence:

(i) **"A" level evidence:** Shows the requested service or equipment is a proven benefit to the client's condition by strong scientific literature and well-designed clinical trials such as Type I evidence or multiple Type II evidence or combinations of Type II, III or IV evidence with consistent results

(An "A" rating cannot be based on Type III or Type IV evidence alone).

(ii) **"B" level evidence:** Shows the requested service or equipment has some proven benefit supported by:

(A) Multiple Type II or III evidence or combinations of Type II, III or IV evidence with generally consistent findings of effectiveness and safety (A "B" rating cannot be based on Type IV evidence alone); or

(B) Singular Type II, III, or IV evidence in combination with department-recognized:

(I) Clinical guidelines; or

(II) Treatment pathways; or

(III) Other guidelines that use the hierarchy of evidence in establishing the rationale for existing standards.

(ii) **"C" level evidence:** Shows only weak and inconclusive evidence regarding safety and/or efficacy such as:

(A) Type II, III, or IV evidence with inconsistent findings; or

(B) Only Type V evidence is available.

(iv) **"D" level evidence:** Is not supported by any evidence regarding its safety and efficacy, for example that which is considered investigational or experimental.

(c) **Hierarchy of evidence—How applied.** After classifying the available evidence, the department:

(i) Approves "A" and "B" rated requests if the service or equipment:

(A) Does not place the client at a greater risk of mortality or morbidity than an equally effective alternative treatment; and

(B) Is not more costly than an equally effective alternative treatment.

(ii) Approves a "C" rated request only if the provider shows the requested service is the optimal intervention for meeting the client's specific condition or treatment needs, and:

(A) Does not place the client at a greater risk of mortality or morbidity than an equally effective alternative treatment; and

(B) Is less costly to the department than an equally effective alternative treatment; and

(C) Is the next reasonable step for the client in a well-documented tried-and-failed attempt at evidence-based care.

(iii) Denies "D" rated requests unless:

(A) The requested service or equipment has a humanitarian device exemption from the Food And Drug Administration (FDA); or

(B) There is a local institutional review board (IRB) protocol addressing issues of efficacy and safety of the requested service that satisfies both the department and the requesting provider.

(7) Within fifteen days of receiving the request from the client's provider, the department reviews all evidence submitted and:

(a) Approves the request;

(b) Denies the request if the requested service is not medically necessary; or

(c) Requests the provider submit additional justifying information. The department sends a copy of the request to the client at the same time.

(i) The provider must submit the additional information within thirty days of the department's request.

(ii) The department approves or denies the request within five business days of the receipt of the additional information.

(iii) If the provider fails to provide the additional information, the department will deny the requested service.

(8) When the department denies all or part of a request for a covered service(s) or equipment, the department sends the client and the provider written notice, within ten business days of the date the information is received, that:

(a) Includes a statement of the action the department intends to take;

(b) Includes the specific factual basis for the intended action;

(c) Includes reference to the specific WAC provision upon which the denial is based;

(d) Is in sufficient detail to enable the recipient to:

(i) Learn why the department's action was taken; and

(ii) Prepare an appropriate response.

(e) Is in sufficient detail to determine what additional or different information might be provided to challenge the department's determination;

(f) Includes the client's administrative hearing rights;

(g) Includes an explanation of the circumstances under which the denied service is continued or reinstated if a hearing is requested; and

(h) Includes examples(s) of "lesser cost alternatives" that permit the affected party to prepare an appropriate response.

(9) If an administrative hearing is requested, the department or the client may request an independent review organization (IRO) or independent medical examination (IME) to provide an opinion regarding whether the requested service or equipment is medically necessary. The department will pay for the independent assessment if the department agrees that it is necessary, or an administrative law judge orders the assessment.

[Statutory Authority: RCW 74.04.050, 74.08.090, 05-23-031, § 388-501-0165, filed 11/8/05, effective 12/9/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.035, 00-03-035, § 388-501-0165, filed 1/12/00, effective 2/12/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0165, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-038.]

WAC 388-501-0169 Healthcare coverage—Limitation extension. This section addresses requests for limitation extensions (additional covered services when a client has received the maximum services allowed under specific healthcare program rules). The department does not pay for services exceeding the maximum allowed until authorization is obtained.

(1) No extension of covered services will be authorized when prohibited by specific program rules.

(2) When an extension is not prohibited by specific program rules, a client or the client's provider may request a limitation extension.

(3) Under fee-for-service (FFS), the department evaluates requests for limitation extensions using the process described in WAC 388-501-0165. For a managed care enrollee, the client's managed care organization (MCO) evaluates requests for limitation extensions according to the MCO's prior authorization process.

(4) In addition to subsection (3), both the department and MCO consider the following in evaluating a request for a limitation extension:

(a) The level of improvement the client has shown to date related to the requested service and the reasonably calculated probability of continued improvement if the requested service is extended; and

(b) The reasonably calculated probability the client's condition will worsen if the requested service is not extended.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700, 06-24-036, § 388-501-0169, filed 11/30/06, effective 1/1/07.]

WAC 388-501-0175 Medical care provided in bordering cities. (1) An eligible Washington state resident may receive medical care in a recognized out-of-state bordering city on the same basis as in-state care.

(2) The only recognized bordering cities are:

(a) Coeur d'Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho; and

(b) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

[Statutory Authority: RCW 74.04.050 and 74.08.090, 00-01-088, § 388-501-0175, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0175, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-130.]

WAC 388-501-0180 Out-of-state medical care. (1) The department considers cities bordering Washington state and listed in WAC 388-501-0175 the same as in-state cities for:

(a) Medical care coverage under all medical programs administered by the department; and

(b) Reimbursement purposes.

(2) The department does not cover out-of-state medical care for clients under the following state-administered (Washington state medical care only) medical programs:

(a) General assistance-unemployable (GA-U); or

(b) Alcohol and Drug Addiction Treatment and Support Act (ADATSA).

(3) Subject to the exceptions and limitations in this section, the department covers out-of-state medical care provided to eligible clients when the services are:

(a) Within the scope of the client's medical care program as specified in WAC 388-501-0060; and

(b) Medically necessary as defined in WAC 388-500-0005.

(4) If the client travels out-of-state expressly to obtain medical care, the medical services must have prior authorization through the department's determination process described in WAC 388-501-0165.

(5) See WAC 388-501-0165 for the department's determination process for requests for:

(a) A service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550; or

(b) A covered service that is subject to the department's limitations or other restrictions and the request for the service exceeds those limitations or restrictions (see also WAC 388-501-0169).

(6) The department evaluates a request for a noncovered service if an exception to rule is requested according to the provisions in WAC 388-501-0160.

(7) The department determines out-of-state coverage for transportation services, including ambulance services, according to chapter 388-546 WAC.

(8) The department reimburses an out-of-state provider for medical care provided to an eligible client if the provider:

(a) Meets the licensing requirements of the state in which care is provided;

(b) Contracts with the department to be an enrolled provider; and

(c) Meets the same criteria for payment as in-state providers.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-501-0180, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.035. 01-01-011, § 388-501-0180, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0180, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-135 and 388-92-015.]

WAC 388-501-0200 Third-party resources. (1) MAA requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) MAA pays for medical services and seeks reimbursement from the liable third party when the claim is for any of the following:

(a) Prenatal care;

(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(c) Preventive pediatric services as covered under the EPSDT program.

(3) MAA pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to MAA documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill MAA or the client for a covered service when a third party pays a provider the same amount as or more than the MAA rate.

(5) When the provider receives payment from the third party after receiving reimbursement from MAA, the provider must refund to MAA the amount of the:

(a) Third-party payment when the payment is less than MAA's maximum allowable rate; or

(b) MAA payment when the third-party payment is equal to or greater than MAA's maximum allowable rate.

(6) MAA is not responsible to pay for medical services when the third-party benefits are available to pay for the client's medical services at the time the provider bills MAA, except as described under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third party payment when the client either:

(a) Receives direct third-party reimbursement for such services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 388-505-0540 for assignment of rights.

(8) MAA considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, MAA is responsible for providing medical services as described under WAC 388-501-0100.

[Statutory Authority: RCW 74.04.050, 74.08.090. 00-11-141, § 388-501-0200, filed 5/23/00, effective 6/23/00; 00-01-088, § 388-501-0200, filed 12/14/99, effective 1/14/00.]

WAC 388-501-0213 Case management services. (1) The department shall provide case management services to medical assistance recipients:

(a) By contract with providers of case management services.

(b) Limited to target groups of clients as determined by the contract.

(c) Limited to services as determined by the contract.

(2) Case management services are services which will assist clients in gaining access to needed medical, social, educational, and other services.

[00-23-067, recodified as § 388-501-0213, filed 11/15/00, effective 11/15/00. Statutory Authority: RCW 74.08.090. 87-22-094 (Order 2555), § 388-86-017, filed 11/4/87.]

Chapter 388-502 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—PROVIDERS

WAC

388-502-0010	Payment—Eligible providers defined.
388-502-0020	General requirements for providers.
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388-502-0100	General conditions of payment.
388-502-0110	Conditions of payment—Medicare deductible and coinsurance.
388-502-0120	Payment for medical care outside the state of Washington.
388-502-0130	Interest penalties—Providers.
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388-502-0160	Billing a client.
388-502-0210	Statistical data-provider reports.
388-502-0220	Administrative appeal contractor/provider rate reimbursement.
388-502-0230	Provider review and appeal.
388-502-0240	Audits and the audit appeal process for contractors/providers.
388-502-0260	Appeals and dispute resolution for providers with contracts other than core provider agreements.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

- 388-502-0205 Civil rights. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0205, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-010 (part).] Repealed by 00-15-050, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530.
- 388-502-0250 Interest penalties—Providers. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.] Amended and decodified by 00-01-088, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.04.050 and 74.08.090. Later promulgation, see WAC 388-502-0130.

WAC 388-502-0010 Payment—Eligible providers defined. The department reimburses enrolled providers for covered medical services, equipment and supplies they provide to eligible clients.

(1) To be eligible for enrollment, a provider must:

- (a) Be licensed, certified, accredited, or registered according to Washington state laws and rules; and
- (b) Meet the conditions in this chapter and chapters regulating the specific type of provider, program, and/or service.

(2) To enroll, an eligible provider must sign a core provider agreement or a contract with the department and receive a unique provider number. (Note: Section 13 of the core provider agreement, DSHS 09-048 (REV. 06/2002), is hereby rescinded. The department and each provider signing a core provider agreement will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of the agreement.)

(3) Eligible providers listed in this subsection may request enrollment. Out-of-state providers listed in this subsection are subject to conditions in WAC 388-502-0120.

(a) Professionals:

- (i) Advanced registered nurse practitioners;
- (ii) Anesthesiologists;
- (iii) Audiologists;
- (iv) Chiropractors;
- (v) Dentists;
- (vi) Dental hygienists;
- (vii) Denturists;
- (viii) Dietitians or nutritionists;
- (ix) Maternity case managers;
- (x) Midwives;
- (xi) Occupational therapists;
- (xii) Ophthalmologists;
- (xiii) Opticians;
- (xiv) Optometrists;
- (xv) Orthodontists;
- (xvi) Osteopathic physicians;
- (xvii) Podiatric physicians;
- (xviii) Pharmacists;
- (xix) Physicians;
- (xx) Physical therapists;
- (xxi) Psychiatrists;
- (xxii) Psychologists;
- (xxiii) Registered nurse delegators;
- (xxiv) Registered nurse first assistants;
- (xxv) Respiratory therapists;
- (xxvi) Speech/language pathologists;
- (xvii) Radiologists; and

- (xviii) Radiology technicians (technical only);
- (b) Agencies, centers and facilities:
 - (i) Adult day health centers;
 - (ii) Ambulance services (ground and air);
 - (iii) Ambulatory surgery centers (Medicare-certified);
 - (iv) Birthing centers (licensed by the department of health);
 - (v) Blood banks;
 - (vi) Chemical dependency treatment facilities certified by the department of social and health services (DSHS) division of alcohol and substance abuse (DASA), and contracted through either:
 - (A) A county under chapter 388-810 WAC; or
 - (B) DASA to provide chemical dependency treatment services;
 - (vii) Centers for the detoxification of acute alcohol or other drug intoxication conditions (certified by DASA);
 - (viii) Community AIDS services alternative agencies;
 - (ix) Community mental health centers;
 - (x) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics;
 - (xi) Family planning clinics;
 - (xii) Federally qualified health care centers (designated by the Federal Health Care Financing Administration);
 - (xiii) Genetic counseling agencies;
 - (xiv) Health departments;
 - (xv) HIV/AIDS case management;
 - (xvi) Home health agencies;
 - (xvii) Hospice agencies;
 - (xviii) Hospitals;
 - (xix) Indian Health Service;
 - (xx) Tribal or urban Indian clinics;
 - (xxi) Inpatient psychiatric facilities;
 - (xxii) Intermediate care facilities for the mentally retarded (ICF-MR);
 - (xxiii) Kidney centers;
 - (xxiv) Laboratories (CLIA certified);
 - (xxv) Maternity support services agencies;
 - (xxvi) Neuromuscular and neurodevelopmental centers;
 - (xxvii) Nursing facilities (approved by DSHS Aging and Adult Services);
 - (xxviii) Pharmacies;
 - (xxix) Private duty nursing agencies;
 - (xxx) Rural health clinics (Medicare-certified);
 - (xxxi) Tribal mental health services (contracted through the DSHS mental health division); and
 - (xxxii) Washington state school districts and educational service districts.
- (c) Suppliers of:
 - (i) Durable and nondurable medical equipment and supplies;
 - (ii) Infusion therapy equipment and supplies;
 - (iii) Prosthetics/orthotics;
 - (iv) Hearing aids; and
 - (v) Oxygen equipment and supplies;
- (d) Contractors of:
 - (i) Transportation brokers;
 - (ii) Interpreter services agencies; and
 - (iii) Eyeglass and contact lens providers.

(4) Nothing in this chapter precludes the department from entering into other forms of written agreements to provide services to eligible clients.

(5) The department does not enroll licensed or unlicensed practitioners who are not specifically addressed in subsection (3) of this section, including, but not limited to:

- (a) Acupuncturists;
- (b) Counselors;
- (c) Sanipractors;
- (d) Naturopaths;
- (e) Homeopaths;
- (f) Herbalists;
- (g) Massage therapists;
- (h) Social workers; or
- (i) Christian Science practitioners or theological healers.

[Statutory Authority: RCW 74.08.090, 74.09.080, 74.09.120. 03-14-106, § 388-502-0010, filed 6/30/03, effective 7/31/03. Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. 01-07-076, § 388-502-0010, filed 3/20/01, effective 4/20/01; 00-15-050, § 388-502-0010, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0020 General requirements for providers. (1) Enrolled providers must:

(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

- (i) Patient's name and date of birth;
- (ii) Dates of services;
- (iii) Name and title of person performing the service, if other than the billing practitioner;
- (iv) Chief complaint or reason for each visit;
- (v) Pertinent medical history;
- (vi) Pertinent findings on examination;
- (vii) Medications, equipment, and/or supplies prescribed or provided;
- (viii) Description of treatment (when applicable);
- (ix) Recommendations for additional treatments, procedures, or consultations;
- (x) X rays, tests, and results;
- (xi) Dental photographs and teeth models;
- (xii) Plan of treatment and/or care, and outcome; and
- (xiii) Specific claims and payments received for services.

(b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;

(c) Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation;

(d) Bill the department according to department rules and billing instructions;

(e) Accept the payment from the department as payment in full;

(f) Follow the requirements in WAC 388-502-0160 and 388-538-095 about billing clients;

(g) Fully disclose ownership and control information requested by the department;

(h) Provide all services without discriminating on the grounds of race, creed, color, age, sex, religion, national origin, marital status, or the presence of any sensory, mental or physical handicap; and

(i) Provide all services according to federal and state laws and rules, and billing instructions issued by the department.

(2) A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the department's programs.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 74.09.530. 01-07-076, § 388-502-0020, filed 3/20/01, effective 4/20/01; 00-15-050, § 388-502-0020, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0030 Denying, suspending, and terminating a provider's enrollment. (1) The department terminates enrollment or does not enroll or reenroll a provider if, in the department's judgement, it may be a danger to the health or safety of clients.

(2) Except as noted in subsection (3) of this section, the department does not enroll or reenroll a provider to whom any of the following apply:

- (a) Has a restricted professional license;
- (b) Has been terminated, excluded, or suspended from Medicare/Medicaid; or
- (c) Has been terminated by the department for quality of care issues or inappropriate billing practices.

(3) The department may choose to enroll or reenroll a provider who meets the conditions in subsection (2) of this section if all of the following apply:

- (a) The department determines the provider is not likely to repeat the violation that led to the restriction or sanction;
- (b) The provider has not been convicted of other offenses related to the delivery of professional or other medical services in addition to those considered in the previous sanction; and
- (c) If the United States Department of Health and Human Services (DHHS) or Medicare suspended the provider from Medicare, DHHS or Medicare notifies the department that the provider may be reinstated.

(4) The department gives thirty days written notice before suspending or terminating a provider's enrollment. However, the department suspends or terminates enrollment immediately if any one of the following situations apply:

- (a) The provider is convicted of a criminal offense related to participation in the Medicare/Medicaid program;
- (b) The provider's license, certification, accreditation, or registration is suspended or revoked;
- (c) Federal funding is revoked;
- (d) By investigation, the department documents a violation of law or contract;
- (e) The MAA medical director or designee determines the quality of care provided endangers the health and safety of one or more clients; or
- (f) The department determines the provider has intentionally used inappropriate billing practices.

(5) The department may terminate a provider's number if:

- (a) The provider does not disclose ownership or control information;
 - (b) The provider does not submit a claim to the department for twenty-four consecutive months;
 - (c) The provider's address on file with the department is incorrect;
 - (d) The provider requests a new provider number (e.g., change in tax identification number or ownership); or
 - (e) The provider voluntarily withdraws from participation in the medical assistance program.
- (6) Nothing in this chapter obligates the department to enroll all eligible providers who request enrollment.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0030, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0100 General conditions of payment.

(1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

- (a) The service is within the scope of care of the client's medical assistance program;
 - (b) The service is medically or dentally necessary;
 - (c) The service is properly authorized;
 - (d) The provider bills within the time frame set in WAC 388-502-0150;
 - (e) The provider bills according to department rules and billing instructions; and
 - (f) The provider follows third-party payment procedures.
- (2) The department is the payer of last resort, unless the other payer is:

- (a) An Indian health service;
- (b) A crime victims program through the department of labor and industries; or
- (c) A school district for health services provided under the Individuals with Disabilities Education Act.

(3) The department does not reimburse providers for medical services identified by the department as client financial obligations, and deducts from the payment the costs of those services identified as client financial obligations. Client financial obligations include, but are not limited to, the following:

- (a) Co-payments (co-pays) (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);
- (b) Deductibles (unless the criteria in chapter 388-517 WAC or WAC 388-501-0200 are met);
- (c) Emergency Medical Expense Requirements (EMER); and
- (d) Spenddown (see WAC 388-519-0110).

(4) The provider must accept Medicare assignment for claims involving clients eligible for both Medicare and medical assistance before MAA makes any payment.

(5) The provider is responsible for verifying whether a client has medical assistance coverage for the dates of service.

(6) The department may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service at the time it was provided if:

- (a) The department considered the person eligible at the time of service;
- (b) The service was not otherwise paid for; and

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(c) The provider submits a request for payment to the department.

(7) The department does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the department.

(8) Information about medical care for jail inmates is found in RCW 70.48.130.

(9) The department pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the department, whichever is lower.

[Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 06-13-042, § 388-502-0100, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0100, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0110 Conditions of payment—Medicare deductible and coinsurance. (1) The department pays the deductible and coinsurance amounts for a client participating in Parts A and/or B of Medicare (Title XVIII of the Social Security Act) when the:

(a) Total reimbursement to the provider from Medicare and the department does not exceed the rate in the department's fee schedule; and

(b) Provider accepts assignment for Medicare payment.

(2) The department pays the deductible and coinsurance amounts for a client who has Part A of Medicare. If the client:

(a) Has not exhausted lifetime reserve days, the department considers the Medicare diagnostic related group (DRG) as payment in full; or

(b) Has exhausted lifetime reserve days during an inpatient hospital stay, the department considers the Medicare DRG as payment in full until the Medicaid outlier threshold is reached. After the Medicaid outlier threshold is reached, the department pays an amount based on the policy described in the Title XIX state plan.

(3) If Medicare and Medicaid cover the service, the department pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less. If only Medicare and not Medicaid covers the service, the department pays only the deductible and/or coinsurance up to Medicare's allowed amount.

(4) The department bases its outlier policy on the methodology described in the department's Title XIX state plan, methods, and standards used for establishing payment rates for hospital inpatient services.

(5) The department pays, according to department rules and billing instructions, for Medicaid covered services when the client exhausts Medicare benefits.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.530. 00-15-050, § 388-502-0110, filed 7/17/00, effective 8/17/00.]

WAC 388-502-0120 Payment for medical care outside the state of Washington. (1) The medical assistance administration (MAA) pays the provider of service in designated bordering cities as if the care were provided within the state of Washington (see WAC 388-501-0175). MAA requires providers to meet the licensing requirements of the state in which care is rendered.

(2) MAA does not authorize payment for out-of-state medical care furnished to clients in state-only funded medical programs.

(3) MAA applies the three-month retroactive coverage as defined under WAC 388-500-0005 to covered medical services that are furnished to eligible clients by out-of-state providers.

(4) MAA requires out-of-state providers to obtain a valid provider number in order to be reimbursed.

(a) MAA requires a completed core provider agreement, and furnishes the necessary billing forms, instructions, and a core provider agreement to providers.

(b) MAA issues a provider number after receiving the signed core provider agreement.

(c) The billing requirements of WAC 388-502-0100 and 388-502-0150 apply to out-of-state providers.

(5) For Medicare-eligible clients, providers must submit Medicare claims, on the appropriate Medicare billing form, to the intermediary or carrier in the provider's state. If the provider checks the Medicare billing form to show the state of Washington as being responsible for medical billing, the intermediary or carrier may either:

(a) Forward the claim to MAA on behalf of the provider; or

(b) Return the claim to the provider, who then submits it to MAA.

(6) For covered services for eligible clients, MAA reimburses approved out-of-state nursing facilities at the lower of:

(a) The billed amount; or

(b) The adjusted statewide average reimbursement rate for in-state nursing facility care.

(7) For covered services for eligible clients, MAA reimburses approved out-of-state hospitals at the lower of:

(a) The billed amount; or

(b) The adjusted statewide average reimbursement rate for in-state hospitals.

(8) For covered services for eligible clients, MAA reimburses other approved out-of-state providers at the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX Medicaid program.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-502-0120, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-502-0120, filed 12/14/99, effective 1/14/00.]

WAC 388-502-0130 Interest penalties—Providers.

(1) Providers who are enrolled as contractors with the department's medical care programs may be assessed interest on excess benefits or other inappropriate payments. Nursing home providers are governed by WAC 388-96-310 and are not subject to this section.

(2) The department assesses interest when:

(a) The excess benefits or other inappropriate payments were not the result of department error; and

(b) A provider is found liable for receipt of excess benefits or other payments under RCW 74.09.220; or

(c) A provider is notified by the department that repayment of excess benefits or other payments is due under RCW 74.09.220.

(3) The department assesses interest at the rate of one percent for each month the overpayment is not satisfied.

[Title 388 WAC—p. 922]

Daily interest calculations and assessments are made for partial months.

(4) Interest is calculated beginning from the date the department receives payment from the provider. Interest ceases to be calculated and collected from the provider once the overpayment amount is received by the department.

(5) The department calculates interest and amounts, which are identified on all department collection notices and statements.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, recodified as § 388-502-0130, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.]

WAC 388-502-0150 Time limits for providers to bill MAA. Providers may bill the medical assistance administration (MAA) for covered services provided to eligible clients.

(1) MAA requires providers to submit initial claims and adjust prior claims in a timely manner. MAA has three timeliness standards:

(a) For initial claims, see subsections (3), (4), (5), and (6) of this section;

(b) For resubmitted claims other than prescription drug claims, see subsections (7) and (8) of this section; and

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section.

(2) The provider must submit claims to MAA as described in MAA's billing instructions.

(3) Providers must submit their claim to MAA and have an internal control number (ICN) assigned by MAA within three hundred sixty-five days from any of the following:

(a) The date the provider furnishes the service to the eligible client;

(b) The date a final fair hearing decision is entered that impacts the particular claim;

(c) The date a court orders MAA to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) MAA may grant exceptions to the three hundred sixty-five-day time limit for initial claims when billing delays are caused by either of the following:

(a) The department's certification of a client for a retroactive period; or

(b) The provider proves to MAA's satisfaction that there are other extenuating circumstances.

(5) MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties in addition to MAA's billing limits.

(6) When a client is covered by both Medicare and MAA, the provider must bill Medicare for the service before billing Medicaid. If Medicare:

(a) Pays the claim the provider must bill MAA within six months of the date Medicare processes the claim; or

(b) Denies payment of the claim, MAA requires the provider to meet the three hundred sixty-five-day requirement for timely initial claims as described in subsection (3) of this section.

(7) MAA allows providers to resubmit, modify, or adjust any claim, other than a prescription drug claim, with a timely

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ICN within thirty-six months of the date the service was provided to the client. This applies to any claim, other than a prescription drug claim, that met the time limits for an initial claim, whether paid or denied. MAA does not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(8) The thirty-six-month period described in subsection (7) of this section does not apply to overpayments that a provider must refund to the department. After thirty-six months, MAA does not allow a provider to refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(9) MAA allows providers to resubmit, modify, or adjust any prescription drug claim with a timely ICN within fifteen months of the date the service was provided to the client. After fifteen months, MAA does not accept any prescription drug claim for resubmission, modification or adjustment.

(10) The fifteen-month period described in subsection (9) of this section does not apply to overpayments that a prescription drug provider must refund to the department. After fifteen months a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(11) MAA does not allow a provider or any provider's agent to bill a client or a client's estate when the provider fails to meet the requirements of this section, resulting in the claim not being paid by MAA.

[Statutory Authority: RCW 74.08.090 and 42 C.F.R. 447.45. 00-14-067, § 388-502-0150, filed 7/5/00, effective 8/5/00.]

WAC 388-502-0160 Billing a client. (1) A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay the provider because the provider failed to satisfy the conditions of payment in MAA billing instructions, this chapter, and other chapters regulating the specific type of service provided.

(2) The provider is responsible for verifying whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.

(3) A provider may bill a client only if one of the following situations apply:

(a) The client is enrolled in medical assistance managed care and the client and provider comply with the requirements in WAC 388-538-095;

(b) The client is not enrolled in medical assistance managed care, and the client and provider sign an agreement regarding payment for the service. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for department review upon request. The agreement must include each of the following elements to be valid:

(i) A statement listing the specific service to be provided;

(ii) A statement that the service is not covered by MAA;

(iii) A statement that the client chooses to receive and pay for the specific service; and

(iv) The client is not obligated to pay for the service if it is later found that the service was covered by MAA at the time it was provided, even if MAA did not pay the provider

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for the service because the provider did not satisfy MAA's billing requirements.

(c) The client or the client's legal guardian was reimbursed for the service directly by a third party (see WAC 388-501-0200);

(d) The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by MAA;

(e) The provider has documentation that the client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a MAA medical program. This documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the client's file for department review upon request. In this case, the provider may bill the client without fulfilling the requirements in subsection (3)(b) of this section regarding the agreement to pay. However, if the patient later becomes eligible for MAA coverage of a provided service, the provider must comply with subsection (4) of this section for that service;

(f) The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by MAA; or

(g) The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a three-dollar copayment may be imposed on the client by the hospital, except when:

(i) Reasonable alternative access to care was not available;

(ii) The "indigent person" criteria in WAC 246-453-040(1) applies;

(iii) The client was eighteen years of age or younger;

(iv) The client was pregnant or within sixty days post-pregnancy;

(v) The client is an American Indian or Alaska Native;

(vi) The client was enrolled in a MAA managed care plan, including primary care case management (PCCM);

(vii) The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or

(viii) The client receives waived services such as community options program entry system (COPES) and community alternatives program (CAP).

(4) If a client becomes eligible for a covered service that has already been provided because the client:

(a) Applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), the provider must:

(i) Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and

(ii) Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service;

(b) Receives a delayed certification as defined in WAC 388-500-0005, the provider must:

(i) Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and

(ii) Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service; or

(c) Receives a retroactive certification as defined in WAC 388-500-0005, the provider:

(i) Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and

(ii) May refund any payment received from the client or anyone on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

(5) Hospitals may not bill, demand, collect, or accept payment from a medically indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstance described in subsection (3)(g) of this section.

(6) A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

(a) Medical charts;

(b) Radiological or imaging films; and

(c) Laboratory or other diagnostic test results.

[Statutory Authority: RCW 74.08.090, 74.09.055, 2001 c 7, Part II. 02-12-070, § 388-502-0160, filed 5/31/02, effective 7/1/02. Statutory Authority: RCW 74.08.090, 01-21-023, § 388-502-0160, filed 10/8/01, effective 11/8/01; 01-05-100, § 388-502-0160, filed 2/20/01, effective 3/23/01. Statutory Authority: RCW 74.08.090 and 74.09.520, 00-14-069, § 388-502-0160, filed 7/5/00, effective 8/5/00.]

WAC 388-502-0210 Statistical data-provider reports. (1) At the request of the medical assistance administration (MAA), all providers enrolled with MAA programs must submit full reports, as specified by MAA, of goods and services furnished to eligible medical assistance clients. MAA furnishes the provider with a standardized format to report these data.

(2) MAA analyzes the data collected from the providers' reports to secure statistics on costs of goods and services furnished and makes a report of the analysis available to MAA's advisory committee, the state welfare medical care committee, representative organizations of provider groups enrolled with MAA, and any other interested organizations or individuals.

[Statutory Authority: RCW 74.08.090, 74.09.035, 00-15-049, § 388-502-0210, filed 7/17/00, effective 8/17/00. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-502-0210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-020.]

WAC 388-502-0220 Administrative appeal contractor/provider rate reimbursement. (1) Any enrolled contractor/provider of medical services has a right to an administrative appeal when the contractor/provider disagrees with the medical assistance administration's (MAA) reimbursement rate. The exception to this is nursing facilities governed by WAC 388-96-904.

(2) The first level of appeal. A contractor/provider who wants to contest a reimbursement rate must file a written appeal with MAA.

(a) The appeal must include all of the following:

(i) A statement of the specific issue being appealed;

(ii) Supporting documentation; and

(iii) A request for MAA to recalculate the rate.

(b) When a contractor/provider appeals a portion of a rate, MAA may review all components of the reimbursement rate.

(c) In order to complete a review of the appeal, MAA may do one or both of the following:

(i) Request additional information; and/or

(ii) Conduct an audit of the documentation provided.

(d) MAA issues a decision or requests additional information within sixty calendar days of receiving the rate appeal request.

(i) When MAA requests additional information, the contractor/provider has forty-five calendar days from the date of MAA's request to submit the additional information.

(ii) MAA issues a decision within thirty calendar days of receipt of the completed information.

(e) MAA may adjust rates retroactively to the effective date of a new rate or a rate change. In order for a rate increase to be retroactive, the contractor/provider must file the appeal within sixty calendar days of the date of the rate notification letter from MAA. MAA does not consider any appeal filed after the sixty day period to be eligible for retroactive adjustment.

(f) MAA may grant a time extension for the appeal period if the contractor/provider makes such a request within the sixty-day period referenced under (e) of this subsection.

(g) Any rate increase resulting from an appeal filed within the sixty-day period described in subsection (2)(e) of this section is effective retroactively to the rate effective date in the notification letter.

(h) Any rate increase resulting from an appeal filed after the sixty-day period described in subsection (2)(e) of this section is effective on the date the rate appeal is received by the department.

(i) Any rate decrease resulting from an appeal is effective on the date specified in the appeal decision letter.

(j) Any rate change that MAA grants that is the result of fraudulent practices on the part of the contractor/provider as described under RCW 74.09.210 is exempt from the appeal provisions in this chapter.

(3) The second level of appeal. When the contractor/provider disagrees with a rate review decision, it may file a request for a dispute conference with MAA. For this section "dispute conference" means an informal administrative hearing for the purpose of resolving contractor/provider disagreements with a department action as described under subsection (1) of this section, and not agreed upon at the first level of appeal. The dispute conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(a) If a contractor/provider files a request for a dispute conference, it must submit the request to MAA within thirty calendar days after the contractor/provider receives the rate review decision. MAA does not consider dispute conference requests submitted after the thirty-day period for the first level decision.

(b) MAA conducts the dispute conference within ninety calendar days of receiving the request.

(c) A department-appointed conference chairperson issues the final decision within thirty calendar days of the

conference. Extensions of time for extenuating circumstances may be granted if all parties agree.

(d) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(e) The dispute conference is the final level of administrative appeal within the department and precede judicial action.

(4) MAA considers that a contractor/provider who fails to attempt to resolve disputed rates as provided in this section has abandoned the dispute.

[Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-502-0220, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-043.]

WAC 388-502-0230 Provider review and appeal. (1)

As authorized by chapter 74.09 RCW, the medical assistance administration (MAA) monitors and reviews all providers who furnish medical, dental, or other services to eligible medical assistance clients. MAA determines whether the providers are complying with the rules and regulations of the program(s) and providing appropriate quality of care, and recovers any identified overpayments. Examples of provider reviews are:

(a) A review of all billing/medical/dental/service records for medical assistance clients;

(b) A statistical sampling of billing/medical/dental/service records for medical assistance clients, extrapolated per WAC 388-502-0240 (9), (10), and (11); and

(c) A review focused on selected billing/medical/dental/service records for medical assistance clients.

(2) The Washington State Health Professions Quality Assurance Commissions serve in an advisory capacity to MAA in conducting provider reviews and monitoring.

(3) MAA may determine that a provider's billing does not comply with program regulations or the provider is not meeting quality of care practices. MAA may do, but is not limited to, any of the following:

(a) Conduct pre-pay reviews of all claims the provider submits to MAA;

(b) Refer the provider to MAA's auditors (see WAC 388-502-0240);

(c) Refer the provider to Medicaid's Fraud Control Unit;

(d) Refer the provider to the appropriate state health professions quality assurance commission;

(e) Impose provisional stipulations for the provider to continue participation in medical assistance programs;

(f) Terminate the provider's participation in medical assistance programs;

(g) Assess a civil penalty against the provider, per RCW 74.09.210; and

(h) Recover any monies that the provider received as a result of inappropriate payments.

(4) When any part of the time period that is reviewed or monitored falls on or before June 30, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request an administrative review hearing to dispute the action(s).

(a) The request for an administrative review hearing must be in writing and:

(i) Be sent within twenty-eight days of the date of the notice of action(s);

(ii) State the reason(s) why the provider thinks the action(s) are incorrect;

(iii) Be sent by certified mail (return receipt) or other means that provides proof of delivery to:

The Medical Assistance Administration

Attn: Deputy Assistant Secretary

P.O. Box 45500

Olympia WA 98504-5500

(b) The administrative review hearing consists of a review by MAA's deputy assistant secretary of all documents submitted by the provider and MAA. At the deputy assistant secretary's discretion, the administrative review hearing may be conducted in person, as a telephone conference, in written submissions, or a combination thereof.

(c) When a final decision is issued, the office of financial recovery collects any amount the provider is ordered to repay.

(d) The administrative review hearing referenced in this subsection is the final level of administrative review.

(5) When the entire time period that is reviewed or monitored falls on or after July 1, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request a hearing to dispute the action(s).

(a) The request for hearing must be in writing and;

(i) Be sent within twenty-eight days of the date of the notice of action(s), by certified mail (return receipt) or other means that provides proof of delivery to:

The Office of Financial Recovery

P.O. Box 9501

Olympia, WA 98507-5501; and

(ii) State the reason(s) why the provider thinks the action(s) are incorrect.

(b) The office of administrative hearings schedules and conducts the hearing under the Administrative Procedure Act, chapter 34.05 RCW. MAA offers a pre-hearing/alternative dispute conference prior to the hearing.

(c) The office of financial recovery collects any amount the provider is ordered to repay.

(6) A provider who disagrees with a department action regarding termination may appeal the action per WAC 388-502-0260. The provider may request a dispute conference; the request must be:

(a) In writing;

(b) Sent within thirty days of the date the provider received the termination notice;

(c) Include a statement of the action(s) appealed and supporting justification; and

(d) Sent to:

DSHS Central Contract Services

P.O. Box 45811

Olympia, WA 98504-5811

(7) See WAC 388-502-0220 for rate reimbursement appeals. See WAC 388-502-0240 for appeals of audit findings. See WAC 388-502-0260 for appeals related to contracts other than MAA's core provider agreements.

[Statutory Authority: RCW 74.08.090, 74.09.520, 34.05.020, 34.05.220. 00-22-017, § 388-502-0230, filed 10/20/00, effective 11/20/00. Statutory

Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-502-0230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-042.]

WAC 388-502-0240 Audits and the audit appeal process for contractors/providers. (1) This section applies to all contractor/providers except the following:

(a) Nursing homes as described in chapters 388-96, 388-97, and 388-98 WAC; and

(b) Managed care contractors as described in chapter 388-538 WAC.

(2) Subject to the limitations in subsection (1) of this section, the following definitions apply to this section:

(a) **"Contractor/provider"** means any person or organization that has a signed core provider agreement with the medical assistance administration (MAA) to provide services to eligible clients.

(b) **"Extrapolation"** means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

(c) **"Probability sample"** means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(3) MAA may audit an MAA contractor/provider who furnishes medical or other covered services to eligible clients. See WAC 388-502-0220 for rate appeals. See WAC 388-502-0230 for dispute appeals involving provider review, termination and appeal. See WAC 388-502-0260 for contract appeals, other than those contained in core provider.

(4) MAA conducts audits as necessary to identify benefits or payments to which contractor/providers are not entitled.

(5) The Washington state health professions quality assurance commissions serve in an advisory capacity to MAA in conducting audits.

(6) An MAA audit includes the following:

(a) An examination of provider records, by either an on-site or desk audit. See subsections (7) and (8) of this section;

(b) A draft audit report, which contains preliminary findings and recommendations. See subsection (13) of this section;

(c) A dispute conference, if the contractor/provider requests it. See subsection (14) of this section;

(d) A final audit report. See subsection (15) of this section; and

(e) The right to an administrative appeal, if the contractor/provider requests it. See subsections (15) and (16) of this section.

(7) MAA audits providers who furnish medical and other services as authorized by chapter 74.09 RCW. An audit:

(a) Determines whether providers are:

(i) Complying with the rules and regulations of the program;

(ii) Meeting the community standard of practice; and

(iii) Billing allowable costs; or

(b) Investigates any of the following:

(i) Complaints/allegations;

(ii) Actions taken regarding Medicare or medical assistance; or

(iii) Actions taken by the health profession's quality assurance commissions.

(8) As part of the audit:

(a) MAA examines provider records.

(i) MAA examines those records, or portion thereof, that were reimbursed by MAA.

(ii) MAA examines records as necessary to verify usual and customary charges and payable and receivable accounts to verify third party liability.

(iii) MAA may remove copies of, but not original, records from the provider's premises.

(b) MAA gives a provider twenty days advance notice that it is going to audit paid claims or patient medical records for compliance with program rules, standards, or the community standard of practice. See subsection (16) of this section to request an extension of this notification period. This notice does not:

(i) Apply to providers who are suspected of fraudulent or abusive practices;

(ii) Apply to providers whose practices MAA considers may present a risk of imminent danger to medical assistance clients;

(iii) Include names of patient files that MAA will review; and

(iv) Apply to medical assistance provider business and financial records and patient financial records when they are reviewed as part of a third-party liability compliance audit.

(c) Whenever possible, MAA works with the provider to minimize inconvenience and disruption of health care delivery during the audit.

(d) MAA destroys all copies of identified client medical records made during an audit, after all appeal rights are exhausted.

(9) MAA may audit on a claim-by-claim basis, or using a probability sample.

(10) When MAA conducts a probability sample audit, all of the following apply:

(a) The sample claims are selected on the basis of recognized and generally accepted sampling methods;

(b) The sample claims are examined for compliance with relevant federal and state laws and regulations, department billing instructions, and numbered memoranda; and

(c) When projecting the overpayment, MAA uses a sample that is sufficient to ensure a minimum ninety-five percent confidence level.

(11) MAA uses probability sampling as described in subsection (10) of this section.

(a) If the audit findings demonstrate that MAA has made an overpayment to a Washington state Title XIX or other medical program provider(s), MAA recovers those statistically calculated overpayments.

(b) When calculating the amount to be recovered, MAA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(c) MAA does not consider nonbilled services or supplies when calculating underpayments or overpayments.

(12) When MAA uses the results of a probability sample to extrapolate the amount to be recovered as described in subsection (11) of this section, the provider may request a description of all of the following:

- (a) The universe from which MAA drew the sample;
- (b) The sample size and method that MAA used to select the sample; and
- (c) The formulas and calculation procedures MAA used to determine the amount to be recovered.

(13) Upon completion of the audit, MAA identifies for the contractor/provider those files or records that are necessary for the audit, but were not located at the time of the audit.

(a) MAA allows the contractor/provider thirty calendar days from the date of completion of the on-site audit to locate and provide the missing files or records. Undocumented services will be considered as program overpayments; and

(b) At the end of this thirty day period, MAA issues the draft audit report. At this time:

(i) The contractor/provider may review, comment, and provide any additional information related to the draft audit report, that the contractor/provider wants considered. This information must be submitted within forty-five days of the date the contractor/provider received the draft audit report. See subsection (16) of this section to request an extension of this time period;

(ii) MAA works with the contractor/provider to resolve areas of disagreement; and

(iii) If necessary, MAA issues a revised draft audit report.

(14) A contractor/provider who wants to dispute draft audit findings must request a dispute conference.

(a) The contractor/provider must submit a written request for a dispute conference within forty-five calendar days of the date the draft audit report was received by the contractor/provider. MAA may grant an additional thirty day extension of the forty-five day limit as long as the contractor/provider requests the time extension in writing within the forty-five day limit and states the reason for the request.

(b) The dispute request must:

(i) Specify which finding(s) the contractor/provider is disputing; and

(ii) Supply documentation to support the contractor/provider's position.

(c) MAA acknowledges each request for a dispute conference.

(d) MAA responds to each disputed item in writing.

(e) If MAA and the contractor/provider reach an agreement during the dispute conference process, MAA issues the final audit report and the recommendations are binding.

(f) If MAA and the contractor/provider cannot reach an agreement during the dispute conference process, and the contractor/provider has had the opportunity to raise all concerns related to the audit findings, MAA may close the dispute conference process and issue a final audit report. After MAA issues the final audit report, the contractor/provider may request an audit appeal hearing per subsection (15) of this section.

(15) After MAA issues the final audit report, the contractor/provider may appeal findings in the report and request an audit appeal hearing. When the contractor/provider requests an audit appeal hearing, and when any part of the audited time period falls on or before June 30, 1998, the following process applies. This hearing is not governed by the Administrative Procedure Act (chapter 34.05 RCW).

(a) The request for an audit appeal hearing must meet all of the following:

(i) Be in writing;

(ii) Be submitted within twenty-eight calendar days of the date of delivery of the final audit report, by certified mail. (Contact the office of financial recovery to request an extension of this time period.) Send the request to:

Office of Financial Recovery/DSHS

POB 45862

Olympia, WA 98504-5862

(iii) Include a copy of the final audit report cover letter;

(iv) State the contractor/provider's name, address, and contract number (DSHS contract number or core provider agreement number);

(v) State the audit time period's beginning and ending dates; and

(vi) Provide additional documentation, limited to the issues identified in the audit, that the contractor/provider requests to be considered within the hearing.

(b) The audit appeal hearing consists of an administrative review of all documents submitted for consideration by the contractor/provider and MAA. DSHS appoints a hearing officer to conduct such a review. At the hearing officer's discretion, the review may be conducted as a telephone conference, as an in-person meeting in Olympia, Washington, or as a combination thereof.

(c) The decision made by the hearing officer serves as the final agency action and is binding.

(d) The office of financial recovery collects any amount the provider is ordered to repay.

(16) A contractor/provider may request an extension of the time periods in this section by sending a request to MAA that contains all of the following. The request must:

(a) Be in writing;

(b) Be received by MAA before the applicable time period has elapsed;

(c) Include the reason(s) for the request; and

(d) Include the date the contractor/provider expects to submit or respond to requested information.

(17) When a contractor/provider requests an audit appeal hearing, and the entire audit period falls on or after July 1, 1998, the audit hearing is governed by the process in RCW 43.20B.675.

(18) MAA considers that a contractor/provider has abandoned the dispute, if the provider fails to identify and attempt to resolve disputed audit findings as provided in this section, has abandoned the dispute. MAA proceeds with issuing and/or implementing the final audit report.

(19) Based on the findings of an audit, MAA may order the provider to repay excess benefits or payments received, as follows:

(a) MAA may assess civil penalties as provided for in chapter 74.09 RCW;

(b) The amount of civil penalties may not exceed three times the amount of excess benefits or payments the provider received; and

(c) The repayment includes interest on the amount of excess benefits or payments, per RCW 43.20B.695.

(20) When MAA imposes a civil penalty or suspends or terminates a provider from the program, written notice of the

action taken is given to the appropriate licensing agency, disciplinary commission, and/or other entity requiring a report.

(21) When an audit shows that a provider has demonstrated a significant noncompliance with the provisions of the medical care program, MAA may refer that provider to the appropriate disciplinary commission.

(22) Where MAA finds evidence of or has reason to suspect fraud, those contractors/providers are referred to the appropriate prosecuting authority for possible criminal action.

[Statutory Authority: RCW 74.08.090, 43.20B.675, 00-23-014, § 388-502-0240, filed 11/3/00, effective 12/4/00.]

WAC 388-502-0260 Appeals and dispute resolution for providers with contracts other than core provider agreements. (1) Providers of medical services who have a contract, other than a core provider agreement, with a dispute resolution provision must follow the dispute resolution process described in the contract.

(2) See WAC 388-502-0220 for disputes involving rates. See WAC 388-502-0240 for disputes involving audits. See WAC 388-502-0230 for disputes involving provider reviews and termination.

[Statutory Authority: RCW 74.08.090, 74.09.290, 00-22-016, § 388-502-0260, filed 10/20/00, effective 11/20/00.]

Chapter 388-503 WAC

PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

WAC

388-503-0505	General eligibility requirements for medical programs.
388-503-0510	How a client is determined "related to" a categorical program.
388-503-0515	Medical coverage resulting from a cash grant.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-503-0305	Program priorities. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-503-0305, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.
388-503-0310	Categorically needy eligible persons. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997, 98-15-066, § 388-503-0310, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090 and 74.04.050, 97-03-036, § 388-503-0310, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090 and SPA 95-11, 96-12-001 (Order 3981), § 388-503-0310, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090, 94-17-036 (Order 3769), § 388-503-0310, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-503-0310, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-010 and 388-82-115.] Repealed by 99-19-091, filed 9/17/99, effective 10/18/99. Statutory Authority: RCW 74.08.090.
388-503-0320	Medically needy eligible persons. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b, 95-24-017 (Order 3921, #100267), § 388-503-0320, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-503-0320, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-005 and 388-99-010.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0100.

388-503-0350 Medical care services—GAU/ADATSA. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-503-0350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-126 and 388-83-006.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110 and 388-529-0100.

388-503-0370 Medically indigent eligible persons. [Statutory Authority: RCW 74.08.090, 95-22-039 (Order 3913, #100246), § 388-503-0370, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-503-0370, filed 5/3/94, effective 6/3/94. Formerly WAC 388-100-005 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110 and 388-438-0100.

WAC 388-503-0505 General eligibility requirements for medical programs. (1) Persons applying for benefits under the medical coverage programs established under chapter 74.09 RCW must meet the eligibility criteria established by the department in chapters 388-400 through 388-555 WAC.

(2) Persons applying for medical coverage are considered first for federally funded or federally matched programs. State-funded programs are considered after federally funded programs are not available to the client except for brief periods when the state-funded programs offer a broad scope of care which meet a specific client need.

(3) Unless otherwise specified in program specific WAC, the eligibility criteria for each medical program is as follows:

(a) Verification of age and identity (chapters 388-404, 388-406, and 388-490 WAC); and

(b) Residence in Washington state (chapter 388-468 WAC); and

(c) Citizenship or immigration status in the United States (chapter 388-424 WAC); and

(d) Possession of a valid Social Security Account Number (chapter 388-476 WAC); and

(e) Assignment of medical support rights to the state of Washington (WAC 388-505-0540); and

(f) Cooperation in securing medical support (chapter 388-422 WAC); and

(g) Countable resources within program limits (chapters 388-470 and 388-478 WAC); and

(h) Countable income within program limits (chapters 388-450 and 388-478 WAC).

(4) In addition to the general eligibility requirements in subsection (3) of this section, each program has specific eligibility requirements as described in applicable WAC.

(5) Persons living in a public institution, including a correctional facility, are not eligible for the department's medical coverage programs. For a person under age twenty or over age sixty-five who is a patient in an institution for mental disease see WAC 388-513-1315(13) for exception.

(6) Persons terminated from SSI or TANF cash grants and those who lose eligibility for categorically needy (CN) medical coverage have their CN coverage continued while their eligibility for other medical programs is redetermined. This continuation of medical coverage is described in chapter 388-434 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 1st sp.s. c 25, 04-07-141, § 388-503-0505, filed 3/22/04, effective 4/22/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415, 02-17-

030, § 388-503-0505, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0505, filed 7/31/98, effective 9/1/98. Formerly WAC 388-501-0110, 388-503-0305 and 388-505-0501.]

WAC 388-503-0510 How a client is determined "related to" a categorical program. (1) A person is related to the Supplemental Security Income (SSI) program if they are:

(a) Aged, blind, or disabled as defined in WAC 388-511-1105(1) or chapter 388-475 WAC; or

(b) Considered as eligible for SSI under WAC 388-511-1105(5) or chapter 388-475 WAC; or

(c) Children meeting the requirements of WAC 388-505-0210(5).

(2) A person or family is considered to be related to the temporary assistance for needy families (TANF) program if they:

(a) Meet the program requirements for the TANF cash assistance programs or the requirements of WAC 388-505-0220; or

(b) Would meet such requirements except that the assistance unit's countable income exceeds the TANF program standards in WAC 388-478-0065.

(3) Persons related to SSI or to TANF are eligible for categorically needy (CN) or medically needy (MN) medical coverage if they meet the other eligibility criteria for these medical programs. See chapters 388-475, 388-505 and 388-519 WAC for these eligibility criteria.

(4) Persons related to SSI or to TANF and who receive the related CN medical coverage have redetermination rights as described in WAC 388-503-0505(6).

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 05-07-097, § 388-503-0510, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-503-0510, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0510, filed 7/31/98, effective 9/1/98.]

WAC 388-503-0515 Medical coverage resulting from a cash grant. (1) Families or individuals eligible for SSI, SSI state supplement or TANF cash grants are automatically eligible for categorically needy (CN) medical coverage. These clients receive medical coverage benefits without making a separate application. Certification for CN medical coverage parallels that for the cash benefits.

(2) Upon termination of cash benefits as described in subsection (1) of this section, medical coverage continues until the client's eligibility for other medical coverage can be completed. Continuing medical coverage is terminated if the client does not cooperate with the eligibility redetermination process.

(3) Individuals eligible for state financial assistance (SFA) cash grants may receive medical coverage for:

(a) An emergent medical condition as described in WAC 388-438-0110; or

(b) Pregnancy as described in WAC 388-462-0015.

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-503-0515, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0515, filed 7/31/98, effective 9/1/98.]

(2007 Ed.)

Chapter 388-505 WAC

FAMILY MEDICAL

WAC

388-505-0110	Medical assistance coverage for adults not covered under family medical programs.
388-505-0210	Children's medical eligibility.
388-505-0211	Premium requirements for SCHIP children.
388-505-0220	Family medical eligibility.
388-505-0540	Assignment of rights and cooperation.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-505-0501	Eligibility—General. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0501, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-015.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.-055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.
388-505-0505	Age. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-505-0510	Residence. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2). 97-15-025, § 388-505-0510, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-025.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-468-0010.
388-505-0520	Citizenship. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-505-0520, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 96-13-002 (Order 3983), § 388-505-0520, filed 6/6/96, effective 7/7/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-24-016 (Order 3923), § 388-505-0520, filed 11/22/95, effective 12/23/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0520, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-015.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-424-0005 and 388-424-0010.
388-505-0530	Social Security number. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-017.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.-055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-476-0005.
388-505-0560	Cooperation in securing medical support. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0560, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-013.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-472-0005, 388-505-0540, 388-422-0005, 388-422-0010 and 388-422-0020.
388-505-0570	Good cause for noncooperation—Medical care support. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0570, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-014.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-422-0020(4)(c).
388-505-0580	Resources. [Statutory Authority: RCW 74.08.090. 96-01-005 (Order 3932, # 100268), § 388-505-0580, filed 12/6/95, effective 1/6/96; 95-02-026 (Order 3817), § 388-505-0580, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-505-0580, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-026.] Repealed by

- 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-470-0015, 388-470-0020, 388-470-0040, 388-488-0005 and 388-450-0210.
- 388-505-0590 Income. [Statutory Authority: RCW 74.08.090, 95-17-031 (Order 3878), § 388-505-0590, filed 8/9/95, effective 9/9/95; 95-04-047 (Order 3827), § 388-505-0590, filed 1/25/95, effective 2/25/95; 94-10-065 (Order 3732), § 388-505-0590, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-041.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0005, 388-450-0015, 388-450-0210 and 388-450-0215.
- 388-505-0595 Trusts. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0595, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-041.] Repealed by 01-06-043, filed 3/5/01, effective 5/1/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500.

WAC 388-505-0110 Medical assistance coverage for adults not covered under family medical programs. (1) An adult who does not meet the institutional status requirements as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for categorically needy (CN) coverage under this chapter. Persons excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section a person is eligible for CN coverage when the person:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has CN countable income and resources that do not exceed the income and resource standards in WAC 388-478-0080; and

(c) Is sixty-five years of age or older, or meets the blind and/or disability criteria of the federal SSI program.

(2) An adult not meeting the conditions of subsection (1)(b) is eligible for CN medical coverage if the person:

(a) Is a current beneficiary of Title II of the Social Security Act (SSA) benefits who:

(i) Was a concurrent beneficiary of Title II and Supplemental Security Income (SSI) benefits;

(ii) Is ineligible for SSI benefits and/or state supplemental payments (SSP); and

(iii) Would be eligible for SSI benefits if certain cost-of-living (COLA) increases are deducted from the client's current Title II benefit amount:

(A) All Title II COLA increases under P.L. 94-566, section 503 received by the client since their termination from SSI/SSP; and

(B) All Title II COLA increases received during the time period in subsection (1)(d)(iii)(A) of this section by the client's spouse or other financially responsible family member living in the same household.

(b) Is an SSI beneficiary, no longer receiving a cash benefit due to employment, who meets the provisions of section 1619(b) of Title XVI of the SSA;

(c) Is a currently disabled client receiving widow's or widower's benefits under section 202 (e) or (f) of the SSA if the disabled client:

(i) Was entitled to a monthly insurance benefit under Title II of the SSA for December 1983; and

(ii) Was entitled to and received a widow's or widower's benefit based on a disability under section 202 (e) or (f) of the SSA for January 1984;

(iii) Became ineligible for SSI/SSP in the first month in which the increase provided under section 134 of P.L. 98-21 was paid to the client;

(iv) Has been continuously entitled to a widow's or widower's benefit under section 202 (e) or (f) of the SSA;

(v) Would be eligible for SSI/SSP benefits if the amount of that increase, and any subsequent COLA increases provided under section 215(i) of the SSA, were disregarded;

(vi) Is fifty through fifty-nine years of age; and

(vii) Filed an application for Medicaid coverage before July 1, 1988.

(d) Was receiving, as of January 1, 1991, Title II disabled widow or widower benefits under section 202 (e) or (f) of the SSA if the person:

(i) Is not eligible for the hospital insurance benefits under Medicare Part A;

(ii) Received SSI/SSP payments in the month before receiving such Title II benefits;

(iii) Became ineligible for SSI/SSP due to receipt of or increase in such Title II benefits; and

(iv) Would be eligible for SSI/SSP if the amount of such Title II benefits or increase in such Title II benefits under section 202 (e) or (f) of the SSA, and any subsequent COLA increases provided under section 215(i) of the act were disregarded.

(e) Is a disabled or blind client receiving Title II Disabled Adult Childhood (DAC) benefits under section 202(d) of the SSA if the client:

(i) Is at least eighteen years old;

(ii) Lost SSI/SSP benefits on or after July 1, 1988, due to receipt of or increase in DAC benefits; and

(iii) Would be eligible for SSI/SSP if the amount of the DAC benefits or increase under section 202(d) of the DAC and any subsequent COLA increases provided under section 215(i) of the SSA were disregarded.

(f) Is a client who:

(i) In August 1972, received:

(A) Old age assistance (OAA);

(B) Aid to blind (AB);

(C) Aid to families with dependent children (AFDC); or

(D) Aid to the permanently and totally disabled (APTD);

and

(ii) Was entitled to or received retirement, survivors, and disability insurance (RSDI) benefits; or

(iii) Is eligible for OAA, AB, AFDC, SSI, or APRD solely because of the twenty percent increase in Social Security benefits under P.L. 92-336.

(3) An adult who does not meet the institutional status requirement as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for medically needy (MN) coverage under this chapter. Persons excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section a person is eligible for MN coverage when the person:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has MN countable income that does not exceed the income standards in WAC 388-478-0070, or meets the excess income spenddown requirements in WAC 388-519-0110; and

(c) Meets the countable resource standards in WAC 388-478-0070; and

(d) Is sixty-five years of age or older or meets the blind and/or disability criteria of the federal SSI program.

(4) MN coverage is available for an aged, blind, or disabled ineligible spouse of an SSI recipient. See WAC 388-519-0100 for additional information.

(5) An adult may be eligible for the alien emergency medical program as described in WAC 388-438-0110.

(6) An adult is eligible for the state-funded general assistance - expedited Medicaid disability (GA-X) program when they:

(a) Meet the requirements of the cash program in WAC 388-400-0025 and 388-478-0030; or

(b) Meet the SSI-related disability standards but cannot get the SSI cash grant due to immigration status or sponsor deeming issues.

Clients may be eligible for GA cash benefits and CN medical coverage due to different sponsor deeming requirements.

(7) An adult is eligible for the state-funded medical care services (MCS) program when the person is eligible for GAU or ADATSA program coverage as described in WAC 388-400-0025 and 388-800-0048. GAU clients residing in counties designated as mandatory managed care plan counties must enroll in a plan, pursuant to WAC 388-538-063.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.522, and 2003 1st sp.s. c 25 § 209(15). 04-15-003, § 388-505-0110, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-505-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0350 and 388-503-0370.]

WAC 388-505-0210 Children's medical eligibility.

(1) A child under the age of one is eligible for categorically needy (CN) medical assistance when:

(a) The child's mother was eligible for and receiving coverage under a medical program at the time of the child's birth; and

(b) The child remains with the mother and resides in the state.

(2) Children under the age of nineteen are eligible for CN medical assistance when they meet the requirements for:

(a) Citizenship or U.S. national status as defined in WAC 388-424-0001 or "qualified alien" status as described in WAC 388-424-0006 (1) or (4);

(b) State residence as described in chapter 388-468 WAC;

(c) A Social Security number as described in chapter 388-476 WAC; and

(d) Family income does not exceed two hundred percent federal poverty level (FPL) as described in WAC 388-478-0075 at each application or review.

(3) Children under the age of nineteen are eligible for the state children's health insurance program (SCHIP), as described in chapter 388-542 WAC, when:

(a) They meet the requirements of subsection (2)(a), (b), and (c) of this section;

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(b) They do not have other creditable health insurance coverage; and

(c) Family income exceeds two hundred percent of the federal poverty level (FPL), but does not exceed two hundred fifty percent of the FPL as described in WAC 388-478-0075.

(4) Children under the age of twenty-one are eligible for CN medical assistance when they meet:

(a) Citizenship or immigrant status, state residence, and social security number requirements as described in subsection (2)(a), (b), and (c) of this section;

(b) Income levels described in WAC 388-478-0075; and

(c) One of the following criteria:

(i) Reside, or are expected to reside, in a medical hospital, intermediate care facility for mentally retarded (ICF/MR), or nursing facility for thirty days or more;

(ii) Reside in a psychiatric or chemical dependency facility for ninety days or more;

(iii) Are in foster care; or

(iv) Receive subsidized adoption services.

(d) For a child meeting the criteria (c)(i) of this subsection, the only parental income the department considers available to the child is the amount the parent chooses to contribute.

(e) For a child meeting the criteria in (c)(ii) of this subsection, parental income is counted as described in WAC 388-408-0055 (1)(c).

(5) Children are eligible for CN medical assistance if they:

(a) Receive Supplemental Security Income (SSI) payments based upon their own disability; or

(b) Received SSI cash assistance for August 1996, and except for the August 1996 passage of amendments to federal disability definitions, would be eligible for SSI cash assistance.

(6) Children under the age of nineteen are eligible for medically needy (MN) medical assistance as defined in chapter 388-500 WAC when they:

(a) Meet citizenship or immigrant status, state residence, and social security number requirements as described in subsection (2)(a), (b), and (c); and

(b) Have income above two hundred fifty percent federal poverty level (FPL) as described in WAC 388-478-0075.

(7) A child is eligible for SSI-related MN when the child:

(a) Meets the blind and/or disability criteria of the federal SSI program or the condition in subsection (5)(b); and

(b) Has countable income above the level described in WAC 388-478-0070(1).

(8) Noncitizen children under the age of eighteen, including visitors or students from another country, undocumented children and "qualified alien" children as defined in WAC 388-424-0001 who are ineligible due to the five-year bar as described in WAC 388-424-0006(3), are eligible for the state-funded children's health program, if:

(a) The department determines the child ineligible for any CN or MN scope of care medical program;

(b) Family income does not exceed one hundred percent federal poverty level (FPL) as described in WAC 388-478-0075;

(c) They meet state residence as described in chapter 388-468 WAC; and

(d) Program limits established by the legislature would not result in an overexpenditure of funds.

(9) There are no resource limits for children under CN, MN, SCHIP, or children's health coverage.

(10) Children may also be eligible for:

(a) Family medical as described in WAC 388-505-0220; or

(b) Medical extensions as described in WAC 388-523-0100.

(11) Except for a client described in subsection (4)(c)(i) and (ii), an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for CN or MN medical coverage.

[Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-505-0210, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-505-0210, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090 and 74.04.050. 03-14-107, § 388-505-0210, filed 6/30/03, effective 7/31/03. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-505-0210, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090, 74.04.050, [74.04.]055, and [74.04.]057. 01-11-110, § 388-505-0210, filed 5/21/01, effective 6/21/01. Statutory Authority: RCW 74.08.090 and 74.08A.100. 99-17-023, § 388-505-0210, filed 8/10/99, effective 9/10/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0905, 388-509-0910 and 388-509-0920.]

WAC 388-505-0211 Premium requirements for SCHIP children. (1) For the purposes of this chapter, "**premium**" means an amount paid for medical coverage.

(2) For a child found eligible for the state children's health insurance program (SCHIP) under WAC 388-505-0210(3), payment of a premium is required as a condition of eligibility.

(3) A child is exempt from the premium requirement if the child meets one of the following:

(a) The child is pregnant; or

(b) The child is an American Indian or Alaska native.

(4) The premium requirement begins the first of the month following the determination of eligibility. There is no premium requirement for medical coverage received in a month or months before the determination of eligibility.

(5) The premium amount for the assistance unit is based on the net available income as described in WAC 388-450-0005. If the household includes more than one assistance unit, the premium amount billed for the assistance units may be different amounts.

(6) The premium amount for each SCHIP child is fifteen dollars per month.

(7) The department bills the family for the lesser of:

(a) A maximum of forty-five dollars per month; or

(b) The total of the highest premiums, for up to three children in the assistance unit.

(8) Premium payment is a condition of eligibility for assistance units that include SCHIP children. All SCHIP children in an assistance unit are ineligible for medical coverage when the head of household's premium payments are three months in arrears. Three months in arrears means a balance exists for three months.

(9) When the department terminates the medical coverage of a SCHIP child due to nonpayment of premiums, the child has a three-month period of ineligibility beginning the

first of the following month. The three month period of ineligibility is rescinded only when the:

(a) Past due premiums are paid in full prior to the begin date of the period of ineligibility; or

(b) SCHIP child has a change in circumstances such that the child becomes eligible for Medicaid. The department cannot rescind the three-month period of ineligibility for reasons other than the criteria described in this subsection.

(10) The department writes off past-due premiums after twelve months.

(11) When the designated three-month period of ineligibility is over, all past due premiums that are an obligation of the head of household must be paid or written off before a child can become eligible for SCHIP.

(12) A family cannot designate partial payment of the billed premium amount as payment for a specific child in the assistance unit. The full amount of the premium bill is the obligation of the head of household of the assistance unit. A family can decide to request medical coverage only for certain children in the assistance unit, if they want to reduce premium obligation.

(13) A change that affects the premium amount is effective the month after the change is reported and processed.

(14) A sponsor or other third party may pay the premium on behalf of the child or children in the assistance unit. The premium payment requirement remains the obligation of head of household of the assistance unit. The failure of a sponsor or other third party to pay the premium does not eliminate the:

(a) Establishment of the period of ineligibility described in subsection (9) of this section; or

(b) Obligation of the head of household to pay past-due premiums.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-505-0211, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.055, 2004 c 276. 04-08-125, § 388-505-0211, filed 4/7/04, effective 5/8/04.]

WAC 388-505-0220 Family medical eligibility. (1) A person is eligible for categorically needy (CN) medical assistance when they are:

(a) Receiving temporary assistance for needy families (TANF) cash benefits;

(b) Receiving Tribal TANF;

(c) Receiving cash diversion assistance, except SFA relatable families, described in chapter 388-222 WAC;

(d) Eligible for TANF cash benefits but choose not to receive; or

(e) Not eligible for or receiving TANF cash assistance, but meet the eligibility criteria for aid to families with dependent children (AFDC) in effect on July 16, 1996 except that:

(i) Earned income is treated as described in WAC 388-450-0210; and

(ii) Resources are treated as described in WAC 388-470-0005 for applicants and 388-470-0026 for recipients.

(2) An adult cannot receive a family Medicaid program unless the household includes a child who is eligible for:

(a) Family Medicaid;

(b) SSI; or

(c) Children's Medicaid.

(3) A person is eligible for CN family medical coverage when the person is not eligible for or receiving cash benefits solely because the person:

(a) Received sixty months of TANF cash benefits or is a member of an assistance unit which has received sixty months of TANF cash benefits;

(b) Failed to meet the school attendance requirement in chapter 388-400 WAC;

(c) Is an unmarried minor parent who is not in a department-approved living situation;

(d) Is a parent or caretaker relative who fails to notify the department within five days of the date the child leaves the home and the child's absence will exceed ninety days;

(e) Is a fleeing felon or fleeing to avoid prosecution for a felony charge, or is a probation and parole violator;

(f) Was convicted of a drug related felony;

(g) Was convicted of receiving benefits unlawfully;

(h) Was convicted of misrepresenting residence to obtain assistance in two or more states;

(i) Has gross earnings exceeding the TANF gross income level; or

(j) Is not cooperating with WorkFirst requirements.

(4) An adult must cooperate with the division of child support in the identification, use, and collection of medical support from responsible third parties, unless the person meets the medical exemption criteria described in WAC 388-505-0540 or the medical good cause criteria described in chapter 388-422 WAC.

(5) Except for a client described in WAC 388-505-0210 (4)(c)(i) and (ii), a person who is an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for CN or MN medical coverage.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. 05-16-127, § 388-505-0220, filed 8/3/05, effective 9/3/05. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-505-0220, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090, 74.04.050, [74.04.]055, and [74.04.]057. 01-11-110, § 388-505-0220, filed 5/21/01, effective 6/21/01; 98-16-044, § 388-505-0220, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0740 and 388-522-2210.]

WAC 388-505-0540 Assignment of rights and cooperation. (1) When a person becomes eligible for any of the department's medical programs, they make assignment of certain rights to the state of Washington. This assignment includes all rights to any type of coverage or payment for medical care which results from:

(a) A court order;

(b) An administrative agency order; or

(c) Any third-party benefits or payment obligations for medical care which are the result of **subrogation** or contract (see WAC 388-501-0100).

(2) **Subrogation** is a legal term which describes the method by which the state acquires the rights of a client for whom or to whom the state has paid benefits. The subrogation rights of the state are limited to the recovery of its own costs.

(3) The person who signs the application makes the assignment of rights to the state. Assignment is made on their own behalf and on behalf of any eligible person for whom they can legally make such assignment.

(2007 Ed.)

(4) A person must cooperate with the department in the identification, use or collection of third-party benefits. Failure to cooperate results in a termination of eligibility for the responsible person. Other obligations for cooperation are located in chapters 388-14A and 388-422 WAC. The following clients are exempt from termination of eligibility for medical coverage as a result of noncooperation:

(a) A pregnant woman, and

(b) Minor children, and

(c) A person who has been determined to have "good cause" for noncooperation (see WAC 388-422-0015).

(5) A person will not lose eligibility for medical assistance programs due solely to the noncooperation of any third party.

(6) A person will be responsible for the costs of otherwise covered medical services if:

(a) The person received and kept the third-party payment for those services; or

(b) The person refused to provide to the provider of care their legal signature on insurance forms.

[Statutory Authority: RCW 74.08.090. 01-02-076, § 388-505-0540, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050, 74.04.-055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0540, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.522. 97-04-005, § 388-505-0540, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0540, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-012, 388-501-0170 and 388-505-0560.]

Chapter 388-506 WAC

MEDICAL FINANCIAL RESPONSIBILITY

WAC

388-506-0620 SSI-related medical clients.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-506-0610 AFDC-related medical programs. [Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48. 95-19-007 (Order 3895), § 388-506-0610, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090. 95-10-025 (Order 3847), § 388-506-0610, filed 4/26/95, effective 5/27/95; 94-17-034 (Order 3767), § 388-506-0610, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-506-0610, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-046 and 388-99-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055, 388-450-0005 and 388-470-0070.

388-506-0630 SSI-related income deeming. [Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-506-0630, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-506-0630, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-92-027 and 388-99-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055 and 388-450-0150.

WAC 388-506-0620 SSI-related medical clients. (1) The department shall consider income and resources for an institutionalized:

(a) Child as described under WAC 388-513-1315(6); or

(b) Spouse as described under WAC 388-513-1330 and 388-513-1350.

(2) The department shall consider the income and resources of spouses as available to each other through the month in which the spouses stopped living together. See WAC 388-513-1330 and 388-513-1350 when a spouse is institutionalized.

(3) The department shall follow WAC 388-515-1505, 388-515-1510, or 388-515-1530 when one or both spouses are receiving community options program entry system (COPES), community alternatives program (CAP), outward bound residential alternatives (OBRA), or coordinated community aids service alternatives (CASA) waived service program.

(4) The department shall allow a community spouse applying for medically needy a spousal deduction equal to the one-person medically needy income level (MNIL) less the spouse's income when:

(a) The community spouse is living in the same household as the spouse; and

(b) The spouse is receiving home-based and community-based services.

(5) The department shall consider income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a congregate care facility (CCF), adult family home (AFH), adult residential rehabilitation center/adult residential treatment facility (ARRC/ARTF), or division of developmental disability-group home (DDD-GH) facility when:

(a) Only one spouse enters the facility;

(b) Both spouses enter the same facility but have separate rooms; or

(c) Both spouses enter separate facilities.

(6) The department shall consider income and resources jointly when spouses are placed in a CCF, AFH, ARRC/ARTF, or DDD-GH facility and share a room.

(7) See Wac 388-408-0055 for rules on medical assistance units that include SSI-related persons.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-506-0620, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-506-0620, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-025.]

Chapter 388-511 WAC

SSI-RELATED MEDICAL ELIGIBILITY

WAC

388-511-1105 SSI-related eligibility requirements.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-511-1110 SSI-related resource standards. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1110, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-050.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0050 and 388-478-0080.

388-511-1115 SSI-related income standards. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1115, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0070 and 388-478-0055.

388-511-1130 SSI-related income availability. [Statutory Authority: RCW 74.04.050, 74.08.090. 00-22-029, § 388-511-1130, filed 10/23/00, effective 12/1/00. Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-511-1130, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1130, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-034 (part).] Repealed by 04-09-004, filed 4/7/04, effective 6/1/04. Statutory Authority: RCW 74.04.050, 74.08.090. Later promulgation, see chapter 388-475 WAC.

388-511-1140 SSI-related income exemptions. [Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-511-1140, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and State Plan Amendment Sup. 8a to Article 2.6-A page 6. 96-05-010 (Order 3943, #100295), § 388-511-1140, filed 2/9/96, effective 3/11/96. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605. 95-08-070 (Order 3845), § 388-511-1140, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1140, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-92-034 and 388-92-036.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020 and 388-450-0040.

388-511-1150 SSI-related resource availability. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-040.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see chapter 388-470 WAC.

388-511-1160 SSI-related resource exemptions. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 42 CFR 435.601 and Section 4735 of the Federal Balanced Budget Act of 1997 (Public Law 105-33 (H.R. 2015)), 98-04-031, § 388-511-1160, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-034, § 388-511-1160, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605. 95-08-070 (Order 3845), § 388-511-1160, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-045.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-470-0040.

388-511-1170 SSI—State data exchange. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1170, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-511-1105 SSI-related eligibility requirements. (1) For the purposes of SSI-related medical assistance, the client shall be:

(a) Sixty-five years of age or over; or

(b) Blind with:

(i) Central visual acuity of 20/200 or less in the better eye with the use of a correcting lens; or

(ii) A limitation in the fields of vision so the widest diameter of the visual field subtends an angle no greater than twenty degrees; or

(c) Disabled.

(i) Decisions on SSI-related disability are the responsibility of the medical assistance administration (MAA) and shall be subject to the authority of:

(A) Federal statutes and regulations codified at 42 U.S.C. Sec 1382c and 20 C.F.R. Parts 404 and 416, as amended; or

(B) Controlling federal court decisions which define the OASDI and SSI disability standard and determination process.

(ii) For MAA's purposes, "disabled" means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which:

(A) Can be expected to result in death; or

(B) Has lasted or can be expected to last for a continuous period of not less than twelve months.

(iii) In the case of a child seventeen years of age or younger, if the child suffers from any medically determinable physical or mental impairment of comparable severity.

(2) When a person has applied for Title II or Title XVI benefits and the SSA has denied the person's application solely because of a failure to meet Title II and Title XVI blindness or disability criteria, the SSA denial shall be binding on the department, unless the applicant's:

(a) SSA denial is under appeals in the reconsideration stage, the SSA's administrative hearing process, or the SSA's appeals council; or

(b) Medical condition has changed since the SSA denial was issued.

(3) The ineligible spouse, of an SSI beneficiary receiving a state supplement payment for the ineligible spouse, shall not be eligible for Medicaid as noninstitutional categorically needy. Such ineligible spouse may be eligible for noninstitutional medically needy.

(4) The client shall be resource eligible under WAC 388-478-0080 on the first day of the month to be eligible for any day or days of that month. The department shall make a resource determination of the first moment of the first day of the month. The department shall determine changes in the amount of a client's countable resources during a month do not affect eligibility or ineligibility for that month. Refer to WAC 388-513-1395 for an institutionalized client.

(5) The department shall consider a client under 1619(b) of the Social Security Act as eligible for SSI.

(6) The department shall provide a resident of Washington requiring medical assistance outside the United States care according to WAC 388-501-0180.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-511-1105, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-036, § 388-511-1105, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605. 95-08-070 (Order 3845), § 388-511-1105, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-511-1105, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-85-115 and 388-92-015.]

Chapter 388-512 WAC

SSI-RELATED GRANDFATHERED RECIPIENTS

WAC

388-512-1210 Program description.

(2007 Ed.)

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-512-1215	General eligibility. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1215, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-015.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1220	Eligibility—Blindness. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-020.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1225	Permanently and totally disabled. [Statutory Authority: RCW 74.08.090. 95-02-025 (Order 3816), § 388-512-1225, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-512-1225, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-025.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1230	Refusal to accept medical treatment. [Statutory Authority: RCW 74.08.090. 01-02-076, § 388-512-1230, filed 12/29/00, effective 1/29/01; 94-10-065 (Order 3732), § 388-512-1230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-030.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1235	Review for disability or blindness. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1235, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-035.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1240	Computation of available income. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1240, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-040.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1245	Monthly maintenance standard—Own home. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1245, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-045.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1250	Monthly maintenance standard—Person in institution. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-050.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1255	Available income and nonexempt resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1255, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-055.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1260	Exempt resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1260, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-060.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1265	Nonexempt resources. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1265, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-065.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1275	Continuing certification. [Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510. 98-04-004, § 388-512-1275, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1275, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-075.] Repealed by 01-06-042, filed 3/5/01, effective 4/5/01. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055.
388-512-1280	Application following termination. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1280, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-080.] Repealed by 98-04-004, filed 1/22/98,

effective 2/22/98. Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510.

WAC 388-512-1210 Program description. The department shall provide medical assistance within limitations set forth in these rules and regulations to a person who is a grandfathered client.

[Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-512-1210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-010.]

Chapter 388-513 WAC

CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

WAC

388-513-1301	Definitions related to long-term care (LTC) services.
388-513-1305	Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF).
388-513-1315	Eligibility for long-term care (institutional, waiver, and hospice) services.
388-513-1320	Determining institutional status for long-term care (LTC) services.
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388-513-1340	Determining excluded income for long-term care (LTC) services.
388-513-1345	Determining disregarded income for institutional or hospice services under the medically needy (MN) program.
388-513-1350	Defining the resource standard and determining resource eligibility for long-term care (LTC) services.
388-513-1364	Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services.
388-513-1365	Evaluating the transfer of an asset made on or after March 1, 1997 and before April 1, 2003 for long-term care (LTC) services.
388-513-1366	Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services.
388-513-1380	Determining a client's financial participation in the cost of care for long-term care (LTC) services.
388-513-1395	Determining eligibility for institutional or hospice services and for facility care only under the medically needy (MN) program.
388-513-1396	Clients living in a fraternal, religious, or benevolent nursing facility.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-513-1300	Applicability of alternate living and institutional rules. [Statutory Authority: RCW 74.08.090, 95-06-025 (Order 3834), § 388-513-1300, filed 2/22/95, effective 3/25/95.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.-090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act.
388-513-1310	Resource standard—Institutional. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1310, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-390.] Repealed by 00-01-051, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.-090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act.
388-513-1360	Determining excluded resources for long-term care (LTC) services. [Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.-090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and

1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1360, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1360, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and 48.85.020. 96-12-002 (Order 3982), § 388-513-1360, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1360, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-380.] Repealed by 07-01-073, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 2005 Federal Deficit Reduction Act (DRA) Public Law 109-171, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5).

WAC 388-513-1301 Definitions related to long-term care (LTC) services. This section defines the meaning of certain terms used in chapters 388-513 and 388-515 WAC. Within these chapters, institutional, waiver, and hospice services are referred to collectively as LTC services. Other terms related to LTC services that also apply to other programs are found in the sections in which they are used. Definitions of terms used in certain rules that regulate LTC programs are as follows:

"Add-on hours" means additional hours the department purchases from providers to perform medically oriented tasks for clients who require extra help because of a handicapping condition.

"Alternate living facility (ALF)" means one of the following community residential facilities that are contracted with the department to provide certain services:

(1) Adult family home (AFH), a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care.

(2) Adult residential care facility (ARC) (formerly known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision.

(3) Adult residential rehabilitation center (ARRC) or Adult residential treatment facility (ARTF), a licensed facility that provides its residents with twenty-four hour residential care for impairments related to mental illness.

(4) Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living.

(5) Division of developmental disabilities (DDD) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision.

(6) Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs.

"Clothing and personal incidentals (CPI)" means the same as personal needs allowance (PNA) which is defined later in this section.

"Community options program entry system (COPES)" means a Medicaid waiver program that provides an aged or disabled person assessed as needing nursing facility care with the option to remain at home or in an alternate living facility.

"Community spouse (CS)" means a person who does not live in a medical institution or nursing facility, and who is

legally married to an institutionalized client or to a person receiving services from home and community-based waiver programs.

"Comprehensive assessment (CA)" means the evaluation process used by a department designated social services worker to determine the client's need for long-term care services.

"DDD waiver" means Medicaid waiver programs that provide home and community-based services as an alternative to an intermediate care facility for the mentally retarded (ICF-MR) to persons determined eligible for services from DDD. There are four waivers administered by DDD: Basic, Basic Plus, Core and Community Protection.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the local market at the time of transfer or assignment. A transfer of assets for love and affection is not considered a transfer for FMV.

"Federal benefit rate (FBR)" means the basic benefit amount the social security administration (SSA) pays to clients who are eligible for the supplemental security income (SSI) program.

"Institutional services" means services paid for by Medicaid or state payment and provided in a nursing facility or equivalent care provided in a medical facility.

"Institutional status" means what is described in WAC 388-513-1320.

"Institutionalized client" means a client who has attained institutional status as described in WAC 388-513-1320.

"Institutionalized spouse" means a client who has attained institutional status as described in WAC 388-513-1320 and is legally married to a person who is not an institutionalized client.

"Legally married" means persons legally married to each other under provision of Washington state law. Washington recognizes other states' legal and common-law marriages. Persons are considered married if they are not divorced, even when they are physically or legally separated.

"Likely to reside" means a determination by the department that a client is reasonably expected to remain in a medical facility for thirty consecutive days. Once made, the determination stands, even if the client does not actually remain in the facility for that length of time.

"Look-back period" means the number of months prior to the month of application for LTC services that the department will consider for transfer of assets.

"Maintenance needs amount" means a monthly income amount a client keeps or that is allocated to a spouse or dependent family member who lives in the client's home.

"Medically intensive children (MIC)" program means a Medicaid waiver program that enables medically fragile children under age eighteen to live in the community. The program allows them to obtain medical and support services necessary for them to remain at home or in a home setting instead of in a hospital. Eligibility is included in the OBRA program described in WAC 388-515-1510.

"Noninstitutional medical assistance" means medical benefits provided by Medicaid or state-funded programs that do not include LTC services.

"Nursing facility turnaround document (TAD)" means the billing document nursing facilities use to request payment for institutionalized clients.

"Outward bound residential alternative (OBRA)" means a Medicaid waiver program that provides a person approved for services from DDD with the option to remain at home or in an alternate living facility.

"Participation" means the amount a client is responsible to pay each month toward the total cost of care they receive each month. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income.

"Penalty period" means a period of time for which a client is not eligible to receive LTC services.

"Personal needs allowance (PNA)" means a standard allowance for clothing and other personal needs for clients who live in a medical or alternate living facility. This allowance is sometimes referred to as "CPI."

"Prouty benefits" means special "age seventy-two" Social Security benefits available to persons born before 1896 who are not otherwise eligible for Social Security.

"Short stay" means a person who has entered a medical facility but is not likely to remain institutionalized for thirty consecutive days.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program that is three hundred percent of the SSI federal benefit rate (FBR).

"Swing bed" means a bed in a medical facility that is contracted as both a hospital and a nursing facility bed.

"Transfer of a resource or asset" means any act or failure to act, by a person or a nonapplying joint tenant, whereby title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means the person is not able to meet shelter, food, clothing, or health needs.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(1) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(2) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal Department of Veterans Affairs (VA). Some may include additional allowances for:

(1) Aid and attendance for an individual needing regular help from another person with activities of daily living;

(2) "Housebound" for an individual who, when without assistance from another person, is confined to the home;

(3) Improved pension, the newest type of VA disability pension, available to veterans and their survivors whose income from other sources (including service connected disability) is below the improved pension amount; or

(4) Unusual medical expenses (UME), determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit.

The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both.

"Waiver programs/services" means programs for which the federal government authorizes exceptions to federal Medicaid rules. Such programs provide to an eligible client a variety of services not normally covered under Medicaid. In Washington state, waiver programs are DDD waivers, COPES, MIC, and OBRA.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, chapters 71A.10 and 71A.12 RCW, 2004 c 276, 04-18-054, § 388-513-1301, filed 8/27/04, effective 9/27/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575, 02-09-052, § 388-513-1301, filed 4/12/02, effective 5/13/02. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1301, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1305 Determining eligibility for non-institutional medical assistance in an alternate living facility (ALF). This section describes how the department defines the monthly income standard and uses it to determine eligibility for noninstitutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC 388-478-0045 for the personal needs allowance (PNA) amount that applies in this rule.

(1) Alternate living facilities include the following:

- (a) An adult family home (AFH);
- (b) An adult residential care facility (ARC);
- (c) An adult residential rehabilitation center (ARRC);
- (d) An adult residential treatment facility (ARTF);
- (e) An assisted living facility (AL);
- (f) A division of developmental disabilities (DDD) group home (GH); and

(g) An enhanced adult residential care facility (EARC).

(2) The monthly income standard for noninstitutional medical assistance under the categorically needy (CN) program that cannot exceed the special income level (SIL) equals the following amounts. For a client who lives in:

(a) An ARC, an ARRC, an ARTF, an AL, a DDD GH, or an EARC, the department-contracted rate based on a thirty-one day month plus the PNA; or

(b) An AFH, the department-contracted rate based on a thirty-one day month plus the PNA plus the cost of any add-on hours authorized by the department.

(3) The monthly income standard for noninstitutional medical assistance under the medically needy (MN) program equals the private facility rate based on a thirty-one-day month plus the PNA.

(4) The monthly income standard for noninstitutional medical assistance under the general assistance (GA) program equals the GA grant standard described in WAC 388-478-0045.

(5) The department determines a client's nonexcluded resources for noninstitutional medical assistance under the:

(a) General assistance (GA) and Temporary Assistance for Needy Families (TANF) programs as described in chapter 388-470 WAC; and

(b) SSI-related medical program as described in chapter 388-475 WAC.

(6) The department determines a client's nonexcluded income for noninstitutional medical assistance as described in:

(a) Chapter 388-450 WAC for GA and TANF programs; and

(b) Chapter 388-475 WAC and WAC 388-506-0620 for SSI-related medical programs.

(7) The department approves CN noninstitutional medical assistance for a period of up to twelve months for a client who receives supplemental security income (SSI) or who is SSI-related as described in WAC 388-475-0050, if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client's nonexcluded income described in subsection (6) does not exceed the CN standard described in subsection (2).

(8) The department approves MN noninstitutional medical assistance for a period of months described in chapter 388-416 WAC for an SSI-related client, if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client satisfies any spenddown liability as described in chapter 388-519 WAC.

(9) The department approves GA and TANF noninstitutional medical assistance for a period of months described in chapter 388-416 WAC.

(10) The client described in subsections (7) and (9) keeps the PNA amount and pays remaining income to the facility for board and room.

[Statutory Authority: RCW 74.08.090, 06-07-077, § 388-513-1305, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1305, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500, 99-06-045, § 388-513-1305, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1305, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-036 and 388-99-036.]

WAC 388-513-1315 Eligibility for long-term care (institutional, waiver, and hospice) services. This section describes how the department determines a client's eligibility for institutional, waiver, or hospice services under the categorically needy (CN) program and institutional or hospice services under the medically needy (MN) program. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (11) and emergency medical programs described in subsections (10) and (12).

(1) To be eligible for long-term care (LTC) services described in this section, a client must:

(a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a) through (f);

(b) Attain institutional status as described in WAC 388-513-1320; and

(c) Not be subject to a penalty period of ineligibility as described in WAC 388-513-1364 through 388-513-1366.

(2) To be eligible for institutional, waiver, or hospice services under the CN program, a client must either:

(a) Be related to the Supplemental Security Income (SSI) program as described in WAC 388-475-0050(1) or be approved for the general assistance expedited Medicaid disability (GA-X) program; and

(b) Meet the following financial requirements, by having:

(i) Gross nonexcluded income described in subsection (7)(a) that does not exceed the special income level (SIL); and

(ii) Nonexcluded resources described in subsection (6) that do not exceed the resource standard described in WAC 388-513-1350(1), unless subsection (3) applies; or

(c) Be eligible for the CN children's medical program as described in WAC 388-505-0210; or

(d) Be eligible for the temporary assistance for needy families (TANF) program or state family assistance (SFA) program as described in WAC 388-505-0220.

(3) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the SIL.

(4) To be eligible for waiver or hospice services, a client must also meet the program requirements described in:

(a) WAC 388-515-1505 for COPES services;

(b) WAC 388-515-1510 for DDD waiver and OBRA services; or

(c) Chapter 388-551 WAC for hospice services.

(5) To be eligible for institutional or hospice services under the MN program, a client must be:

(a) Eligible for the MN children's medical program as described in WAC 388-505-0210; or

(b) Related to the SSI program as described in WAC 388-475-0050(1) and meet all requirements described in WAC 388-513-1395.

(6) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers resources available as described in WAC 388-513-1350;

(b) Excludes resources described in WAC 388-513-1360 and 388-513-1364 through 388-513-1366; and

(c) Compares the nonexcluded resources to the standard described in WAC 388-513-1350(1).

(7) To determine income eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;

(b) Excludes income for CN and MN programs as described in WAC 388-513-1340;

(c) Disregards income for the MN program as described in WAC 388-513-1345; and

(d) Follows program rules for the MN program as described in WAC 388-513-1395.

(8) A client who meets the requirements of the CN program is approved for a period of up to twelve months for:

(a) Institutional services in a medical facility;

(b) Waiver services at home or in an alternate living facility; or

(c) Hospice services at home or in a medical facility.

(9) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395 (5)(a)(ii) for:

(a) Institutional services in a medical facility; or

(b) Hospice services at home or in a medical facility.

(10) The department determines eligibility for LTC services under the alien emergency medical (AEM) program described in WAC 388-438-0110 for a client who meets all other requirements for such services but does not meet citizenship requirements.

(11) The department determines eligibility for institutional services under the GA program described in WAC 388-448-0001 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (8) through (10).

(12) A client is eligible for Medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 388-513-1320; and

(b) Is less than twenty-one years old or is at least sixty-five years old.

(13) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

(14) The department considers the parents' income and resources available for a minor who is less than eighteen years old and is receiving or is expected to receive inpatient chemical dependency and/or inpatient mental health treatment.

(15) The department considers the parents' income and resources available only as contributed for a client who is less than twenty-one years old and has attained institutional status as described in WAC 388-513-1320.

(16) The department determines a client's participation in the cost of care for LTC services as described in WAC 388-513-1380.

[Statutory Authority: RCW 74.08.090. 06-07-077, § 388-513-1315, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 71A.12.030, 71A.10.020, chapters 71A.10 and 71A.12 RCW, 2004 c 276. 04-18-054, § 388-513-1315, filed 8/27/04, effective 9/27/04. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1315, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1315, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.08.090 and 42 CFR 435.1005. 98-04-003, § 388-513-1315, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 96-11-072 (Order 3980), § 388-513-1315, filed 5/10/96, effective 6/10/96. Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48. 95-19-007 (Order 3895), § 388-513-1315, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1315, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1320 Determining institutional status for long-term care (LTC) services. Institutional status is an eligibility requirement for LTC services.

(1) To attain institutional status, a client must:

(a) Be approved for and receiving waiver or hospice services; or

(b) Reside or be likely to reside in a medical facility for a continuous period of:

(i) Ninety days for a child seventeen years of age or younger receiving inpatient chemical dependency and/or inpatient mental health treatment; or

(ii) Thirty days for:

(A) An SSI-related client;

(B) A child not described in subsection (1)(b)(i); or

(C) A client related to medical eligibility as described in WAC 388-513-1315 (10) or (11).

(2) A client's institutional status is not affected by a:

(a) Transfer between medical facilities; or

(b) Change from one kind of long-term care services to another.

(3) A client loses institutional status when the client:

(a) Is absent from the medical facility for at least thirty consecutive days; or

(b) Does not receive waiver or hospice services for at least thirty consecutive days.

[Statutory Authority: RCW 74.08.090, 06-07-077, § 388-513-1320, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1320, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500, 99-06-045, § 388-513-1320, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2), 97-15-025, § 388-513-1320, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090, 96-11-072 (Order 3980), § 388-513-1320, filed 5/10/96, effective 6/10/96; 94-10-065 (Order 3732), § 388-513-1320, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1325 Determining available income for a single client for long-term care (LTC) services. This section describes income the department considers available when determining a single client's eligibility for LTC services.

(1) Refer to WAC 388-513-1330 for rules related to available income for legally married couples.

(2) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 388-450-0005 (3) and (4), Income—Ownership and availability;

(b) WAC 388-450-0085, Self-employment income—Allowable expenses;

(c) WAC 388-450-0210 (4)(b), (e), and (h), Countable income for medical programs;

(d) WAC 388-506-0620, SSI-related medical clients;

(e) WAC 388-511-1130, SSI-related income availability; and

(f) WAC 388-513-1315 (15) and (16), Eligibility for long-term care (institutional, waived, and hospice) services.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1325, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1330 Determining available income for legally married couples for long-term care (LTC) services. This section describes income the department considers available when determining a legally married client's eligibility for LTC services.

[Title 388 WAC—p. 940]

(1) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 388-450-0005(3), Income—Ownership and availability and WAC 388-475-0200, SSI-related medical;

(b) WAC 388-450-0085, Self-employment income—Allowable expenses;

(c) WAC 388-450-0210 (4)(b) and (e), Countable income for medical programs, and WAC 388-475-0750, SSI-related medical - Countable unearned income;

(d) WAC 388-506-0620, SSI-related medical clients; and

(e) WAC 388-513-1315 (15) and (16), Eligibility for long-term care (institutional, waiver, and hospice) services.

(2) For an institutionalized client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available, unless subsection (4) applies:

(a) Income received in the client's name;

(b) Income paid to a representative on the client's behalf;

(c) One-half of the income received in the names of both spouses; and

(d) Income from a trust as provided by the trust.

(3) The department considers the following income unavailable to an institutionalized client:

(a) Separate or community income received in the name of the community spouse; and

(b) Income established as unavailable through a fair hearing.

(4) For the determination of eligibility only, if available income described in subsections (2)(a) through (d) minus income exclusions described in WAC 388-513-1340 exceeds the special income level (SIL), then:

(a) The department follows community property law when determining ownership of income;

(b) Presumes all income received after marriage by either or both spouses to be community income; and

(c) Considers one-half of all community income available to the institutionalized client.

(5) If both spouses are either applying or approved for LTC services, then:

(a) The department allocates one-half of all community income described in subsection (4) to each spouse; and

(b) Adds the separate income of each spouse respectively to determine available income for each of them.

(6) The department considers income generated by a transferred resource to be the separate income of the person or entity to which it is transferred.

(7) The department considers income not generated by a transferred resource available to the client, even when the client transfers or assigns the rights to the income to:

(a) The spouse; or

(b) A trust for the benefit of the spouse.

(8) The department evaluates the transfer of a resource described in subsection (6) according to WAC 388-513-1365 and 388-513-1366 to determine whether a penalty period of ineligibility is required.

[Statutory Authority: RCW 74.08.090, 06-07-077, § 388-513-1330, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1330,

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filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1330, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160. 97-10-022, § 388-513-1330, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1330, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1330, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-335 and 388-95-340.]

WAC 388-513-1340 Determining excluded income for long-term care (LTC) services. This section describes income the department excludes when determining a client's eligibility and participation in the cost of care for LTC services with the exceptions described in subsections (30) and (33).

- (1) Crime victim's compensation;
- (2) Earned income tax credit (EITC);
- (3) Native American benefits excluded by federal statute (refer to WAC 388-450-0040);
- (4) Tax rebates or special payments excluded by other statutes;
- (5) Any public agency's refund of taxes paid on real property and/or on food;
- (6) Supplemental security income (SSI) and certain state public assistance based on financial need;
- (7) The amount a representative payee charges to provide services when the services are a requirement for the client to receive the income;
- (8) The amount of expenses necessary for a client to receive compensation, e.g., legal fees necessary to obtain settlement funds;
- (9) Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, and/or other necessary educational expenses at any educational institution;
- (10) Child support payments received from an absent parent for a minor child who is not institutionalized;
- (11) The amount of expenses related to impairments of a permanently and totally disabled client that allow the client to work;
- (12) The amount of expenses related to blindness that allow the client to work;
- (13) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);
- (14) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;
- (15) Assistance (other than wages or salary) received under the Older Americans Act;
- (16) Assistance (other than wages or salary) received under the foster grandparent program;
- (17) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;
- (18) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;
- (19) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

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(20) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(21) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(22) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(23) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(24) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(25) Payments made from *Susan Walker v. Bayer Corporation, et. al.*, 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(26) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(27) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(28) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(29) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(30) Interest earned from payments described in subsections (24) through (29) is considered available and counted as nonexcluded income;

(31) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, e.g., chore services;

(32) Department of Veterans Affairs benefits designated for:

- (a) The veteran's dependent;
- (b) Unusual medical expenses, aid and attendance allowance, and housebound allowance, with the exception described in subsection (33);

(33) Benefits described in subsection (32)(b) for a client who resides in a state veterans' home and has no dependents are excluded when determining eligibility, but are considered available when determining participation in the cost of care.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-513-1340, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1340, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1340, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 388-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program. This section describes income the department disregards when determining a client's eligibility for institutional or hospice services under the MN program. The department considers disregarded income available when determining a client's participation in the cost of care.

(1) The department disregards the following income amounts in the following order:

[Title 388 WAC—p. 941]

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

- (i) Twenty dollars per month if unearned; or
- (ii) Ten dollars per month if earned.

(b) The first twenty dollars per month of earned or unearned income, unless the income paid to a client is:

- (i) Based on need; and
- (ii) Totally or partially funded by the federal government or a private agency.

(2) For a client who is related to the Supplemental Security Income (SSI) program as described in WAC 388-475-0050(1), the first sixty-five dollars per month of earned income not excluded under WAC 388-513-1340, plus one-half of the remainder.

(3) For a TANF/SFA-related client, fifty percent of gross earned income.

(4) Department of Veterans Affairs benefits if:

(a) Those benefits are designated for:

- (i) Unusual medical expenses;
- (ii) Aid and attendance allowance; or
- (iii) Housebound allowance; and

(b) The client:

- (i) Resides in a state veterans' home; and
- (ii) Has no dependents.

(5) Income the Social Security Administration (SSA) withholds from SSA Title II benefits for the recovery of an SSI overpayment.

[Statutory Authority: RCW 74.08.090, 06-07-077, § 388-513-1345, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-513-1345, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. 95-02-028 (Order 3819), § 388-513-1345, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1345, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 388-513-1350 Defining the resource standard and determining resource eligibility for long-term care (LTC) services. This section describes how the department defines the resource standard and available or excluded resources when determining a client's eligibility for LTC services. The department uses the term "resource standard" to describe the maximum amount of resources a client can have and still be resource eligible for program benefits.

(1) The resource standard used to determine eligibility for LTC services equals:

(a) Two thousand dollars for:

- (i) A single client; or
- (ii) A legally married client with a community spouse, subject to the provisions described in subsections (8) through (11) of this section; or

(b) Three thousand dollars for a legally married couple, unless subsection (3) of this section applies.

(2) When both spouses apply for LTC services the department considers the resources of both spouses as available to each other through the month in which the spouses stopped living together.

(3) When both spouses are institutionalized, the department will determine the eligibility of each spouse as a single client the month following the month of separation.

(4) If the department has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, (but after eligibility has been established and services authorized for the institutional spouse), then the department applies the standard described in subsection (1)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the department applies (a)(b) of this section for a couple.

(5) When a single institutionalized individual marries, the department will redetermine eligibility applying the rules for a legally married couple.

(6) The department applies the following rules when determining available resources for LTC services:

(a) WAC 388-475-0300, Resource eligibility;

(b) WAC 388-475-0250, How to determine who owns a resource; and

(c) WAC 388-470-0060(6), Resources of an alien's sponsor.

(7) For LTC services the department determines a client's nonexcluded resources as follows:

(a) The department determines available resources for SSI-related clients as described in WAC 388-475-0350 through 388-475-0550 and resources excluded by federal law with the exception of:

(i) WAC 388-475-0550(16);

(ii) WAC 388-475-0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006 and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty-one is lawfully residing in the primary residence. Clients denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver.

(b) For an SSI-related client one automobile per household is excluded regardless of value if it is used for transportation of the eligible individual/couple.

(i) For an SSI-related client with a community spouse, the value of one automobile is excluded regardless of its use or value.

(ii) Vehicles not meeting the definition of automobile is a vehicle that has been junked or a vehicle that is used only as a recreational vehicle.

(c) For a SSI-related client, the department adds together the available resources of both spouses if subsections (2), (5), (6), (7) and (8)(a) or (b) apply, but not if subsection (3) or (4) apply.

(d) For an SSI-related client, excess resources are reduced in an amount equal to medical expenses incurred by the client (for definition see WAC 388-519-0110(10)) that are not subject to third-party payment and for which the client is liable, including:

(i) Health insurance and Medicare premiums, deductions, and co-insurance charges;

(ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan with the exception of the deduction for medical and remedial care expenses that were incurred during a transfer of asset penalty established per WAC 388-513-1363, 388-513-1364 or 388-515-1365; and

(iii) The amount of excess resources is limited to the following amounts:

(A) For LTC services provided under the categorically needy (CN) program, the amount described in WAC 388-513-1315(3); or

(B) For LTC services provided under the medically needy (MN) program, the amount described in WAC 388-513-1395 (2)(a) or (b).

(e) For a client not related to SSI, the department applies the resource rules of the program used to relate the client to medical eligibility.

(8) For legally married clients when only one spouse meets institutional status, the following rules apply. If the client's current period of institutional status began:

(a) Before October 1, 1989, the department adds together one-half the total amount of nonexcluded resources held in the name of:

(i) The institutionalized spouse; or

(ii) Both spouses.

(b) On or after October 1, 1989, the department adds together the total amount of nonexcluded resources held in the name of:

(i) Either spouse; or

(ii) Both spouses.

(9) If subsection (8)(b) of this section applies, the department determines the amount of resources that are allocated to the community spouse before determining nonexcluded resources used to establish eligibility for the institutionalized spouse, as follows:

(a) If the client's current period of institutional status began on or after October 1, 1989 and before August 1, 2003, the department allocates the maximum amount of resources ordinarily allowed by law. The maximum allocation amount is ninety-nine thousand five hundred forty dollars effective January 1, 2006. Effective January 1, 2007, the maximum allocation is one hundred and one thousand six hundred and forty dollars. (This standard increases annually on January 1st based on the consumer price index); or

(b) If the client's current period of institutional status began on or after August 1, 2003, the department allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined nonexcluded resources as of the beginning of the current period of institutional status, up to the amount described in subsection (9)(a) of this section; or

(ii) The state spousal resource standard of forty-one thousand nine hundred forty-three dollars effective July 1, 2005 (this standard increases every odd year on July 1st).

(10) The amount of the spousal share described in (9)(b)(i) can be determined anytime between the date that the current period of institutional status began and the date that eligibility for LTC services is determined. The following rules apply to the determination of the spousal share:

(a) Prior to an application for LTC services, the couple's combined countable resources are evaluated from the date of the current period of institutional status at the request of either member of the couple. The determination of the spousal share is completed when necessary documentation and/or verification is provided; or

(b) The determination of the spousal share is completed as part of the application for LTC services if the client was

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institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The client is required to provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.

(11) The amount of allocated resources described in subsection (9) of this section can be increased, only if:

(a) A court transfers additional resources to the community spouse; or

(b) An administrative law judge establishes in a fair hearing described in chapter 388-02 WAC, that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(12) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (13)(a), (b), or (c) of this section applies.

(13) A redetermination of the couple's resources as described in subsections (7) is required, if:

(a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status;

(b) The institutionalized spouse's nonexcluded resources exceed the standard described in subsection (1)(a), if subsection (8)(b) applies; or

(c) The institutionalized spouse does not transfer the amount described in subsections (9) or (11) to the community spouse or to another person for the sole benefit of the community spouse as described in WAC 388-513-1365(4) by either:

(i) The first regularly scheduled eligibility review; or

(ii) The reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 2005 Federal Deficit Reduction Act (DRA) Public Law 109-171, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). 07-01-073, § 388-513-1350, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). 05-07-033, § 388-513-1350, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396R-5). 04-04-072, § 388-513-1350, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396R-5). 01-18-055, § 388-513-1350, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1350, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1350, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.575 and Section 1924 (42 USC 1396r-5). 98-11-033, § 388-513-1350, filed 5/14/98, effective 6/14/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 97-09-112, § 388-513-1350, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1350, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1350, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-23-129 (Order 3808), § 388-513-1350, filed 11/23/94, effective 12/24/94; 94-10-065 (Order 3732), § 388-513-1350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-337 and 388-95-340.]

WAC 388-513-1364 Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1365 for rules used to evaluate the transfer of an asset made before April 1, 2003.

(1) The department does not apply a penalty period to the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC 388-513-1360 with the exception of the client's home, unless the transfer of the client's home meets the conditions described in subsection (1)(d);

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided care that enabled the client to remain in the home; or

(iii) Brother or sister, who has:

(A) Equity in the home; and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset, if the transfer meets the conditions described in subsection (4), and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the client's child who meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c); or

(f) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c).

(2) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of institutional status, if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the Medicaid state plan or the department's waived services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(3) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (2) as the transfer of an asset without adequate consideration.

(4) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (1)(e), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term or the trust, whichever is less; and

(d) The requirements in subsection (4)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b).

(5) If a client or the client's spouse transfers an asset within the look-back period described in WAC 388-513-1365 without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that begin on the latter of:

(i) The first day of the month in which the transfer is made; or

(ii) The first day after any previous penalty period has ended and end on the last day of the whole number of days as described in subsection (5)(a)(ii).

(6) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC 388-513-1360 does not affect the client's eligibility;

(b) That remain after an acquisition described in subsection (6)(a) becomes an available resource as of the first day of the following month.

(7) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (6) through (8).

(8) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in subsection (8)(a) is divided by the statewide average daily private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole days found by following subsections (5)(a) and (b) and (8)(a) and (b) is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(9) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(10) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 03-20-059, § 388-513-1364, filed 9/26/03, effective 10/27/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575, 03-06-048, § 388-513-1364, filed 2/28/03, effective 4/1/03.]

WAC 388-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997 and before April 1, 2003 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after March 1, 1997 and before April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1366 for rules used to evaluate the transfer of an asset made before March 1, 1997. Refer to WAC 388-513-1364 for rules used to evaluate the transfer of an asset made on or after March 31, 2003.

(1) The department disregards the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC 388-513-1360 with the exception of the client's home, unless the transfer meets the conditions described in subsection (1)(d);

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department that satisfies one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(iii) A son or daughter, who:

(A) Lived in the home for at least two years immediately before the client's current period of institutional status; and

(B) Provided care that enabled the client to remain in the home; or

(iv) A brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset other than the home, if the transfer meets the conditions described in subsection (4), and the asset is transferred:

(i) To the client's spouse or to another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To the client's child who meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c) or to a trust established for the sole benefit of this child; or

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 388-511-1105 (1)(b) or (c).

(f) The transfer of an asset to a member of the client's family in exchange for care the family member provided the client before the current period of institutional status, if a written agreement that describes the terms of the exchange:

(i) Was established at the time the care began;

(ii) Defines a reasonable FMV for the care provided that reflects a time frame based on the actuarial life expectancy of the client who transfers the asset; and

(iii) States that the transferred asset is considered payment for the care provided.

(2) When the fair market value of the care described in subsection (1)(f) is less than the value of the transferred asset, the department considers the difference the transfer of an asset without adequate consideration.

(3) The department considers the transfer of an asset in exchange for care given by a family member without a writ-

ten agreement as described under subsection (1)(f) as the transfer of an asset without adequate consideration.

(4) The transfer of an asset or the establishment of a trust is considered to be for the sole benefit of a person described in subsection (1)(e), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable; and

(b) Provides for spending all funds involved for the benefit of the person for whom the transfer is made within a time frame based on the actuarial life expectancy of that person.

(5) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received on or after October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty-six months, if all or part of the assets were transferred on or after August 11, 1993; and

(b) Sixty months, if all or part of the assets were transferred into a trust as described in WAC 388-561-0100.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after March 1, 1997 and before April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that:

(i) Begin on the latter of:

(A) The first day of the month in which the transfer is made; or

(B) The first day after any previous penalty period has ended; and

(ii) End on the last day of the whole number of months as described in subsection (6)(a)(ii).

(7) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC 388-513-1360 does not affect the client's eligibility;

(b) That remains after an acquisition described in subsection (7)(a) becomes an available resource as of the first day of the following month.

(8) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (6) through (8).

(9) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream not

generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in (9)(a) is divided by the statewide average monthly private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole months found by following subsections (9)(a) and (b) is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(10) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(11) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 03-14-038, § 388-513-1365, filed 6/23/03, effective 8/1/03. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-513-1365, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 11.92.180, 43.20B.-460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1365, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1365, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.585 and § 17 of the Social Security Act. 97-05-040, § 388-513-1365, filed 2/14/97, effective 3/17/97. Statutory Authority: RCW 74.08.090. 95-02-027 (Order 3818), § 388-513-1365, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-513-1365, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-395.]

WAC 388-513-1366 Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made before March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1365 for rules used to evaluate the transfer of an asset on or after March 1, 1997.

(1) When evaluating the transfer of an asset made before March 1, 1997, the department must apply rules described in WAC 388-513-1365 (1) through (4) and (7) through (11) in addition to the rules described in this section.

(2) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received before October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty months, if the asset was transferred before August 11, 1993; or

(b) Thirty-six months, if the asset was transferred on or after August 11, 1993.

(3) If a client or the client's spouse transferred an asset without receiving adequate compensation before August 11, 1993, the department must establish a penalty period that:

(a) Runs concurrently for transfers made in more than one month in the look-back period; and

(b) Begins on the first day of the month in which the asset is transferred and ends on the last day of the month which is the lesser of:

(i) Thirty months after the month of transfer; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(4) If a client or the client's spouse transferred an asset without receiving adequate compensation on or after August 11, 1993 and before March 1, 1997, the department must establish a penalty period as follows:

(a) If the transfer is made during the look-back period, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

(b) If the transfer is made while the client is receiving LTC services or during a period of ineligibility, then the penalty period:

(i) Begins on the latter of the first day of the month:

(A) In which the transfer is made; or

(B) After a previous penalty period has ended; and

(ii) Ends on the last day of the number of whole months described in subsection (3)(b)(ii).

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1366, filed 12/8/99, effective 1/8/00.]

WAC 388-513-1380 Determining a client's financial participation in the cost of care for long-term care (LTC) services. This rule describes how the department allocates income and excess resources when determining participation in the cost of care (in the post-eligibility process). The department applies rules described in WAC 388-513-1315 to define which income and resources must be used in this process.

(1) For a client receiving institutional or hospice services in a medical institution, the department applies all subsections of this rule.

(2) For a client receiving waiver services at home or in an alternate living facility, the department applies only those subsections of this rule that are cited in the rules for those programs.

(3) For a client receiving hospice services at home, or in an alternate living facility, the department applies rules used for the community options program entry system (COPES) for hospice applicants with income under the Medicaid special income level (SIL), if the client is not otherwise eligible for another noninstitutional categorically needy Medicaid program. (Note: For hospice applicants with income over the Medicaid SIL, medically needy Medicaid rules apply.)

(4) Excess resources are reduced in an amount equal to medical expenses incurred by the institutional client (for definition see WAC 388-519-0110(10)) that are not subject to third-party payment and for which the client is liable, including:

(a) Health insurance and Medicare premiums, deductions, and co-insurance charges of the institutional client;

(b) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan with the exception of the deduction for medical and remedial care expenses that were incurred during a transfer of asset penalty established per WAC 388-513-1363, 388-513-1364 or 388-513-1365; and

(c) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program, the amount described in WAC 388-513-1315(3); or

(ii) For LTC services provided under the medically needy (MN) program, the amount described in WAC 388-513-1395 (2)(a) or (b).

(5) The department allocates nonexcluded income in the following order and the combined total of (5)(a), (b), (c), and (d) cannot exceed the medically needy income level (MNIL):

(a) A personal needs allowance (PNA) of:

(i) One hundred sixty dollars for a client living in a state veterans' home;

(ii) Ninety dollars for a veteran or a veteran's surviving spouse, who receives the ninety dollar VA improved pension and does not live in a state veterans' home; or

(iii) Forty-one dollars and sixty-two cents for all clients in a medical institution receiving general assistance.

(iv) Effective July 1, 2006, fifty-three dollars and sixty-eight cents for all other clients in a medical institution.

(b) Mandatory federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the supplemental security income (SSI) program as described in WAC 388-503-0510(1); and

(ii) Receives the wages as part of a department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction employment expenses are not deducted.

(d) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(6) The department allocates nonexcluded income after deducting amounts described in subsection (5) in the following order:

(a) Income garnisheed for child support:

(i) For the time period covered by the PNA; and

(ii) Not deducted under another provision in the post-eligibility process.

(b) A monthly maintenance needs allowance for the community spouse not to exceed, effective January 1, 2007, two thousand five hundred forty-one dollars, unless a greater amount is allocated as described in subsection (8) of this section. The community spouse maintenance allowance is increased each January based on the consumer price index increase (from September to September, <http://www.bls.gov/cpi/>). The monthly maintenance needs allowance:

(i) Consists of a combined total of both:

(A) An amount added to the community spouse's gross income to provide a total of one thousand six hundred fifty dollars. This standard is based on one hundred fifty percent of the two person federal poverty level and increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>); and

(B) Excess shelter expenses as described under subsection (7) of this section; and

(ii) Is allowed only to the extent the client's income is made available to the community spouse.

(c) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community spouse or institutionalized person who:

(i) Resides with the community spouse:

(A) In an amount equal to one-third of one thousand six hundred fifty dollars less the dependent family member's income. This standard is based on one hundred fifty percent of the two person federal poverty level and increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>).

(ii) Does not reside with the community spouse or institutionalized person, in an amount equal to the MNIL for the number of dependent family members in the home less the dependent family member's income.

(iii) Child support received from noncustodial parent is the child's income.

(d) Incurred medical expenses described in subsections (4)(a) and (b) not used to reduce excess resources with the following exceptions:

(i) Private health insurance premiums for Medicare/Medicaid integration project (MMIP);

(ii) Managed care health insurance premiums for program of all-inclusive care for the elderly (PACE); and

(iii) The deduction for medical and remedial care expenses that were incurred during a transfer of asset penalty per WAC 388-513-1363, 388-513-1364 or 388-513-1365.

(e) Maintenance of the home of a single client or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client is likely to return to the home within the six-month period; and

(iv) When social services staff documents initial need for the income exemption.

(7) For the purposes of this section, "excess shelter expenses" means the actual expenses under subsection (7)(b) less the standard shelter allocation under subsection (7)(a). For the purposes of this rule:

(a) The standard shelter allocation is four hundred ninety-five dollars. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>); and

(b) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;

(ii) Mortgage;

(iii) Taxes and insurance;

(iv) Any maintenance care for a condominium or cooperative; and

(v) The food stamp standard utility allowance for four persons, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(8) The amount allocated to the community spouse may be greater than the amount in subsection (6)(b) only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(9) A client who is admitted to a medical facility for ninety days or less and continues to receive full SSI benefits is not required to use the SSI income in the cost of care for medical services. Income allocations are allowed as described in this section from non-SSI income.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and 2006 c 372, 07-01-072, § 388-513-1380, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530 and 2005 c 518 § 207 and Sec. 1924 Social Security Act (42 U.S.C. 1396r-5). 06-07-144, § 388-513-1380, filed 3/21/06, effective 4/21/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). 05-07-033, § 388-513-1380, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396r-5). 04-04-072, § 388-513-1380, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396r-5). 01-18-055, § 388-513-1380, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924(g) of the Social Security Act. 00-17-058, § 388-513-1380, filed 8/9/00, effective 9/9/00. Statutory Authority: RCW 72.36.160, 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924(g) of the Social Security Act, Section 4715 of the BBA of 1997 (Public Law 105-33, HR 2015). 99-11-017, § 388-513-1380, filed 5/10/99, effective 6/10/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 43.20B.460, 11.92.180, and Section 1924 (42 USC 396r-5). 98-08-077, § 388-513-1380, filed 3/31/98, effective 4/1/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(1)(m). 97-16-008, § 388-513-1380, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1380, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 95-11-045 (Order 3848), § 388-513-1380, filed 5/10/95, effective 6/10/95. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1380, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1380, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-360.]

WAC 388-513-1395 Determining eligibility for institutional or hospice services and for facility care only under the medically needy (MN) program. This section describes how the department determines a client's eligibility for institutional or hospice services and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance under the MN program.

(1) To be eligible for institutional or hospice services under the MN program, a client must meet the financial requirements described in subsection (5)(a). In addition, a client must meet program requirements described in WAC 388-513-1315; and

(a) Be an SSI-related client with nonexcluded income as described in subsection (4)(a) that is more than the special income level (SIL); or

(b) Be a child not described in subsection (1)(a) with nonexcluded income as described in subsection (4)(b) that exceeds the categorically needy (CN) standard for the children's medical program.

(2) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total is less than the:

(a) Private facility rate plus the amount of recurring medical expenses, for institutional services; or

(b) Private hospice rate plus the amount of recurring medical expenses, for hospice services received at home.

(3) The department determines a client's nonexcluded resources for institutional and hospice services under the MN program in the following way:

(a) For an SSI-related client, the department reduces available resources described in WAC 388-513-1350 by excluding resources described in WAC 388-513-1360;

(b) For a child not described in subsection (3)(a), no determination of resource eligibility is required.

(4) The department determines a client's nonexcluded income for institutional and hospice services under the MN program in the following way:

(a) For an SSI-related client, the department reduces available income as described in WAC 388-513-1325 and 388-513-1330 by:

(i) Excluding income described in WAC 388-513-1340;

(ii) Disregarding income described in WAC 388-513-1345; and

(iii) Subtracting previously incurred medical expenses that:

(A) Are not subject to third-party payment;

(B) Have not been used to satisfy a previous spenddown liability; and

(C) Are amounts for which the client remains liable.

(b) For a child not described in subsection (4)(a), the department:

(i) Follows the income rules described in WAC 388-505-0210 for the children's medical program; and

(ii) Subtracts the medical expenses described in subsection (4)(a)(iii).

(5) If the combined total of a client's nonexcluded income, which when added to nonexcluded resources in excess of the standard described in WAC 388-513-1350(1), is:

(a) Less than the department-contracted rate plus the amount of recurring medical expenses, the client:

(i) Is eligible for institutional and hospice services and noninstitutional medical assistance;

(ii) Is approved for a choice of three or six months as described in chapter 388-416 WAC; and

(iii) Participates in the cost of care as described in WAC 388-513-1380;

(b) Less than the private facility rate plus the amount of recurring medical expenses, but more than the department-contracted rate, the client:

(i) Is eligible for facility care only that is approved for a choice of three or six months as described in chapter 388-416 WAC;

(ii) Participates in the cost of care as described in WAC 388-513-1380; and

(iii) Is approved for noninstitutional medical assistance for a choice of three or six months as described in chapters 388-416 and 388-519 WAC, if income and resources remaining after allocations described in WAC 388-513-1380 are used to satisfy any spenddown liability.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1395, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1395, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-513-1395, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-513-1395, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1395, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-400.]

WAC 388-513-1396 Clients living in a fraternal, religious, or benevolent nursing facility. This section describes how the department determines eligibility for institutional services and noninstitutional medical assistance for a client living in a fraternal, religious, or benevolent nursing facility.

(1) For a client living in a licensed nursing facility operated by a fraternal, religious, or benevolent organization who meets all other eligibility requirements, the department approves institutional services and noninstitutional medical assistance, if:

(a) Any contract between the client and the facility excludes such benefits on a free or prepaid basis for life; or

(b) The facility is unable to fulfill the terms of the contract and has:

(i) Voided the contract; and

(ii) Refunded any of the client's existing assets to the client.

(2) For a client described in subsection (1), the department denies institutional services and noninstitutional medical assistance, if the client:

(a) Signs a contract with the organization that includes such benefits on a free or prepaid basis for life; and

(b) Surrenders income and/or resources to the organization in exchange for such benefits.

[Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1396, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1396, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-310.]

Chapter 388-515 WAC

ALTERNATE LIVING—INSTITUTIONAL MEDICAL

WAC

388-515-1505	Financial eligibility requirements for long-term care services under COPEs, New Freedom, PACE, MMIP, and WMIP.
388-515-1510	Division of developmental disabilities (DDD) waivers and outward bound residential alternatives (OBRA).
388-515-1540	Medically needy residential waiver (MNRW) effective March 17, 2003.

388-515-1550 Medically needy in-home waiver (MNIW) effective May 1, 2004.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

388-515-1530 Coordinated community AIDS services alternatives (CASA) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1530, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-515-1530, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1530, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 95-18-001 (Order 3882), § 388-515-1530, filed 8/23/95, effective 9/23/95; 94-10-065 (Order 3732), § 388-515-1530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-220.] Repealed by 03-08-067, filed 3/31/03, effective 5/1/03. Statutory Authority: RCW 74.08.090, 34.05.353 (2)(c).

WAC 388-515-1505 Financial eligibility requirements for long-term care services under COPES, New Freedom, PACE, MMIP, and WMIP. (1) This section describes the financial eligibility requirements and the rules used to determine a client's participation in the total cost of care for home or community-based long-term care (LTC) services provided under the following programs:

- (a) Community options program entry system (COPES);
- (b) Program of all-inclusive care for the elderly (PACE);
- (c) Medicare/Medicaid integration project (MMIP);
- (d) Washington Medicaid integration partnership (WMIP); and
- (e) New Freedom consumer directed services (New Freedom).

(2) To be eligible, a client must:

(a) Meet the program and age requirements for the specific program, as follows:

- (i) COPES, per WAC 388-106-0310;
- (ii) PACE, per WAC 388-106-0705;
- (iii) MMIP waiver services, per WAC 388-106-0725;
- (iv) WMIP waiver services, per WAC 388-106-0750; or
- (v) New Freedom, per WAC 388-106-1410.

(b) Meet the aged, blind or disability criteria of the Supplemental Security Income (SSI) program as described in WAC 388-511-1105(1);

(c) Require the level of care provided in a nursing facility as described in WAC 388-106-0355;

(d) Be residing in a medical facility as defined in WAC 388-500-0005, or likely to be placed in one within the next thirty days in the absence of home or community-based LTC services provided under one of the programs listed in subsection (1) of this section;

(e) Have attained institutional status as described in WAC 388-513-1320;

(f) Be determined in need of home or community-based LTC services and be approved for a plan of care as described in subsection (2)(a)(i), (ii), or (iii);

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted:

- (i) Enhanced adult residential care (EARC) facility;

(ii) Licensed adult family home (AFH); or

(iii) Assisted living (AL) facility.

(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1364, 388-513-1365 and 388-513-1366; and

(i) Meet the resource and income requirements described in subsections (3), (4), and (5) or be an SSI beneficiary not subject to a penalty period as described in subsection (2)(h).

(3) Refer to WAC 388-513-1315 for rules used to determine nonexcluded resources and income.

(4) Nonexcluded resources above the standard described in WAC 388-513-1350(1):

(a) Are allowed during the month of an application or eligibility review, when the combined total of excess resources and nonexcluded income does not exceed the special income level (SIL).

(b) Are reduced by medical expenses incurred by the client (for definition, see WAC 388-519-0110(10)) that are not subject to third-party payment and for which the client is liable, including:

(i) Health insurance and Medicare premiums, deductions, and co-insurance charges; and

(ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan.

(c) Not allocated to participation must be at or below the resource standard. If excess resources are not allocated to participation, then the client is ineligible.

(5) Nonexcluded income must be at or below the SIL and is allocated in the following order:

(a) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Maintenance and personal needs allowances as described in subsection (7), (8), and (9) of this section;

(c) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(d) Income garnisheed for child support or withheld according to a child support order:

(i) For the time period covered by the maintenance amount; and

(ii) Not deducted under another provision in the post-eligibility process.

(e) Monthly maintenance needs allowance for the community spouse not to exceed that in WAC 388-513-1380 (6)(b) unless a greater amount is allocated as described in subsection (6) of this section. This amount:

(i) Is allowed only to the extent that the client's income is made available to the community spouse; and

(ii) Consists of a combined total of both:

(A) An amount added to the community spouse's gross income to provide the amount described in WAC 388-513-1380 (6)(b)(i)(A); and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for the community spouse's principal residence. These expenses are:

(I) Rent;

(II) Mortgage;

(III) Taxes and insurance;

(IV) Any maintenance care for a condominium or cooperative; and

(V) The food assistance standard utility allowance (for LTC services this is set at the standard utility allowance (SUA) for a four-person household), provided the utilities are not included in the maintenance charges for a condominium or cooperative;

(VI) LESS the standard shelter allocation listed in WAC 388-513-1380 (7)(a).

(f) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community or institutionalized spouse based on the living arrangement of the dependent. If the dependent:

(i) Resides with the community spouse, the amount is equal to one-third of the community spouse income allocation as described in WAC 388-513-1380 (6)(b)(i)(A) that exceeds the dependent family member's income;

(ii) Does not reside with the community spouse, the amount is equal to the MNIL for the number of dependent family members in the home less the income of the dependent family members. Child support received from an absent parent is the child's income;

(g) Incurred medical expenses described in subsection (4)(b) not used to reduce excess resources, with the following exceptions:

Private health insurance premiums for PACE, MMIP, or WMIP.

(6) The amount allocated to the community spouse may be greater than the amount in subsection (5)(e) only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(7) A client who receives SSI does not use income to participate in the cost of personal care, but does use SSI income to participate in paying costs of board and room. When such a client lives:

(a) At home, the SSI client does not participate in the cost of personal care;

(b) In an enhanced adult residential center (EARC), adult family home (AFH), or assisted living (AL), the SSI client:

(i) Retains a personal needs allowance (PNA) of fifty-eight dollars and eighty-four cents;

(ii) Pays the facility for the cost of board and room. Board and room is the SSI federal benefit rate (FBR) minus fifty-eight dollars and eighty-four cents; and

(iii) Does not participate in the cost of personal care if any income remains.

(8) An SSI-related client living:

(a) At home, retains a maintenance needs amount equal to the following:

(i) Up to one hundred percent of the one-person FPL, if the client is:

(A) Single; or

(B) Married, and is:

(I) Not living with the community spouse; or

(II) Whose spouse is receiving long-term care (LTC) services outside of the home.

(ii) Up to one hundred percent of the one-person FPL for each client, if both spouses are receiving COPEs, New Freedom, PACE, MMIP, or WMIP services;

(iii) Up to the one-person medically needy income level (MNIL) for a married client who is living with a community spouse who is not receiving COPEs, New Freedom, PACE, MMIP, or WMIP.

(b) In an EARC, AFH, or AL, retains a maintenance needs amount equal to the SSI FBR and:

(i) Retains a personal needs allowance (PNA) of fifty-eight dollars and eighty-four cents from the maintenance needs; and

(ii) Pays the remainder of the maintenance needs to the facility for the cost of board and room. (Refer to subsection (11) in this section for allocation of the balance of income remaining over maintenance needs.)

(9) A client who is eligible for the general assistance expedited Medicaid disability (GAX) program does not participate in the cost of personal care. When such a client lives:

(a) At home, the client retains the cash grant amount authorized under the general assistance program;

(b) In an AFH, the client retains a PNA of thirty-eight dollars and eighty-four cents, and pays remaining income and GAX grant to the facility for the cost of board and room; or

(c) In an EARC or AL, the client only receives a PNA of thirty-eight dollars and eighty-four cents and retains it.

(10) The total of the following amounts cannot exceed the SIL:

(a) Maintenance and personal needs allowances as described in subsections (7), (8), and (9);

(b) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (5)(a); and

(c) Guardianship fees and administrative costs in subsection (5)(c).

(11) The client's remaining income after the allocations described in subsections (5) through (9) is the client's participation in the total cost of care.

[Statutory Authority: RCW 74.08.090, 42 C.F.R. 441.302(a), Social Security Act section 1915(c) waiver rules, 42 C.F.R. 438.06-18-058, § 388-515-1505, filed 8/31/06, effective 10/1/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530. 06-03-079, § 388-515-1505, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 05-03-077, § 388-515-1505, filed 1/17/05, effective 2/17/05; 02-05-003, § 388-515-1505, filed 2/7/02, effective 3/10/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 01-02-052, § 388-515-1505, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). 00-01-087, § 388-515-1505, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-14-058 (Order 100346), § 388-515-1505, filed 6/27/96, effective 7/28/96; 95-20-030 (Order 3899), § 388-515-1505, filed 9/27/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-515-1505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-200.]

WAC 388-515-1510 Division of developmental disabilities (DDD) waivers and outward bound residential alternatives (OBRA). This section describes the eligibility requirements for waiver services under the four DDD waivers and OBRA programs and the rules used to determine a client's participation in the cost of care.

(1) The four DDD waivers are:

(a) Basic,

(b) Basic Plus,

(c) Core, and

(d) Community protection.

(2) The requirements for services for DDD waivers are contained in chapter 388-845 WAC. The department establishes eligibility for DDD waivers and OBRA services for a client who:

(a) Is both Medicaid eligible under the categorically needy (CN) program and meets the requirements for services provided by the division of developmental disabilities (DDD);

(b) Has attained institutional status as described in WAC 388-513-1320;

(c) Has been assessed as requiring the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR);

(d) Has a department-approved plan of care that includes support services to be provided in the community;

(e) Is able to reside in the community according to the plan of care and chooses to do so;

(f) Meets the income and resource requirements described in subsection (3); and

(g) For the OBRA program only, the client must be a medical facility resident at the time of application.

(3) The department allows a client to have nonexcluded resources in excess of the standard described in WAC 388-513-1350(1) during the month of either an application or eligibility review if, when excess resources are added to nonexcluded income, the combined total does not exceed the special income level (SIL). Refer to WAC 388-513-1315 for rules used to determine nonexcluded income and resources. During other months, financial requirements include the following:

(a) Nonexcluded income must be at or below the SIL; and

(b) Nonexcluded resources not allocated to participation in a prior month must be at or below the resource standard.

(4) A client who is eligible for supplemental security income (SSI) does not participate in the cost of care for DDD waivers or OBRA services.

(5) An SSI-related client retains a maintenance needs amount of up to the SIL, who is:

(a) Living at home; or

(b) Living in an alternate living facility described in WAC 388-513-1305(1).

(6) A client described in subsection (5)(b) retains the greater of:

(a) The SSI grant standard; or

(b) An amount equal to a total of the following:

(i) A personal needs allowance (PNA) of thirty-eight dollars and eighty-four cents; plus

(ii) The facility's monthly rate for board and room, which the client pays to the facility; plus

(iii) The first twenty dollars of monthly earned or unearned income; and

(iv) The first sixty-five dollars plus one-half of the remaining earned income not previously excluded.

(7) If a client has a spouse in the home who is not receiving DDD waivers or OBRA services, the department allocates the client's income in excess of the amounts described in subsections (5) and (6) as an additional maintenance needs amount in the following order:

(a) One for the spouse, as described in WAC 388-513-1380 (7)(b); and

(b) One for any other dependent family member in the home, as described in WAC 388-513-1380 (7)(c).

(8) A client's participation in the cost of care for DDD waivers or OBRA services is the client's income:

(a) That exceeds the amounts described in subsections (5), (6), and (7); and

(b) Remains after deductions for medical expenses not subject to third-party payment for which the client remains liable, included in the following:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical care recognized under state law but not covered by Medicaid.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, chapters 71A.10 and 71A.12 RCW, 2004 c 276, 04-18-054, § 388-515-1510, filed 8/27/04, effective 9/27/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500; 01-02-052, § 388-515-1510, filed 12/28/00, effective 1/28/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-515-1510, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-515-1510, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-515-1510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-210.]

WAC 388-515-1540 Medically needy residential waiver (MNRW) effective March 17, 2003. This section describes the financial eligibility requirements for waiver services under the medically needy residential waiver (MNRW) and the rules used to determine a client's responsibility in the total cost of care.

(1) To be eligible for MNRW, a client must meet the following conditions:

(a) Does not meet financial eligibility for Medicaid personal care or the COPES program;

(b) Is eighteen years of age or older;

(c) Meets the SSI related criteria described in WAC 388-511-1105(1);

(d) Requires the level of care provided in a nursing facility as described in WAC 388-106-0355;

(e) In the absence of waiver services described in WAC 388-106-0400, would continue to reside in a medical facility as defined in WAC 388-513-1301, or will likely be placed in one within the next thirty days;

(f) Has attained institutional status as described in WAC 388-513-1320;

(g) Has been determined to be in need of waiver services as described in WAC 388-106-0410;

(h) Lives in one of the following department-contracted residential facilities:

(i) Licensed adult family home (AFH);

(ii) Assisted living (AL) facility; or

(iii) Enhanced adult residential care (EARC) facility.

(i) Is not subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1364, 388-513-1365 and 388-513-1366; and

(j) Meets the resource and income requirements described in subsections (2) through (6).

(2) The department determines a client's nonexcluded resources under MNRW as described in WAC 388-513-1350 (1) through (4)(a) and WAC 388-513-1360;

(3) Nonexcluded resources, after disregarding excess resources described in (4), must be at or below the resource standard described in WAC 388-513-1350 (1) and (2).

(4) In determining a client's resource eligibility, the department disregards excess resources above the standard described in subsection (3) of this section:

(a) In an amount equal to incurred medical expenses such as:

(i) Premiums, deductibles, and co-insurance/co-payment charges for health insurance and Medicare premiums;

(ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan; or

(iii) Necessary medical care covered under the state's Medicaid plan.

(b) As long as the incurred medical expenses:

(i) Are not subject to third-party payment or reimbursement;

(ii) Have not been used to satisfy a previous spend down liability;

(iii) Have not previously been used to reduce excess resources;

(iv) Have not been used to reduce client responsibility toward cost of care; and

(v) Are amounts for which the client remains liable.

(5) The department determines a client's countable income under MNRW in the following way:

(a) Considers income available described in WAC 388-513-1325 and 388-513-1330 (1), (2), and (3);

(b) Excludes income described in WAC 388-513-1340;

(c) Disregards income described in WAC 388-513-1345;

(d) Deducts monthly health insurance premiums, except Medicare premiums.

(6) If the client's countable income is:

(a) Less than the residential facility's department-contracted rate, based on an average of 30.42 days in a month the client may qualify for MNRW subject to availability per WAC 388-106-0435;

(b) More than the residential facility's department-contracted rate, based on an average of 30.42 days in a month the client may qualify for MNRW when they meet the requirements described in subsections (7) through (9), subject to availability per WAC 388-106-0435.

(7) The portion of a client's countable income over the department-contracted rate is called "excess income."

(8) A client who meets the requirements for MNRW chooses a three or six month base period. The months must be consecutive calendar months.

(9) A client who has or will have "excess income" is not eligible for MNRW until the client has medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown." The excess income from each of the months in the base period is added together to determine the total "spenddown" amount.

(10) Medical expenses described in subsection (4) of this WAC may be used to meet spenddown if not already used in subsection (4) of this WAC to disregard excess resources or to reduce countable income as described in subsection (5)(d).

(11) In cases where spenddown has been met, medical coverage begins the day services are authorized.

(12) The client's income that remains after determining available income in WAC 388-513-1325 and 388-513-1330

(1), (2), (3) and excluded income in WAC 388-513-1340 is paid towards the cost of care after deducting the following amounts in the order listed:

(a) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Personal needs allowance (PNA) described in WAC 388-515-1505 (7)(b);

(c) Medicare and health insurance premiums not used to meet spenddown or reduce excess resources;

(d) Incurred medical expenses described in (4) not used to meet spenddown or reduce excess resources.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-515-1540, filed 5/17/05, effective 6/17/05. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-515-1540, filed 6/12/03, effective 7/13/03.]

WAC 388-515-1550 Medically needy in-home waiver (MNIW) effective May 1, 2004. This section describes the financial eligibility requirements for waiver services under the medically needy in-home waiver (MNIW) and the rules used to determine a client's responsibility in the total cost of care.

(1) To be eligible for MNIW, a client must:

(a) Not meet financial eligibility for Medicaid personal care or the COPES program;

(b) Be eighteen years of age or older;

(c) Meet the SSI-related criteria described in WAC 388-475-0050(1);

(d) Require the level of care provided in a nursing facility as described in WAC 388-106-0355;

(e) In the absence of waiver services described in WAC 388-106-0500, continue to reside in a medical facility as defined in WAC 388-513-1301, or will likely be placed in one within the next thirty days;

(f) Have attained institutional status as described in WAC 388-513-1320;

(g) Have been determined to be in need of waiver services as described in WAC 388-106-0510;

(h) Be able to live at home with community support services and choose to remain at home;

(i) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1364, 388-513-1365 and 388-513-1366; and

(j) Meet the resource and income requirements described in subsections (2) through (6) of this section.

(2) The department determines a client's nonexcluded resources under MNIW as described in WAC 388-513-1350 (1) through (4)(a) and 388-513-1360;

(3) Nonexcluded resources, after disregarding excess resources described in subsection (4) of this section, must be at or below the resource standard described in WAC 388-513-1350 (1) and (2).

(4) In determining a client's resource eligibility, the department disregards excess resources above the standard described in subsection (3) of this section:

(a) In an amount equal to incurred medical expenses such as:

(i) Premiums, deductibles, and co-insurance/co-payment charges for health insurance and Medicare premiums;

(ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan; or

(iii) Necessary medical care covered under the state's Medicaid plan.

(b) As long as the incurred medical expenses:

(i) Are not subject to third-party payment or reimbursement;

(ii) Have not been used to satisfy a previous spenddown liability;

(iii) Have not previously been used to reduce excess resources;

(iv) Have not been used to reduce client responsibility toward cost of care; and

(v) Are amounts for which the client remains liable.

(5) The department determines a client's countable income under MNIW in the following way:

(a) Considers income available described in WAC 388-513-1325 and 388-513-1330 (1), (2), and (3);

(b) Excludes income described in WAC 388-513-1340;

(c) Disregards income described in WAC 388-513-1345;

(d) Deducts monthly health insurance premiums, except Medicare premiums, not used to reduce excess resources in subsection (4) of this section;

(e) Allows an income deduction for a nonapplying spouse, equal to the one person medically needy income level (MNIL) less the nonapplying spouse's income, if the nonapplying spouse is living in the same home as the applying person.

(6) A client whose countable income exceeds the MNIL may become eligible for MNIW:

(a) When they have or expect to have medical expenses to offset their income which is over the MNIL; and

(b) Subject to availability in WAC 388-106-0535.

(7) The portion of a client's countable income over the MNIL is called "excess income."

(8) A client who has or will have "excess income" is not eligible for MNIW until the client has medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown." The excess income from each of the months in the base period is added together to determine the total "spenddown" amount.

(9) The following medical expenses may be used to meet spenddown if not already used in subsection (4) of this section to disregard excess resources or to reduce countable income as described in subsection (5)(d) of this section:

(a) An amount equal to incurred medical expenses such as:

(i) Premiums, deductibles, and co-insurance/co-payment charges for health insurance and Medicare premiums;

(ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan; and

(iii) Necessary medical care covered under the state's Medicaid plan.

(b) The cost of waiver services authorized during the base period.

(c) As long as the incurred medical expenses:

(i) Are not subject to third-party payment or reimbursement;

(ii) Have not been used to satisfy a previous spenddown liability;

(iii) Have not been used to reduce client responsibility toward cost of care; and

(iv) Are amounts for which the client remains liable.

(10) Eligibility for MNIW is effective the first full month the client has met spenddown.

(11) In cases where spenddown has been met, medical coverage and MNIW begin the day services are authorized.

(12) A client who meets the requirements for MNIW chooses a three or six month base period. The months must be consecutive calendar months.

(13) The client's income that remains after determining available income in WAC 388-513-1325 and 388-513-1330 (1), (2), (3) and excluded income in WAC 388-513-1340 is paid towards the cost of care after deducting the following amounts in the order listed:

(a) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Personal needs allowance (PNA) in an amount equal to the one-person MNIL described in WAC 388-478-0070 (1)(a);

(c) Medicare and health insurance premiums not used to meet spenddown or reduce excess resources;

(d) Incurred medical expenses described in subsection (4) of this section not used to meet spenddown or reduce excess resources.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-515-1550, filed 5/17/05, effective 6/17/05. Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-515-1550, filed 7/26/04, effective 8/26/04.]

Chapter 388-517 WAC

MEDICARE-RELATED MEDICAL ELIGIBILITY

WAC

388-517-0300	Federal Medicare savings and state-funded Medicare buy-in programs.
388-517-0310	Eligibility for federal Medicare savings and state-funded Medicare buy-in programs.
388-517-0320	Medicare savings and state-funded Medicare buy-in programs cover some client costs.
388-517-0400	Medicare coinsurance payment—Extended care patient.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-517-1710	Medicare cost-sharing programs. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1710, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1710, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-060.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300.
388-517-1715	Qualified Medicare beneficiary (QMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1715, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090. 95-14-046 (Order 3863), § 388-517-1715, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1715, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(1) and 388-517-0500(6).
388-517-1720	Qualified Medicare beneficiaries—Income and resources. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 -

- 10859, 42 U.S.C. 1396 (a)(1)(m). 97-16-008, § 388-517-1720, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090, 96-15-029, § 388-517-1720, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1720, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.
- 388-517-1730 Special low-income Medicare beneficiaries (SLMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1730, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090, 95-14-046 (Order 3863), § 388-517-1730, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1730, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(2) and 388-517-0300(4).
- 388-517-1740 Special low-income Medicare beneficiaries (SLMB)—Income and resources. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(1)(m). 97-16-008, § 388-517-1740, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090, 96-15-029, § 388-517-1740, filed 7/10/96, effective 7/10/96; 95-23-030 (Order 3917, #100251), § 388-517-1740, filed 11/8/95, effective 12/9/95; 95-11-056 (Order 3848A), § 388-517-1740, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1740, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.
- 388-517-1750 Qualified disabled working individuals (QDWI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1750, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090, 95-14-046 (Order 3863), § 388-517-1750, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1750, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-160 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(6) and 388-478-0085.
- 388-517-1760 Qualified disabled working individuals (QDWI) income and resources. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(1)(m). 97-16-008, § 388-517-1760, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090, 96-15-029, § 388-517-1760, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1760, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1760, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-160 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.
- 388-517-1770 Qualified individuals (QI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1770, filed 5/19/98, effective 6/19/98.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(7) and 388-478-0085(5).

WAC 388-517-0300 Federal Medicare savings and state-funded Medicare buy-in programs. (1) Federal Medicare savings and state-funded Medicare buy-in programs help clients pay some of the costs that Medicare does

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not cover under WAC 388-517-0320 (for program eligibility, see WAC 388-517-0310).

(2) The department offers the following Medicare savings programs to eligible clients:

- (a) Qualified medicare beneficiary (QMB);
- (b) Specified low-income medicare beneficiary (SLMB);
- (c) Qualified individual (QI-1); and
- (d) Qualified disabled working individual (QDWI).

(3) The department offers the state-funded Medicare buy-in program for clients who receive Medicaid but do not qualify for the federal Medicare savings programs.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and 42 U.S.C. 1396a(a) (Section 1902 (n)(2) of the Social Security Act of 1924). 05-14-125, § 388-517-0300, filed 7/1/05, effective 8/1/05. Statutory Authority: RCW 74.08.090, 74.09.530, 02-11-074, § 388-517-0300, filed 5/13/02, effective 6/13/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-517-0300, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1710, 388-517-1730, 388-517-1750 and 388-517-1770.]

WAC 388-517-0310 Eligibility for federal Medicare savings and state-funded Medicare buy-in programs. (1) Persons eligible for any Medicare savings programs (MSP) must:

- (a) Be eligible for or receiving Medicare Part A. Qualified disabled working individuals (QDWI) clients must be under age sixty-five;
- (b) Meet program income standards, see WAC 388-478-0085; and
- (c) Have resources at or below resource standards, see WAC 388-478-0085(6).

(2) MSP follow SSI related rules in chapter 388-475 WAC.

(3) MSP clients are entitled to a fair hearing when the department takes an adverse action such as denying or terminating MSP benefits.

(4) The department subtracts the allocations and deductions described under WAC 388-513-1380 from a long-term care client's countable income and resources when determining MSP eligibility:

- (a) Allocations to a spouse and/or dependent family member; and
- (b) Client participation in cost of care.

(5) Medicaid eligibility may affect MSP eligibility, as follows:

(a) Qualified medicare beneficiaries (QMB) and specified low income beneficiaries (SLMB) clients can receive Medicaid and still be eligible to receive QMB or SLMB benefits.

(b) Qualified individuals (QI-1) and qualified disabled working individuals (QDWI) clients who begin to receive Medicaid are no longer eligible for QI-1 or QDWI benefits.

(6) Every year, when the federal poverty level changes:

(a) The department adjusts income standards for MSP and state funded Medicare buy-in programs, see WAC 388-478-0085.

(b) The department begins to count the annual Social Security cost-of-living (COLA) increase on April 1st each year when determining eligibility for MSP and state funded Medicaid buy-in programs.

(7) There is no income limit for the state-funded Medicare buy-in program. The state-funded Medicare buy-in program is for clients who receive Medicaid but do not qualify for the federal MSP.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and 42 U.S.C. 1396a(a) (Section 1902 (n)(2) of the Social Security Act of 1924). 05-14-125, § 388-517-0310, filed 7/1/05, effective 8/1/05.]

WAC 388-517-0320 Medicare savings and state-funded Medicare buy-in programs cover some client costs. (1) For qualified medicare beneficiary (QMB) clients, the department:

(a) Pays Medicare Part A premiums (if any);
 (b) Pays Medicare Part B premiums;
 (c) Pays all coinsurance deductibles as described in subsection (6) of this section;

(d) May pay Medicare Advantage Part C premiums, if cost effective, for those clients already enrolled in Medicare Advantage Part C at the time of application for Medicare Advantage Part C premium payment. (The department does not select a Medicare Advantage Part C plan for QMB clients);

(e) Pays all coinsurance deductibles and co-payments for QMB-eligible clients enrolled in Medicare Advantage Part C as described in subsection (6) of this section; and

(f) Pays QMB premiums the first of the month following the month that QMB eligibility is determined.

(2) For specified low-income medicare beneficiary (SLMB) clients, the department pays Medicare Part B premiums effective up to three months prior to the certification period. No other payments are made for SLMBs.

(3) For qualified individual (QI-1) clients, the department pays Medicare Part B premiums effective up to three months prior to the certification period unless:

(a) The client receives Medicaid categorically needy (CN) or medically needy (MN) benefits; and/or

(b) The department's annual federal funding allotment is spent. The department resumes QI-1 benefit payments the beginning of the next calendar year.

(4) For qualified disabled working individual (QDWI) clients, the department pays Medicare Part A premiums effective up to three months prior to the certification period. The department stops paying Medicare Part A premiums if the client begins to receive CN or MN Medicaid.

(5) For state-funded Medicare buy-in program clients, the department pays Medicare:

(a) Part B premiums; and
 (b) Part A and B co-insurance, deductibles, and co-payments described in subsection (6) of this section.

(6) The department limits payments for certain services, provided to Medicare savings and state-funded Medicare buy-in clients, as follows:

(a) If the Medicaid payment rate is higher than the amount paid by Medicare, the department pays only the cost-sharing liability of the Medicare co-insurance charge; and

(b) For Medicaid clients who are entitled to Medicare Part A and/or Medicare Part B (referred to as "dual eligible" clients):

(i) The department pays the Medicare or Medicaid payment rate, whichever is less, for services covered by both Medicare and Medicaid; and

(ii) The department pays the Medicare deductibles and co-insurance services only covered by Medicare.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and 42 U.S.C. 1396a(a) (Section 1902 (n)(2) of the Social Security Act of 1924). 05-14-125, § 388-517-0320, filed 7/1/05, effective 8/1/05.]

WAC 388-517-0400 Medicare coinsurance payment—Extended care patient. The department will pay for a long-term care client's Medicare coinsurance if the:

(1) Client is eligible for extended care Medicare benefits;
 (2) Client is eligible for Medicaid, qualified Medicare beneficiary (QMB) program, or the special low-income Medicare beneficiary (SLMB) program; and

(3) Medicare co-insurance costs less than the Medicaid nursing facility rate.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.055. 01-06-033, § 388-517-0400, filed 3/2/01, effective 4/2/01.]

Chapter 388-519 WAC

SPENDDOWN

WAC

388-519-0100	Eligibility for the medically needy program.
388-519-0110	Spenddown of excess income for the medically needy program.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-519-0120	Spenddown—Medically indigent program. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0120, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1905.] Repealed by 04-20-045, filed 9/30/04, effective 10/31/04. Statutory Authority: RCW 74.08.090 and 34.05.353(2).
388-519-1905	Base period. [Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-519-1905, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-519-1905, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-519-1905, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-416-0025 and 388-519-0120.
388-519-1910	Allowable income deductions and exemptions. [Statutory Authority: RCW 74.08.090. 96-14-057 (Order 3986), § 388-519-1910, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1910, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-020 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020, 388-450-0110, 388-450-0150, 388-450-0210 and 388-519-0110.
388-519-1930	Computing spenddown; allowable spenddown expenses. [Statutory Authority: RCW 74.08.090. 96-14-057 (Order 3986), § 388-519-1930, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1930, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-020 and 388-99-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-519-0100 and 388-476-0070.
388-519-1950	Institutional spenddown. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-519-1950, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-519-0100 Eligibility for the medically needy program. (1) A person who meets the following conditions is considered for medically needy (MN) coverage under the special rules in chapter 388-513 WAC.

(a) A person who meets the institutional status requirements of WAC 388-513-1320; or

(b) A person who receives waiver services under chapter 388-515 WAC.

(2) MN coverage is considered under this chapter when a person:

(a) Is not excluded under subsection (1) of this section; and

(b) Is not eligible for categorically needy (CN) medical coverage because they have CN countable income which is above the CN income standard.

(3) MN coverage is available for children, for persons who are pregnant or for persons who are SSI-related. MN coverage is available to an aged, blind, or disabled ineligible spouse of an SSI recipient even though that spouse's countable income is below the CN income standard. Adults with no children must be SSI related in order to be qualified for MN coverage.

(4) A person not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to those used to arrive at CN countable income. The following deductions are used to calculate their countable income for MN. Those deductions to income are applied to each month of the base period and determine MN countable income:

(a) All health insurance premiums expected to be paid by the client during the base period are deducted from their income; and

(b) For persons who are SSI-related and who are married, see the income provisions for the nonapplying spouse in WAC 388-450-0210; and

(c) For persons who are not SSI-related and who are married, an income deduction is allowed for a nonapplying spouse:

(i) If the nonapplying spouse is living in the same home as the applying person; and

(ii) The nonapplying spouse is receiving community and home based services under chapter 388-515 WAC; then

(iii) The income deduction is equal to the one person MNIL less the nonapplying spouse's actual income.

(5) A person who meets the above conditions is eligible for MN medical coverage if their MN countable income is at or below the medically needy income level (MNIL) in WAC 388-478-0070. They are certified as eligible for up to twelve months of MN medical coverage. Certain SSI or SSI-related clients have a special MNIL. That MNIL exception is described in WAC 388-513-1305.

(6) A person whose MN countable income exceeds the MNIL may become eligible for MN medical coverage when they have or expect to have medical expenses. Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL.

(7) That portion of a person's MN countable income which is over the department's MNIL standard is called "excess income."

(8) When a person has or will have "excess income" they are not eligible for MN coverage until they have medical

expenses which are equal in amount to that excess income. This is the process of meeting "spenddown."

(9) A person who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter a person is ineligible for MN coverage if their resources exceed the program standard in WAC 388-478-0070. A person who is considered for MN coverage under chapter 388-513 WAC is allowed to spenddown excess resources.

(10) No extensions of coverage or automatic redetermination process applies to MN coverage. A client must submit an application for each eligibility period under the MN program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0320, 388-518-1840, 388-519-1930 and 388-522-2230.]

WAC 388-519-0110 Spenddown of excess income for the medically needy program. (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.

(2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.

(3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three calendar months immediately prior to the month of application.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three month base period would overlap a previous eligibility period; or

(b) A client is not or will not be resource eligible for the required base period; or

(c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

(d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.

(5) The amount of a person's "spenddown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spenddown" for the base period.

(6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).

(7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:

(a) First, Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;

(b) Second, medical expenses which would not be covered by the MN program;

(c) Third, hospital expenses paid by the person during the base period;

(d) Fourth, hospital expenses, regardless of age, owed by the applying person;

(e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and

(f) Sixth, other medical expenses, potentially payable by the MN program which are owed by the applying person.

(8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The beginning date of eligibility would be determined as described in WAC 388-416-0020.

(9) If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount.

(10) To be counted toward spenddown, medical expenses must:

(a) Not have been used to meet a previous spenddown; and

(b) Not be the confirmed responsibility of a third party. The entire expense will be counted unless the third party confirms its coverage within:

(i) Forty-five days of the date of the service; or

(ii) Thirty days after the base period ends; and

(c) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period and be for services for:

(A) The applying person; or

(B) A family member legally or blood-related and living in the same household as the applying person.

(ii) Be for medical services either paid or unpaid and incurred during the base period; or

(iii) Be for medical services paid and incurred during a previous base period if that client payment was made necessary due to delays in the certification for that base period.

(11) An exception to the provisions in subsection (10) of this section exists. Medical expenses the person owes are applied to spenddown even if they were paid by or are subject to payment by a publicly administered program during the base period. To qualify, the program cannot be federally funded or make the payments of a person's medical expenses from federally matched funds. The expenses do not qualify if they were paid by the program before the first day of the base period.

(12) The following medical expenses which the person owes are applied to spenddown. Each dollar of an expense or obligation may count once against a spenddown cycle that leads to eligibility for MN coverage:

(a) Charges for services which would have been covered by the department's medical programs as described in WAC 388-501-0060 and 388-501-0065, less any confirmed third party payments which apply to the charges; and

(b) Charges for some items or services not typically covered by the department's medical programs, less any third party payments which apply to the charges. The allowable

items or services must have been provided or prescribed by a licensed health care provider; and

(c) Medical insurance and Medicare copayments or coinsurance (premiums are income deductions under WAC 388-519-0100(4)); and

(d) Medical insurance deductibles including those Medicare deductibles for a first hospitalization in sixty days.

(13) Medical expenses may be used more than once if:

(a) The person did not meet their total spenddown amount and did not become eligible in that previous base period; and

(b) The medical expense was applied to that unsuccessful spenddown and remains an unpaid bill.

(14) To be considered toward spenddown, written proof of medical expenses for services rendered to the client must be presented to the department. The deadline for presenting medical expense information is thirty days after the base period ends unless good cause for delay can be documented.

(15) The medical expenses applied to the spenddown amount are the client's financial obligation and are not reimbursed by the department (see WAC 388-502-0100).

(16) Once a person meets their spenddown and they are issued a medical identification card for MN coverage, newly identified expenses cannot be considered toward that spenddown. Once the application is approved and coverage begins the beginning date of the certification period cannot be changed due to a client's failure to identify or list medical expenses.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-519-0110, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 06-13-042, § 388-519-0110, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 05-08-093, § 388-519-0110, filed 4/1/05, effective 5/2/05; 98-16-044, § 388-519-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1830, 388-518-1840, 388-519-1905, 388-519-1910, 388-519-1930 and 388-522-2230.]

Chapter 388-523 WAC MEDICAL EXTENSIONS

WAC

388-523-0100	Medical extensions—Eligibility.
388-523-0110	Medical extensions—Reporting requirements.
388-523-0120	Medical extensions—Premiums.
388-523-0130	Medical extension—Redetermination.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-523-2305	Medical extensions. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-523-2305, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-523-2305, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-029.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.
388-523-2320	Medicaid quarterly reporting. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-523-2320, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

WAC 388-523-0100 Medical extensions—Eligibility.

(1) A family who received temporary assistance for needy families (TANF), or family medical program in any three of the last six months in the state of Washington is eligible for extended medical benefits when they become ineligible for their current medical program because the family receives:

(a) Child or spousal support, which exceeds the payment standard described in WAC 388-478-0065, and they are not eligible for any other categorically needy (CN) medical program; or

(b) Increased earned income, resulting in income exceeding the CN income standard described in WAC 388-478-0065.

(2) A family is eligible to receive extended medical benefits beginning the month after termination from TANF cash or family medical program for:

(a) Four months for a family described in subsection (1)(a) of this section; or

(b) Up to twelve months, in two six-month segments, for a family described in subsection (1)(b) of this section. For the purposes of this chapter, months one through six are the initial six-month extension period. Months seven through twelve are the second six-month extension period.

(3) A family member is eligible to receive six months of medical extension benefits as described in subsection (2)(b) of this section unless:

(a) The individual family member:

(i) Moves out of state;

(ii) Dies;

(iii) Becomes an inmate of a public institution;

(iv) Leaves the household; or

(v) Does not cooperate, without good cause, with the division of child support or with third party liability requirements.

(b) The family:

(i) Moves out of state;

(ii) Loses contact with the department or the department does not know the whereabouts of the family; or

(iii) No longer includes a child as defined in WAC 388-404-0005(1).

(4) A family member is eligible to receive the second six months of medical extension benefits as described in subsection (2)(b) of this section unless:

(a) The family is no longer eligible for the reasons described in subsection (3)(a) or (b); or

(b) The individual family member is the caretaker adult who:

(i) Stops working or whose earned income stops;

(ii) Does not, without good cause, complete and return the completed medical extension report or otherwise provide the required income and child care information; or

(iii) Does not, without good cause, pay the billed premium amount for one month.

(5) A family described in subsection (3) will not receive medical extension benefits for any family member who has been found ineligible for TANF/SFA cash because of fraud in any of the six months prior to the medical extension period.

(6) For the purposes of this chapter, only individual family members that are eligible for Medicaid are certified to receive medical benefits under this program.

(2007 Ed.)

[Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-523-0100, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 02-10-018, § 388-523-0100, filed 4/22/02, effective 5/23/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-523-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2210, 388-523-2305 and 388-523-2320.]

WAC 388-523-0110 Medical extensions—Reporting requirements. (1) The family must report family income and employment-related child care costs the family pays by the twenty-first day of:

(a) Month four of the extension period, for months one, two, and three; and

(b) Month seven of the extension period, for months four, five, and six.

(2) Circumstances may prevent a family from meeting the reporting requirements in subsection (1) of this section. The family remains eligible for the medical extension when good cause exists. Reasons for good cause include, but are not limited to:

(a) Illness, mental impairment, injury, trauma, or stress;

(b) Lack of understanding the reporting requirement due to a language barrier;

(c) Transportation problems;

(d) Payment for work in each month of the reporting period was paid in a different month than it was earned;

(e) The client expected to be able to meet the family medical needs, but could not; or

(f) The client was given incorrect information about the reporting requirements. Refer to WAC 388-422-0020 (4) and (5).

[Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 02-10-018, § 388-523-0110, filed 4/22/02, effective 5/23/02.]

WAC 388-523-0120 Medical extensions—Premiums.

(1) "Countable income" means, for the purposes of determining the premium amount described in this chapter, all earned income of the adult family members, minus the amount of employment-related child care paid for by the family. The earned income of an adult, living in the household, who is financially responsible for other members of the assistance unit is included, whether or not the person is an eligible member of the assistance unit.

(2) The department requires the family to pay premiums for medical coverage provided during the second six-month medical extension period. The premium amount is one percent of the family's average countable income rounded down to the nearest whole dollar. This whole dollar amount is billed per adult per month. See subsection (3).

(3) The premiums for:

(a) Months seven, eight, and nine are based solely on the average countable income received in months one, two and three of the medical extension period; and

(b) Months ten, eleven, and twelve are based solely on the average countable income received in months four, five, and six of the medical extension period.

(4) A subsequent change in income does not effect the premium amount described in subsection (2) and (3) of this section.

(5) When a family's premium is one month in arrears, the family is ineligible for the balance of the medical extension

period unless good cause exists. Reasons for good cause include, but are not limited to:

- (a) Illness, mental impairment, injury, trauma, or stress;
- (b) Lack of understanding the premium payment requirement due to a language barrier;
- (c) Transportation problems;
- (d) Nonpayment of the premium because the client expected to be able to meet the family medical needs, but could not; or
- (e) Receipt of incorrect information or nonreceipt of advance and adequate notice about the premium payment requirements. WAC 388-422-0020 (4) and (5) provisions regarding good cause rights and periodic review apply to good cause for nonpayment of premiums.

(6) The department exempts individual family members from premium payment requirements, as follows:

- (a) Children;
- (b) Pregnant women;
- (c) American Indians and Alaska Natives; and
- (d) Caretaker adults in a family whose countable income is equal to or less than one hundred percent of the federal poverty level based on family size as described in WAC 388-478-0075(2).

(7) When determining the exemption described in subsection (6)(b), the premium exemption is effective the first of the month following the client's report of the pregnancy to the department.

(8) When determining the exemption described in subsection (6)(d), the department shall include in the household size an unborn child and a person who is financially responsible for other members of the assistance unit, whether or not the person is an eligible member of the assistance unit. A person receiving SSI cash assistance is not included when determining the household size.

(9) The department determines a family's exemption from the premium requirement as described in subsection (6)(d) for:

- (a) Months seven, eight and nine based solely on information available to the department at the time the premium for these months is calculated; and
- (b) Months ten, eleven, and twelve based solely on information available to the department at the time the premium for these months is calculated.

(10) Any change resulting in an individual meeting the exemption criteria in subsection (6)(d) after the establishment of the premium amount for months seven, eight and nine is used to calculate the premium amount for months ten, eleven, and twelve. Any change resulting in an individual meeting the exemption criteria in subsection (6)(d) after the establishment of the premium amount for months ten, eleven, and twelve is not used to recalculate the premium amount for months ten, eleven, and twelve.

[Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 03-14-108, § 388-523-0120, filed 6/30/03, effective 6/30/03; 02-10-018, § 388-523-0120, filed 4/22/02, effective 5/23/02.]

WAC 388-523-0130 Medical extension—Redetermination. (1) When the department determines the family or an individual family member is ineligible during the medical extension period, the department must determine if they are eligible for another medical program.

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(2) Children are eligible for twelve month continuous eligibility beginning with the first month of the medical extension period.

(3) When a family reports a reduction of income, the family may be eligible for a family medical program instead of medical extension benefits.

(4) Postpartum and family planning extensions are described in WAC 388-462-0015.

[Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-523-0130, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.08.090 and 2001 c 7 § 209. 02-10-018, § 388-523-0130, filed 4/22/02, effective 5/23/02.]

Chapter 388-526 WAC MEDICAL FAIR HEARINGS

WAC

388-526-2610 Prehearing reviews for clients who request a fair hearing.

WAC 388-526-2610 Prehearing reviews for clients who request a fair hearing. (1) A client who does not agree with a department decision regarding medical or dental services has a right to a fair hearing under chapter 388-02 WAC.

(a) See chapter 388-538 WAC for hearing requests regarding managed care plans;

(b) See chapter 388-542 WAC for hearing requests regarding the children's health insurance program (CHIP);

(c) See WAC 388-502-0165 for requests for noncovered services.

(2) When a fair hearing is requested, either the client or MAA has the right to request and the client receive a medical assessment appropriate to the nature of the decision from one or more professionally qualified persons who are not a party to the action being appealed. WAC 388-538-120 applies to clients who are managed care enrollees.

(3) After receiving a request for a fair hearing, MAA may request additional information from the client, the provider, or the department. After MAA reviews the available information, the result may be:

(a) A reversal of the initial department decision;

(b) Resolution of the client's issue(s); or

(c) A fair hearing conducted per chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 34.05.060. 00-21-062, § 388-526-2610, filed 10/16/00, effective 11/16/00. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-526-2610, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-040.]

Chapter 388-527 WAC ESTATE RECOVERY

WAC

388-527-2700	Purpose.
388-527-2730	Definitions.
388-527-2733	Estate liability.
388-527-2737	Deferring recovery.
388-527-2740	Age when recovery applies.
388-527-2742	Services subject to recovery.
388-527-2750	Delay of recovery for undue hardship.
388-527-2754	Assets not subject to recovery and other limits on recovery.
388-527-2790	Filing liens.
388-527-2810	Life estates and joint tenancy.
388-527-2820	Liens prior to death.
388-527-2830	Request for notice of transfer or encumbrance.

(2007 Ed.)

388-527-2840	Termination of request for notice of transfer or encumbrance.
388-527-2850	Notice of transfer or encumbrance.
388-527-2860	Interest assessed on past due debt.
388-527-2870	Serving notices on the office of financial recovery (OFR).

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-527-2710	Recovery from estates. [Statutory Authority: RCW 74.08.090 and OBRA 1993, HB 2492. 94-17-035 (Order 3768), § 388-527-2710, filed 8/10/94, effective 9/10/94. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-527-2710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-047.] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.
388-527-2720	Restitution. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-527-2720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-050] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.
388-527-2735	Liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2735, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.
388-527-2752	Deferring recovery. [Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2752, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.
388-527-2753	No liability for medical care. [Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2753, filed 9/6/95, effective 10/7/95.] Repealed by 99-11-076, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010.
388-527-2792	Interest assessed on past due debt. [Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2792, filed 4/30/04, effective 6/1/04.] Repealed by 06-17-075, filed 8/14/06, effective 9/14/06. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p.
388-527-2795	Serving notices on office of financial recovery (OFR). [Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2795, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2795, filed 5/18/99, effective 6/18/99.] Repealed by 06-17-075, filed 8/14/06, effective 9/14/06. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p.

WAC 388-527-2700 Purpose. This chapter describes the requirements, limitations, and procedures that apply when the department recovers the cost of medical care from the estate of a deceased client and when the department files liens prior to the client's death.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2700, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2700, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2700, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2730 Definitions. The following definitions apply to this chapter:

(2007 Ed.)

"Contract health service delivery area (CHSDA)" means the geographic area within which contract health services will be made available by the Indian Health Service to members of an identified Indian community who reside in the area as identified in 42 C.F.R. Sec. 136.21(d) and 136.22.

"Estate" means all property and any other assets that pass upon the client's death under the client's will or by intestate succession pursuant to chapter 11.04 RCW or under chapter 11.62 RCW. The value of the estate will be reduced by any valid liability against the decedent's property at the time of death. An estate also includes:

(1) For a client who died after June 30, 1995 and before July 27, 1997, nonprobate assets as defined by RCW 11.02.-005, except property passing through a community property agreement; or

(2) For a client who died after July 26, 1997 and before September 14, 2006, nonprobate assets as defined by RCW 11.02.005.

(3) For a client who died on or after September 14, 2006, nonprobate assets as defined by RCW 11.02.005 and any life estate interest held by the recipient immediately before death.

"Heir" means the decedent's surviving spouse and children (natural and adopted); or those persons who are entitled to inherit the decedent's property under a will properly executed under RCW 11.12.020 and accepted by the probate court as a valid will.

"Joint tenancy" means ownership of property held under circumstances that entitle one or more owners to the whole of the property on the death of the other owner(s), including, but not limited to, joint tenancy with right of survivorship.

"Life estate" means an ownership interest in a property only during the lifetime of the person(s) owning the life estate. In some cases, the ownership interest lasts only until the occurrence of some specific event, such as remarriage of the life estate owner. A life estate owner may not have the legal title or deed to the property, but may have rights to possession, use, income and/or selling their life estate interest in the property.

"Lis pendens" means a notice filed in public records warning that title to certain real property is in litigation and the outcome of the litigation may affect the title.

"Long-term care services" means, for the purposes of this chapter only, the services administered directly or through contract by the department of social and health services for clients of the home and community services division and division of developmental disabilities including, but not limited to, nursing facility care and home and community services.

"Medicaid" means the state and federally funded program that provides medical services under Title XIX of the Federal Social Security Act.

"Medical assistance" means both Medicaid and medical care services.

"Medicare Savings programs" means the programs described in WAC 388-517-0300 that help a client pay some of the costs that Medicare does not cover.

"Property": Examples include, but are not limited to, personal property, real property, title property, and trust property as described below:

(1) **"Personal property"** means any property that is not classified as real, title, or trust property in the definitions provided here;

(2) **"Qualified individual"** means an heir or an unmarried individual who, immediately prior to the client's death, was eighteen years of age or older, shared the same regular and permanent residence with the client and with whom the client had an exclusive relationship of mutual support, caring, and commitment.

(3) **"Real property"** means land and anything growing on, attached to, or erected thereon;

(4) **"Title property"** means, for the purposes of this chapter only, property with a title such as motor homes, mobile homes, boats, motorcycles, and vehicles.

(5) **"Trust property"** means any type of property interest titled in, or held by, a trustee for the benefit of another person or entity.

"State-only funded long-term care" means the long-term care services that are financed with state funds only.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2730, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2730, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2730, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2730, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2733 Estate liability. (1) The client's estate is not liable for services provided before July 26, 1987.

(2) The client's estate is not liable when the client died before July 1, 1994 and on the date of death there was:

- (a) A surviving spouse; or
- (b) A surviving child who was either:
 - (i) Under twenty-one years of age; or
 - (ii) Blind or disabled as defined under chapter 388-511 WAC.

(3) The estate of a frail elder or vulnerable adult under RCW 74.34.005 is not liable for the cost of adult protective services (APS) financed with state funds only.

(4) The client's estate is not liable for amounts paid for Medicare premiums and other cost-sharing expenses incurred on behalf of a client who is eligible only for the Medicare Savings programs, and not otherwise Medicaid eligible.

[Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2733, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2733, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2737 Deferring recovery. (1) For a client who died after June 30, 1994, the department defers recovery from the estate until:

- (a) The death of the surviving spouse, if any; and
- (b) There is no surviving child who is:
 - (i) Under twenty-one years of age, or
 - (ii) Blind or disabled as defined under chapter 388-511 WAC.

(2) The department may place a lien against property to evidence the department's right to recover after the deferral period specified in subsection (1) of this section.

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[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2737, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2737, filed 5/18/99, effective 6/18/99.]

WAC 388-527-2740 Age when recovery applies. The client's age and the date when services were received determine whether the client's estate is liable for the cost of medical services provided. Subsection (1) of this section covers liability for Medicaid services and subsection (2) covers liability for state-only funded long-term care services. An estate may be liable under both subsections.

(1) For a client who on July 1, 1994 was:

(a) Age sixty-five or older, the client's estate is liable for Medicaid services that were subject to recovery and provided on and after the date the client became age sixty-five or after July 26, 1987, whichever is later;

(b) Age fifty-five through sixty-four years of age, the client's estate is liable for Medicaid services that were subject to recovery and provided on and after July 1, 1994; or

(c) Under age fifty-five, the client's estate is liable for Medicaid services that were subject to recovery and provided on and after the date the client became age fifty-five.

(2) Regardless of the client's age when the services were provided, the client's estate is liable for state-only funded long-term care services provided to:

(a) Home and community services' clients on and after July 1, 1995; and

(b) Division of developmental disabilities' clients on and after June 1, 2004.

[Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2740, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2740, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2740, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2742 Services subject to recovery. The department considers the medical services the client received and the dates when the services were provided to the client, in order to determine whether the client's estate is liable for the cost of medical services provided. Subsection (1) of this section covers liability for Medicaid services and subsection (2) covers liability for state-only funded long-term care services. An estate can be liable under both subsections.

(1) The client's estate is liable for:

(a) All Medicaid services provided from July 26, 1987 through June 30, 1994;

(b) The following Medicaid services provided after June 30, 1994 and before July 1, 1995:

- (i) Nursing facility services;
- (ii) Home and community-based services; and
- (iii) Hospital and prescription drug services provided to a client while receiving nursing facility services or home and community-based services.

(c) The following Medicaid services provided after June 30, 1995 and before June 1, 2004:

- (i) Nursing facility services;
- (ii) Home and community-based services;
- (iii) Adult day health;
- (iv) Medicaid personal care;

(v) Private duty nursing administered by the aging and disability services administration of the department; and

(vi) Hospital and prescription drug services provided to a client while receiving services described under (c)(i), (ii), (iii), (iv), or (v) of this subsection.

(d) The following services provided on and after June 1, 2004:

(i) All Medicaid services;

(ii) Medicare savings programs services for individuals also receiving Medicaid;

(iii) Medicare premiums only for individuals also receiving Medicaid; and

(iv) Premium payments to managed care organizations.

(2) The client's estate is liable for all state-only funded long-term care services and related hospital and prescription drug services provided to:

(a) Home and community services' clients on and after July 1, 1995; and

(b) Division of developmental disabilities' clients on and after June 1, 2004.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2742, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2742, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2742, filed 5/18/99, effective 6/18/99. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2742, filed 9/6/95, effective 10/7/95.]

WAC 388-527-2750 Delay of recovery for undue hardship. The department delays recovery under this section when the department determines that recovery would cause an undue hardship for a qualified individual(s). This delay is limited to the period during which the undue hardship exists. The undue hardship must exist at the time of the client's death in order to be considered for a delay of recovery.

(1) Undue hardship exists when:

(a) The estate subject to adjustment or recovery is the sole income-producing asset of one or more qualified individuals and income is limited; or

(b) Recovery would deprive a qualified individual of shelter and the qualified individual lacks the financial means to obtain and maintain alternative shelter.

(2) Undue hardship does not exist when:

(a) The adjustment or recovery of the decedent's cost of assistance would merely cause the qualified individual inconvenience or restrict his or her lifestyle; or

(b) The undue hardship was created as a result of estate planning methods by which the qualified individual or deceased client divested, transferred or otherwise encumbered assets, in whole or in part, to avoid recovery from the estate.

(3) When a delay in recovery is not granted, the department provides notice to the person who requested the delay of recovery. The department's notice includes information on how to request an administrative hearing to contest the department's denial.

(4) When a delay of recovery is granted, the department may revoke the delay of recovery if the qualified individual(s):

(a) Fails to supply timely information and resource declaration when requested by the department;

(b) Sells, transfers, or encumbers title to the property;

(c) Fails to reside full-time on the premises;

(d) Fails to pay property taxes and utilities when due;

(e) Fails to identify the state of Washington as the primary payee on the property insurance policies. The person granted the delay of recovery must provide the department with documentation of the coverage status on an annual basis.

(f) Have a change in circumstances under subsection (1) of this section for which the delay of recovery due to undue hardship was granted; or

(g) Dies.

(5) When a delay of recovery is granted due to undue hardship, the department has the option to:

(a) Apply a lien; and/or

(b) Accept a payment plan.

(6) A person may request an administrative hearing to contest the department's denial of delay of recovery due to undue hardship when that person suffered a loss because the delay was not granted.

(7) A request for an administrative hearing under this section must:

(a) Be in writing;

(b) State the basis for contesting the department's denial of the request for a delay of recovery due to an undue hardship;

(c) Include a copy of the department's denial;

(d) Be signed by the requester and include the requester's address and telephone number; and

(e) Be served, as described in WAC 388-527-2870, on the office of financial recovery (OFR) within twenty-eight calendar days of the date that the department sent the decision denying the request for a delay of recovery.

(8) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the property and other assets of the time and place of the administrative hearing.

(9) An adjudicative proceeding held under this section is governed by chapters 34.05 RCW and 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2750, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2750, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-527-2750, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2750, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2750, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2754 Assets not subject to recovery and other limits on recovery. (1) Recovery does not apply to the first fifty thousand dollars of the estate value at the time of death and is limited to thirty-five percent of the remaining value of the estate for services the client:

(a) Received before July 25, 1993; and

(b) When the client died with:

- (i) No surviving spouse;
- (ii) No surviving child who is:
- (A) Under twenty-one years of age;
- (B) Blind; or
- (C) Disabled.
- (iii) A surviving child who is twenty-one years of age or older.

(2) For services received after July 24, 1993, all services recoverable under WAC 388-527-2742 will be recovered, even from the first fifty thousand dollars of estate value that is exempt above, except as set forth in subsections (3) through (8) of this section.

(3) For a client who received services after July 24, 1993 and before July 1, 1994, the following property, up to a combined fair market value of two thousand dollars, is not recovered from the estate of the client:

- (a) Family heirlooms;
- (b) Collectibles;
- (c) Antiques;
- (d) Papers;
- (e) Jewelry;
- (f) Photos; and
- (g) Other personal effects of the deceased client and to which a surviving child is entitled.

(4) Certain properties belonging to American Indians/Alaska Natives (AI/AN) are exempt from estate recovery if at the time of death:

(a) The deceased client was enrolled in a federally recognized tribe; and

(b) The estate or heir documents the deceased client's ownership interest in trust or nontrust real property and improvements located on a reservation, near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior, or located:

(i) Within the most recent boundaries of a prior federal reservation; or

(ii) Within the Contract Health Service Delivery Area boundary for social services provided by the deceased client's tribe to its enrolled members.

(5) Protection of trust and nontrust property under subsection (4) is limited to circumstances when the real property and improvements pass from an Indian (as defined in 25 U.S.C. Chapter 17, Sec. 1452(b)) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses and step-children, that their culture would nonetheless protect as family members, to a tribe or tribal organization and/or to one or more Indians.

(6) Certain AI/AN income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) are exempt from estate recovery by other laws and regulations.

(7) Ownership interests in or usage rights to items that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom.

(8) Government reparation payments specifically excluded by federal law in determining eligibility are exempt from estate recovery as long as such funds have been kept

segregated and not commingled with other countable resources and remain identifiable.

[Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2754, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2754, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2754, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2790 Filing liens. (1) The department files liens, seeks adjustments, and uses other means to recover the cost of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of a client consistent with 42 U.S.C. 1396p and chapters 43.20B RCW and 388-527 WAC.

(2) Prior to the department filing a lien under this section, the department sends a notice via first class mail to:

(a) The address of the property and other assets subject to the lien;

(b) The probate estate's personal representative, if any;

(c) Any other person known to have title to the affected property and/or to the decedent's heir(s) as defined by WAC 388-527-2730; and

(d) The decedent's last known address or the address listed on the title, if any.

(3) The notice in subsection (2) of this section includes:

(a) The decedent's name, identification number, date of birth, and date of death;

(b) The amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the deceased client that the department seeks to recover;

(c) The department's intent to file a lien against the deceased client's property and other assets to recover the amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the deceased client;

(d) The county in which the property and other assets are located; and

(e) The procedures to contest the department's decision to file a lien by applying for an administrative hearing.

(4) An administrative hearing only determines:

(a) Whether the medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the decedent alleged by the department's notice is correct;

(b) Whether the decedent had legal title to the property; and

(c) Whether a lien is allowed under the provisions of Title 42 USC Section 1396p (a) and (b).

(5) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the lien;

(c) Be signed by the requester and must include the requester's address and telephone number; and

(d) Be served to the office of financial recovery (OFR) as described in WAC 388-527-2870, within twenty-eight calendar days of the date the department mailed the notice.

(6) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the

property and other assets of the time and place of the administrative hearing.

(7) An administrative hearing under this section is governed by chapters 34.05 RCW and 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

(8) If an administrative hearing is conducted in accordance with this regulation, and the final agency decision is issued, the department only files a lien against the decedent's property and other assets if upheld by the final agency decision.

(9) If no known title holder requests an administrative hearing, the department files a lien twenty-eight calendar days after the date the department mailed the notice described in subsection (2) of this section.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2790, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2790, filed 4/30/04, effective 6/1/04. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-527-2790, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 43.20B.080, 74.08.090 and 74.34.010. 99-11-076, § 388-527-2790, filed 5/18/99, effective 6/18/99. Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2790, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2810 Life estates and joint tenancy.

(1) The department may enforce a lien authorized under this section against a decedent's life estate or joint tenancy interest in real property held by the decedent immediately prior to his or her death until the lien is satisfied. The department will not apply a lien against a decedent's life estate interest providing the decedent had not previously transferred an interest in the property while retaining a life estate.

(a) The value of the life estate subject to the lien is the fair market value of the decedent's interest in the property subject to the life estate immediately prior to death.

(b) The value of the joint tenancy interest subject to the lien is the value of the decedent's fractional interest he or she would have owned in the jointly held interest in the property had the decedent and the surviving joint tenants held title to the property as tenants in common immediately prior to death.

(2) The department's methodology for calculating the value of the life estate is determined using fair market value of the property. To determine the value of the life estate, the department multiplies the current fair market value of the property by the life estate factor in the life estate table. (The Centers for Medicare and Medicaid Services based table is found in the department's Eligibility A-Z Manual, Long Term Care, Appendix II and is available on-line at: <http://www1.dshs.wa.gov/esa/eazmanual/>.)

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2810, filed 8/14/06, effective 9/14/06.]

WAC 388-527-2820 Liens prior to death. (1) Subject to the requirements of 42 USC Section 1396p and the conditions of this section, the department is authorized to file a lien against the property of a medical assistance client prior to his or her death, and to seek adjustment and recovery from the client's estate or sale of the property subject to the lien if:

(a) The client is permanently an inpatient in a nursing facility, intermediate care facility for individuals with mental retardation, or other medical institution as described in WAC 388-500-0005;

(b) The department determines, after notice and opportunity for a hearing, that the client cannot reasonably be expected to be discharged from the medical institution and return home; and

(c) None of the following are lawfully residing, in the client's home:

(i) The client's spouse;

(ii) The client's child who is under age twenty-one, or is blind or permanently and totally disabled as defined in Title 42 USC Section 1382c; or

(iii) A sibling of the client (who has an equity interest in such home and who was residing in the client's home for a period of at least one year immediately before the date of the client's admission to the medical institution).

(2) If the client is discharged from the medical facility and returns home, the department dissolves the lien.

(3) Prior to the department filing a lien under this section, the department sends a notice via first class mail to:

(a) The address of the property and other assets subject to the lien;

(b) The client's known address;

(c) Any other person known to have title to the affected property and the client's authorized representative, if any.

(4) The notice in subsection (3) of this section includes:

(a) The client's name, and the date the client began to receive services;

(b) The department's intent to file a lien against the client's property to recover the amount of medical assistance or state-only funded long-term care services, or both correctly paid on behalf of the client;

(c) The county in which the property and other assets are located; and

(d) The procedures to contest the department's decision to file a lien by applying for an administrative hearing.

(5) An administrative hearing only determines:

(a) Whether the medical assistance or state-only funded long-term care services, or both, on behalf of the decedent alleged by the department's notice is correct; and

(b) Whether the decedent had legal title to the identified property.

(6) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the lien;

(c) Be signed by the requester and must include the requester's address and telephone number; and

(d) Be served to the office of financial recovery (OFR) as described in WAC 388-527-2870, within twenty-eight calendar days of the date the department mailed the notice.

(7) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the property of the time and place of the administrative hearing.

(8) An administrative hearing under this subsection is governed by chapters 34.05 RCW and 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.

(9) If an administrative hearing is conducted in accordance with this regulation, and the final agency decision is issued, the department only files a lien against the client's property and other assets if upheld by the final agency decision.

(10) If no known title holder requests an administrative hearing, the department files a lien twenty-eight calendar days after the date the department mailed the notice described in subsection (3) of this section.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2820, filed 8/14/06, effective 9/14/06.]

WAC 388-527-2830 Request for notice of transfer or encumbrance. (1) When a client receives medical assistance subject to recovery under this chapter and the client is the holder of record title to real property or the purchaser under a land sale contract, the department files a request for notice of transfer or encumbrance [DSHS form 18-664 Notice of Possible Debt] with the county auditor for recording in the deed and mortgage records.

(2) The request for notice of transfer or encumbrance [DSHS 18-664] complies with the requirements for recording in RCW 36.18.010, and, at a minimum, contains the:

- (a) Client's name and case identifier;
- (b) Legal description of the real property, including parcel number; and
- (c) Mailing address for the department to receive the notice of transfer or encumbrance.

(3) The request for notice of transfer or encumbrance [18-664] described in subsection (1) of this section does not affect title to real property and is not a lien on, encumbrance of, or other interest in the real property.

(4) When filing a request for notice of transfer or encumbrance [DSHS 18-664] with the county auditor, the department gives the opportunity to request an administrative hearing as follows:

(a) Any person known to have title to the property is served with a copy of the notice. The notice states:

- (i) The department's intent to recover from the client's estate the amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the client;
- (ii) The county in which the property is located; and
- (iii) The right of the person known to have title in the property to contest the department's decision to file the notice by applying for an administrative hearing with the office of financial recovery (OFR).

(b) An administrative hearing only determines:

(i) Whether the amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the client alleged by the department's notice is correct; and

(ii) Whether the client has legal title to the identified property.

(5) A request for an administrative hearing must:

- (a) Be in writing;
- (b) State the basis for contesting the department's notice;
- (c) Be signed by the requester and state the requester's address and telephone number; and

(d) Be served on OFR as described in WAC 388-527-2870, within twenty-eight calendar days of the date the individual received the department's notice.

(6) Upon receiving a request for an administrative hearing, the department notifies the persons known to have title to the property of the time and place of the administrative hearing.

(7) An administrative hearing under this section is governed by chapters 388-05 RCW and 388-02 WAC, and this section. If a provision of this section conflicts with a provision in chapter 388-02 WAC, the provision of this section governs.

(8) A title insurance company or agent that discovers the presence of a request for notice of transfer or encumbrance [DSHS 18-664] when performing a title search on real property must disclose the presence of the request for notice of transfer or encumbrance of real property in any report preliminary to, or commitment to offer, a certificate of title insurance for the real property.

(9) If the department has filed a request for notice of transfer or encumbrance [DSHS 18-664], any individual who transfers or encumbers real property must provide the department with a notice of transfer or encumbrance [DSHS 18-663] as described in WAC 388-527-2850.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2830, filed 8/14/06, effective 9/14/06.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 388-527-2840 Termination of request for notice of transfer or encumbrance. (1) The department files a termination of prior notice [DSHS 18-662] of transfer or encumbrance, with the county auditor for recording when, in the judgment of the department, it is no longer necessary or appropriate for the department to monitor transfers or encumbrances related to the real property.

(2) The termination of prior notice [DSHS 18-662] request for notice of transfer or encumbrance complies with the requirements for recording in RCW 36.18.010, and, at a minimum, contains the:

- (a) Client's name and case identifier;
- (b) Legal description of the real property, including parcel number; and
- (c) Mailing address for the department to receive the notice of transfer or encumbrance.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2840, filed 8/14/06, effective 9/14/06.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 388-527-2850 Notice of transfer or encumbrance. (1) If the department has filed a request for notice of transfer or encumbrance [DSHS 18-664 Notice of Possible Debt], any individual who transfers or encumbers real property must provide the department with a notice of transfer or encumbrance [DSHS 18-663] or a substantially similar notice as required by chapter 43.20B RCW.

(2) The department's notice of transfer or encumbrance [DSHS 18-663] is available on-line at <http://www1.dshs.wa>.

gov/msa/forms/eforms.html or by writing to Forms and Records Management Services, PO Box 45805, Olympia, WA 98504-5805.

(3) The notice of transfer or encumbrance [DSHS 18-663] must comply with the requirements for recording in RCW 36.18.010, and, at a minimum, contain the:

(a) Client's name and case identifier as listed on the department's request for notice of transfer or encumbrance;

(b) Recording date and recording reference as listed on the department's request for notice of transfer or encumbrance;

(c) Legal description of the real property as listed on the department's request for notice of transfer or encumbrance; and

(d) Type of instrument; and

(e) Recording date and recording reference.

(4) The notice of transfer or encumbrance [DSHS 18-663] or a similar notice and copy of the transfer or encumbrance related to the real property must be sent to the department as specified in WAC 388-527-2870.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2850, filed 8/14/06, effective 9/14/06.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 388-527-2860 Interest assessed on past due debt. (1) The recovery debt becomes past due and accrues interest at a rate of one percent per month on recoverable estate assets beginning nine months after the earlier of:

(a) The filing of the department's creditor's claim in the probate of the deceased client's estate; or

(b) The recording of the department's lien against the property of the deceased client in the county where the property is located.

(2) The department may waive interest if:

(a) Insufficient cash, accounts, or stock exist to satisfy the department's claim and no sales of estate property has occurred despite its continuous listing or marketing for sale in a commercially reasonable manner for a reasonable fair market value; or

(b) Suit filed in the probate of the deceased client's estate resulted in the filing of a lis pendens or order prohibiting the personal representative from selling the estate property. However, this section does not apply to such suite contesting the department's assessment of interest or claim for reimbursement of medical assistance or state-only funded long-term care services debt.

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2860, filed 8/14/06, effective 9/14/06.]

WAC 388-527-2870 Serving notices on the office of financial recovery (OFR). Serving legal notice on the office of financial recovery (OFR) requires the notice to be served either:

(1) In person at the Blake Office Park, 4450 10th Ave SE, Lacey, Washington; or

(2) By certified mail, return receipt requested, to Office of Financial Recovery, PO Box 9501, Olympia, WA 98507-9501.

(2007 Ed.)

[Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2870, filed 8/14/06, effective 9/14/06.]

Chapter 388-530 WAC PHARMACY SERVICES

WAC

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388-530-1800	Requirements for pharmacy claim payment.
388-530-1850	Drug use review (DUR) board.
388-530-1900	Drug use and claims review.
388-530-1950	Point-of-sale (POS) system/prospective drug use review (Pro-DUR).
388-530-2050	Reimbursement for out-of-state prescriptions.

WAC 388-530-1000 Drug program. (1) The department reimburses providers for prescription drugs and pharmaceutical supplies according to department rules and subject to the exceptions and restrictions listed in this chapter.

(2) The department reimburses only pharmacies that:

(a) Are department-enrolled providers; and

(b) Meet the general requirements for providers described under WAC 388-502-0020.

(3) To be both covered and reimbursed under this chapter, prescription drugs must be:

(a) Medically necessary as defined in WAC 388-500-0005;

(b) Within the scope of coverage of an eligible client's medical assistance program. Refer to WAC 388-501-0060 and 388-501-0065 for scope of coverage information;

(c) For a medically accepted indication appropriate to the client's condition;

(d) Billed according to the conditions under WAC 388-502-0150 and 388-502-0160; and

(e) Billed according to the conditions and requirements of this chapter.

(4) Acceptance and filling of a prescription for a client eligible for a medical care program constitutes acceptance of the department's rules and fees. See WAC 388-502-0100 for general conditions of payment.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-530-1000, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1000, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1000, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1000, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1050 Definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions, apply to this chapter.

"Active ingredient" means the chemical component of a drug responsible for a drug's prescribed/intended therapeutic effect. The medical assistance administration (MAA) limits coverage of active ingredients to those with a national drug code (NDC) and those specifically authorized by MAA.

"Actual acquisition cost (AAC)" means the actual price a provider paid for a drug marketed in the package size of drug purchased, or sold by a particular manufacturer or labeler. Actual acquisition cost is calculated based on factors including, but not limited to:

- (1) Invoice price, including other invoice-based considerations, such as prompt payment discounts;
- (2) Order quantity and periodic purchase volume discount policies of suppliers (wholesalers and/or manufacturers);
- (3) Membership/participation in purchasing cooperatives;
- (4) Advertising and other promotion/display allowances, free merchandise deals; and
- (5) Transportation or freight allowances.

"Administer" means the direct application of a prescription drug by injection, inhalation, ingestion, or any other means, to the body of a patient by a practitioner, or at the direction of the practitioner.

"Appointing authority" means, for the evidence-based prescription drug program of the participating agencies in the state-operated health care programs, the following persons acting jointly: The administrator of the health care authority (HCA), the secretary of the department of social and health services (DSHS), and the director of the department of labor and industries (L&I).

"Automated maximum allowable cost (AMAC)" means the rate established by the medical assistance administration (MAA) for a multiple-source drug that is not on the maximum allowable cost (MAC) list and that is designated by two or more products at least one of which must be under a federal drug rebate contract.

"Average wholesale price (AWP)" means the average price of a drug product that is calculated from wholesale prices nationwide at a point in time and reported to the medical assistance administration (MAA) by MAA's drug pricing file contractor.

"Certified average wholesale price (CAWP)" means the price certified by the First Data Bank to be the actual average wholesale price of an infusion, injectable, or inhalation drug marketed by a manufacturer or labeler who is subject to a consent order with the United States Department of Justice regarding the reporting of average wholesale price(s).

"Combination drug" means a commercially available drug including two or more active ingredients.

"Compendia of drug information" includes the following:

- (1) The American Hospital Formulary Service Drug Information;
- (2) The United States Pharmacopeia Drug Information; and
- (3) DRUGDEX Information System.

"Compounding" means the act of combining two or more active ingredients or adjusting therapeutic strengths in the preparation of a prescription.

"Contract drugs" means drugs manufactured or distributed by manufacturers/labelers who signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

"Deliver or delivery" means the transfer of a drug or device from one person to another.

"Dispense as written (DAW)" means an instruction to the pharmacist forbidding substitution of a generic drug or a therapeutically equivalent product for the specific drug product prescribed.

"Dispensing fee" means the fee the medical assistance administration (MAA) sets to reimburse pharmacy providers for dispensing MAA covered prescriptions. The fee is MAA's maximum reimbursement for expenses involved in the practice of pharmacy and is in addition to MAA's payment for the costs of covered ingredients.

"Drug file" means a list of drug products, pricing and other information provided to the medical assistance administration's (MAA's) drug data base and maintained by a drug file contractor.

"Drug file contractor" also referred to as **"drug pricing file contractor,"** means the entity which has contracted to provide the medical assistance administration (MAA), at specified intervals, the latest information and/or data base on drugs and related supplies produced, prepared, processed, packaged, labeled, distributed, marketed, or sold in the marketplace. Contractor-provided information includes, but is not limited to, identifying characteristics of the drug (national drug code, drug name, manufacturer/labeler, dosage form, and strength) for the purpose of identifying and facilitating payment for drugs billed to MAA.

"Drug rebates" means payments provided by pharmaceutical manufacturers to state Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services.

"Drug-related supplies" means nondrug items necessary for the administration, delivery, or monitoring of a drug or drug regimen.

"Drug use review (DUR)" means a review of covered outpatient drugs that assures prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

"Emergency kit" means a set of limited pharmaceuticals furnished to a nursing facility by the pharmacy that provides prescription dispensing services to that facility. Each kit is specifically set up to meet the emergency needs of each nursing facility's client population and is for use during those hours when pharmacy services are unavailable.

"Endorsing practitioner" means a practitioner who has reviewed the Washington preferred drug list (PDL) and has enrolled with the health care authority (HCA), agreeing to

allow therapeutic interchange (substitution) of a preferred drug for any nonpreferred drug in a given therapeutic class on the Washington PDL.

"Estimated acquisition cost (EAC)" means the medical assistance administration's estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler.

"Evidence-based practice center" means a research organization that has been designated by the Agency for Healthcare Research and Quality (AHRQ) of the U.S. government to conduct systematic reviews of all the evidence to produce evidence tables and technology assessments to guide health care decisions.

"Expedited prior authorization (EPA)" means the process for authorizing selected drugs in which providers use a set of numeric codes to indicate to the medical assistance administration (MAA) the acceptable indications, conditions, diagnoses, and criteria that are applicable to a particular request for drug authorization.

"Experimental drugs" means drugs the Food and Drug Administration (FDA) has not approved, or approved drugs when used for medical indications other than those listed by the FDA.

"Expired drug" means a drug for which the shelf life expiration date has been reached.

"Federal upper limit (FUL)" means the maximum allowable payment set by the Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA) for a multiple-source drug.

"Four brand name prescriptions per calendar month limit" means the maximum number of paid prescription claims for brand name drugs that MAA allows for each client in a calendar month without a complete review of the client's drug profile.

"Generic code number sequence number" means a number used by the medical assistance administration's drug file contractor to group together products that have the same ingredients, route of administration, drug strength, and dosage form. It is applied to all manufacturers and package sizes.

"Generic drug" means a nonproprietary drug that is required to meet the same bioequivalency tests as the original brand name drug.

"Inactive ingredient" means a drug component that remains chemically unchanged during compounding but serves as the:

- (1) Necessary vehicle for the delivery of the therapeutic effect; or
- (2) Agent for the intended method or rate of absorption for the drug's active therapeutic agent.

"Ingredient cost" means the portion of a prescription's cost attributable to the covered drug ingredients or chemical components.

"Less than effective drug" or "DESI" means a drug for which:

- (1) Effective approval of the drug application has been withdrawn by the Food and Drug Administration (FDA) for safety or efficacy reasons as a result of the drug efficacy study implementation (DESI) review; or
- (2) The secretary of the department of health and human services (DHHS) has issued a notice of an opportunity for a hearing under section 505(e) of the federal Food, Drug, and

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Cosmetic Act on a proposed order of the secretary to withdraw approval of an application for such drug under such section because the secretary has determined the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling.

"Long-term therapy" means a drug regimen a client receives or will receive continuously through and beyond ninety days.

"MAA preferred drug list (PDL)" means the medical assistance administration's (MAA's) list of drugs of choice within selected therapeutic drug classes.

"Maximum allowable cost (MAC)" means the maximum amount that the medical assistance administration pays for a specific dosage form and strength of a multiple-source drug product.

"Medically accepted indication" means any use for a covered outpatient drug:

- (1) Which is approved under the federal Food, Drug, and Cosmetic Act; or
- (2) The use of which is supported by one or more citations included or approved for inclusion in any of the compendia of drug information, as defined in this chapter.

"Modified unit dose delivery system" (also known as blister packs or "bingo/punch cards") means a method in which each patient's medication is delivered to a nursing facility:

- (1) In individually sealed, single dose packages or "blisters"; and
- (2) In quantities for one month's supply, unless the prescriber specifies a shorter period of therapy.

"Multiple-source drug" means a drug marketed or sold by:

- (1) Two or more manufacturers or labelers; or
- (2) The same manufacturer or labeler:
 - (a) Under two or more different proprietary names; or
 - (b) Under a proprietary name and a generic name.

"National drug code (NDC)" means the eleven-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The NDC is composed of digits in 5-4-2 groupings. The first five digits comprise the labeler code assigned to the manufacturer by the Food and Drug Administration (FDA). The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the package size.

"Noncontract drugs" are drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the federal Department of Health and Human Services.

"Nonpreferred drug" means a drug that has not been selected as a preferred drug within the therapeutic class(es) of drugs on the preferred drug list.

"Obsolete NDC" means a national drug code replaced or discontinued by the manufacturer or labeler.

"Over-the-counter (OTC) drugs" means drugs that do not require a prescription before they can be sold or dispensed.

"Peer reviewed medical literature" means a research study, report, or findings regarding the specific use of a drug that has been submitted to one or more professional journals,

reviewed by experts with appropriate credentials, and subsequently published by a reputable professional journal. A clinical drug study used as the basis for the publication must be a double blind, randomized, placebo or active control study.

"Pharmacist" means a person licensed in the practice of pharmacy by the state in which the prescription is filled.

"Pharmacy" means every location licensed by the state board of pharmacy in the state where the practice of pharmacy is conducted.

"Point-of-sale (POS)" means a pharmacy claims processing system capable of receiving and adjudicating claims on-line.

"Practice of pharmacy" means the practice of and responsibility for:

- (1) Accurately interpreting prescription orders;
- (2) Compounding drugs;
- (3) Dispensing, labeling, administering, and distributing of drugs and devices;
- (4) Providing drug information to the client that includes, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices;
- (5) Monitoring of drug therapy and use;
- (6) Proper and safe storage of drugs and devices;
- (7) Documenting and maintaining records;
- (8) Initiating or modifying drug therapy in accordance with written guidelines or protocols previously established and approved for a pharmacist's practice by a practitioner authorized to prescribe drugs; and
- (9) Participating in drug utilization reviews and drug product selection.

"Practitioner" means an individual who has met the professional and legal requirements necessary to provide a health care service, such as a physician, nurse, dentist, physical therapist, pharmacist or other person authorized by state law as a practitioner.

"Preferred drug" means drug(s) of choice within a selected therapeutic class that are selected based on clinical evidence of safety, efficacy, and effectiveness.

"Prescriber" means a physician, osteopathic physician/surgeon, dentist, nurse, physician assistant, optometrist, pharmacist, or other person authorized by law or rule to prescribe drugs. See WAC 246-863-100 for pharmacists' prescriptive authority.

"Prescription" means an order for drugs or devices issued by a practitioner authorized by state law or rule to prescribe drugs or devices, in the course of the practitioner's professional practice, for a legitimate medical purpose.

"Prescription drugs" means drugs required by any applicable federal or state law or regulation to be dispensed by prescription only or that are restricted to use by practitioners only.

"Prior authorization program" means a medical assistance administration (MAA) program, subject to the requirements of 42 U.S.C. 1396r-8 (d)(5), that may require, as a condition of payment, that a drug on MAA's drug file be prior authorized. See WAC 388-530-1200.

"Prospective drug use review (Pro-DUR)" means a process in which a request for a drug product for a particular client is screened, before the product is dispensed, for potential drug therapy problems.

"Reconstitution" means the process of returning a single active ingredient, previously altered for preservation and storage, to its approximate original state. Reconstitution is not compounding.

"Retrospective drug use review (Retro-DUR)" means the process in which client's drug utilization is reviewed on a periodic basis to identify patterns of fraud, abuse, gross over-use, or inappropriate or unnecessary care.

"Risk/benefit ratio" means the result of assessing the side effects of a drug or drug regimen compared to the positive therapeutic outcome of therapy.

"Single source drug" means a drug produced or distributed under an original new drug application approved by the Food and Drug Administration (FDA).

"Substitute" means to replace a prescribed drug, with the prescriber's authorization, with:

- (1) An equivalent generic drug product of the identical base or salt as the specific drug product prescribed; or
- (2) A therapeutically equivalent drug other than the identical base or salt.

"Systematic review" means a specific and reproducible method to identify, select, and appraise all the studies that meet minimum quality standards and are relevant to a particular question. The results of the studies are then analyzed and summarized into evidence tables to be used to guide evidence-based decisions.

"TCS" See **"therapeutic consultation service."**

"Terminated NDC" means a national drug code (NDC) that is discontinued by the manufacturer for any reason. The NDC may be terminated immediately due to health or safety issues or it may be phased out based on the product's shelf life.

"Therapeutic alternative" means a drug product that contains a different chemical structure than the drug prescribed, but is in the same pharmacologic or therapeutic class and can be expected to have a similar therapeutic effect and adverse reaction profile when administered to patients in a therapeutically equivalent dosage.

"Therapeutic class" means a group of drugs used for the treatment, remediation, or cure of a specific disorder or disease.

"Therapeutic consultation service (TCS)" means the prescriber and a medical assistance administration (MAA) designated clinical pharmacist jointly review prescribing activity when drug claims for a medical assistance client exceed program limitations.

"Therapeutic interchange" means to dispense a therapeutic alternative to the prescribed drug when an endorsing practitioner who has indicated that substitution is permitted, prescribes the drug. See therapeutic interchange program (TIP).

"Therapeutic interchange program (TIP)" means the process developed by participating state agencies under RCW 69.41.190 and 70.14.050, to allow prescribers to endorse a Washington preferred drug list, and in most cases, required pharmacists to automatically substitute a preferred, equivalent drug from the list.

"Therapeutically equivalent" means drug products that contain different chemical structures but have the same efficacy and safety when administered to an individual, as determined by:

- (1) Information from the Food and Drug Administration (FDA);
- (2) Published and peer-reviewed scientific data;
- (3) Randomized controlled clinical trials; or
- (4) Other scientific evidence.

"Tiered dispensing fee system" means a system of paying pharmacies different dispensing fee rates, based on the individual pharmacy's total annual prescription volume and/or the drug delivery system used.

"True unit dose delivery" means a method in which each patient's medication is delivered to the nursing facility in quantities sufficient only for the day's required dosage.

"Unit dose drug delivery" means true unit dose or modified unit dose delivery systems.

"Usual and customary charge" means the fee that the provider typically charges the general public for the product or service.

"Washington preferred drug list (Washington PDL)" means the list of drugs selected by the appointing authority to be used by applicable state agencies as the basis for purchase of drugs in state-operated health care programs.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1050, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1050, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-24-066, § 388-530-1050, filed 11/30/01, effective 1/2/02; 01-01-028, § 388-530-1050, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090, 96-21-031, § 388-530-1050, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1100 Covered drugs, devices, and pharmaceutical supplies. (1) The medical assistance administration (MAA) covers medically necessary drugs, devices, and pharmaceutical supplies when they are prescribed for medically accepted indications, subject to the restrictions described in this section and other published WAC. For exceptions to the prescription requirement, see subsection (4) of this section.

(2) MAA reimburses a provider for medically necessary drugs, devices and supplies as follows:

(a) Only when the manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS). Exceptions to the drug rebate requirement are described in WAC 388-530-1125 which describes the drug rebate program.

(b) For drugs requiring prior authorization when:

- (i) Prior authorized by MAA: and
- (ii) They meet MAA's published expedited prior authorization (EPA) criteria and the dispensing pharmacist follows the EPA process described in WAC 388-530-1250(4).

(c) For preferred drugs in drug classes on the preferred drug list(s):

- (i) Without prior authorization; and
- (ii) According to WAC 388-530-1280.

(3) MAA covers the following medically necessary drugs, devices, and supplies:

- (a) Outpatient drugs, generic or brand name.
- (b) Over-the-counter (OTC) drugs when the drug:
 - (i) Is prescribed by a provider with prescribing authority (see exceptions in subsection (4) of this section);
 - (ii) Is not excluded from coverage under WAC 388-530-1150;

(iii) Is a less costly therapeutic alternative; and

(iv) Does not require prior authorization.

(c) Oral, topical and/or injectable drugs, vaccines for immunizations, and biologicals, prepared or packaged for individual use.

(d) Drugs with obsolete national drug codes (NDCs) for up to two years from the date the NDC is designated obsolete, unless the drug is expired as defined in WAC 388-530-1050.

(e) Drugs and supplies used in conjunction with family planning under subsection (4) of this section and under chapter 388-532 WAC, including drugs dispensed for emergency contraception and nonprescribed OTC contraceptive supplies.

(f) Drugs, devices, and supplies provided under unusual and extenuating circumstances to clients by providers who request and receive MAA approval.

(g) Drug-related supplies as determined in consultation with federal guidelines.

(4) MAA covers family planning drugs, devices, and supplies per chapter 388-532 WAC and as follows:

(a) MAA covers certain over-the-counter (OTC) family planning drugs, devices, and supplies without a prescription when they meet the criteria of WAC 388-530-1200(3);

(b) MAA may cover family planning drugs that do not meet the federal drug rebate requirement in WAC 388-530-1125 on a case-by-case basis, under the provisions of subsection (6) of this section; and

(c) MAA covers contraceptive patches, contraceptive rings, and oral contraceptives (excluding emergency contraceptive pills, which are not subject to the at-least-three-month supply limitation), only when dispensed in at least a three-month supply, unless otherwise directed by the prescriber.

(5) MAA determines if certain drugs are medically necessary and covered with or without restrictions based on evidence contained in compendia of drug information and peer-reviewed medical literature.

(a) Decisions regarding restrictions are based on, but are not limited to:

- (i) Client safety;
- (ii) FDA-approved indications;
- (iii) Quantity;
- (iv) Client age and/or gender; and
- (v) Cost.

(b) Restrictions and limitations may include, but are not limited to:

- (i) Exclusion of drugs covered in the nursing facility per diem rate;
- (ii) Number of refills within a calendar month;
- (iii) Refills requested before seventy-five percent of the previously dispensed supply is scheduled to be exhausted; and
- (iv) Quantity and days-supply dispensed.

(6) MAA evaluates requests for drugs, devices, and pharmaceutical supplies that are subject to limitations or other restrictions in this chapter on a case-by-case basis. MAA approves the requested services that are beyond the stated limits or restrictions of this chapter when MAA determines that the services are medically necessary, under subsection (5) of this section and under the standards for covered services in WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1100, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1100, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1100, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1100, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1125 Drug rebate program. The medical assistance administration (MAA) covers only those outpatient prescription drugs and over-the-counter (OTC) drugs supplied by manufacturers who have a drug rebate contract with the Department of Health and Human Services (DHHS), according to 42 U.S.C. 1396r-8. MAA may exempt the following from the drug rebate requirement in WAC 388-530-1100(2):

- (1) Family planning drugs as provided by WAC 388-530-1100(4); and
- (2) Other drugs approved under WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1125, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1125, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1125, filed 12/7/00, effective 1/7/01.]

WAC 388-530-1150 Noncovered drugs and pharmaceutical supplies and reimbursement limitations. (1) The department does not cover:

(a) Brand or generic drugs, when the manufacturer has not signed a rebate agreement with the federal Department of Health and Human Services. Refer to WAC 388-530-1125 for information on the drug rebate program.

(b) A drug prescribed:

- (i) For weight loss or gain;
- (ii) For infertility, frigidity, impotency, or sexual dysfunction;
- (iii) For cosmetic purposes or hair growth; or
- (iv) To promote tobacco cessation, except as described in WAC 388-533-0345 (3)(d) tobacco cessation for pregnant women.

(c) Over-the-counter (OTC) drugs and supplies, except as described under WAC 388-530-1100.

(d) Prescription vitamins and mineral products, except:

- (i) When prescribed for clinically documented deficiencies;
- (ii) Prenatal vitamins, only when prescribed and dispensed to pregnant women; or
- (iii) Fluoride preparations for children under the early and periodic screening, diagnosis, and treatment (EPSDT) program.

(e) A drug prescribed for an indication or dosing that is not evidence based as determined by:

- (i) The department in consultation with federal guidelines; or
- (ii) The drug use review (DUR) board; and
- (iii) The department's medical consultants and the department's pharmacist(s).

(f) Drugs listed in the federal register as "less-than-effective" ("DESI" drugs) or which are identical, similar, or related to such drugs.

(g) Drugs that are:

(i) Not approved by the Food and Drug Administration (FDA); or

(ii) Prescribed for non-FDA approved indications or dosing, unless prior authorized; or

(iii) Unproven for efficacy or safety.

(h) Outpatient drugs for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee.

(i) Drugs requiring prior authorization for which department authorization has been denied.

(j) Preservatives, flavoring and/or coloring agents.

(k) Less than a one-month supply of drugs for long-term therapy.

(l) A drug with an obsolete national drug code (NDC) more than two years from the date the NDC is designated obsolete by the manufacturer.

(m) Products or items that do not have an eleven-digit NDC.

(n) Nonpreferred drugs when a therapeutic equivalent is on the preferred drug list(s) (PDL), according to WAC 388-530-1100, and subject to the dispense as written (DAW) provisions of WAC 388-530-1280, and 388-530-1290.

(o) Less than a three-month supply of contraceptive patches, contraceptive rings, or oral contraceptives (excluding emergency contraceptive pills), unless otherwise directed by the prescriber.

(2) The department does not reimburse enrolled providers for:

(a) Outpatient drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods including, but not limited to:

- (i) Diagnosis-related group (DRG);
- (ii) Ratio of costs-to-charges (RCC);
- (iii) Nursing facility daily rate;
- (iv) Managed care capitation rates;
- (v) Block grants; or
- (vi) Drugs prescribed for clients who are on the department's hospice program when the drugs are related to the client's terminal illness and related condition(s).

(b) Any drug regularly supplied as an integral part of program activity by other public agencies (e.g., immunization vaccines for children).

(c) Prescriptions written on pre-signed prescription blanks filled out by nursing facility operators or pharmacists. The department may terminate the core provider agreement of pharmacies involved in this practice.

(d) Drugs used to replace those taken from nursing facility emergency kits.

(e) Drugs used to replace a physician's stock supply.

(f) Free pharmaceutical samples.

(g) A drug product after the product's national drug code (NDC) termination date.

(h) A drug product whose shelf life has expired.

(3) The department evaluates each request for authorization of a noncovered drug, device, or pharmaceutical supply as an exception to rule according to WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-530-1150, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1150, filed 12/30/04, effective

1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1150, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1150, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1150, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1200 Prior authorization program.

(1) The medical assistance administration (MAA) pharmacist(s), medical consultants, and drug utilization review team evaluate drugs to determine prior authorization status on the drug file. MAA may consult with an evidence-based practice center, the drug use review (DUR) board, and/or participating MAA providers in this evaluation.

(2) To facilitate the evaluation process for a drug product, a drug manufacturer may send the MAA pharmacist(s) a written request and the following supporting documentation:

- (a) Background data about the drug;
- (b) Product package information;
- (c) Any pertinent clinical studies;
- (d) Outcome and effectiveness data using the Academy of Managed Care Pharmacy's drug review submission process; and
- (e) Any additional information the manufacturer considers appropriate.

(3) MAA evaluates a drug based on, but not limited to, the following criteria:

- (a) Whether the manufacturer has signed a federal drug rebate agreement except as specified in WAC 388-530-1125;
- (b) Whether the drug is a less-than-effective drug;
- (c) The drug's risk/benefit ratio;
- (d) Whether like drugs are on MAA's drug file list and there are less costly therapeutic alternative drugs;
- (e) Whether the drug falls into one of the categories authorized by federal law to be excluded from coverage;
- (f) The drug's potential for abuse; and
- (g) Whether outcome data demonstrate that the drug is cost effective.

(4) MAA updates and reviews the drug file list as necessary and periodically publishes a list of drugs not requiring prior authorization.

(5) Manufacturers may seek review of MAA's prior authorization decisions by writing to MAA's chief medical officer.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1200, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1200, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1200, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1200, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1250 Prior authorization process. (1)

The medical assistance administration (MAA) requires pharmacies to obtain prior authorization for:

- (a) Drugs with a prior authorization indicator on the MAA drug file list;
- (b) Drugs that exceed specific dosage or unit limits as indicated by the Food and Drug Administration (FDA);
- (c) Additional fills in a calendar month for drugs dispensed for a less than thirty-four day supply when:

(i) Two fills for the same prescription have been dispensed, except for:

- (A) Over-the-counter (OTC) contraceptives; or
- (B) Drugs prescribed to a suicidal patient or a patient at risk for potential drug abuse; or
- (ii) Four fills in the same calendar month for the same prescription have been dispensed for any of the following:
 - (A) Antibiotics;
 - (B) Anti-asthmatics;
 - (C) Schedule II and III drugs;
 - (D) Antineoplastic agents;
 - (E) Topical preparations; or
 - (F) Propoxyphene, propoxyphene napsylate, and all propxyphene combinations.

(d) A nonpreferred drug in a drug class on the Washington PDL when the prescription is received from a nonendorsing practitioner, according to WAC 388-530-1290; and

(e) A nonpreferred drug in a drug class that is not on the Washington PDL and is not subject to TIP, when the prescription is received from an endorsing or a nonendorsing practitioner, according to WAC 388-530-1280.

(2) The pharmacy provider must make a request to MAA for a drug requiring prior authorization before dispensing the drug. The pharmacy provider must:

- (a) Ensure the request states the medical diagnosis and includes medical justification for the drug; and
- (b) Keep on file documentation of the prescriber's medical justification that is communicated to the pharmacy by the prescriber at the time the prescription is filled. The records must be retained for the period specified in WAC 388-502-0020 (1)(c).

(3) MAA evaluates a request for prior authorization based on, but not limited to:

- (a) Requirements in this section;
- (b) Requirements under WAC 388-530-1000, 388-530-1150, and 388-501-0165; and
- (c) The least costly alternative between two or more products of equal effectiveness.

(4) MAA authorizes certain prescribed drugs through a process called "expedited prior authorization (EPA)." MAA determines which drugs can be authorized through the EPA process by using factors that include, but are not limited to:

- (a) Product cost;
- (b) Potential for clinical misuse;
- (c) Narrow therapeutic indication; and
- (d) Safety concerns.

(5) MAA may authorize reimbursement at the brand name estimated acquisition cost (EAC) for a brand name multiple-source drug that would have been reimbursed at the maximum allowable cost (MAC) for that multiple-source drug, if:

- (a) The pharmacist calls for prior authorization; and
- (b) The prescriber indicates:
 - (i) "Dispense as written" on the prescription; and
 - (ii) That a specific brand is "medically necessary" for a particular client; or
- (c) The availability of generic equivalents in the marketplace is severely curtailed and the price disparity between the brand name EAC and the generic MAC reimbursement affects clients' access to the medication.

(6) MAA provides a response, by telephone or other telecommunication device, within twenty-four hours of a request for drugs that require prior authorization, if the request is received during normal state business hours. If a provider needs prior authorization to dispense a drug during a week-end or Washington state holiday, the provider may dispense the drug without prior authorization only when:

(a) Given in an emergency;

(b) MAA receives justification within seventy-two hours of the fill date, excluding weekends and Washington state holidays; and

(c) MAA agrees with the justification and approves the request.

(7) MAA's prior authorization:

(a) Is limited to a decision of medical appropriateness for a drug; and

(b) Does not guarantee payment.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1250, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1250, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1250, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1250, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1260 Therapeutic consultation service. (1) The medical assistance administration (MAA) provides a therapeutic consultation service (TCS) to aid appropriate utilization of prescription drugs, improve quality of care and health care outcomes for medical assistance clients, and promote cost effectiveness.

(2) A TCS review occurs when a drug claim exceeds the four-brand-name-prescriptions-per calendar-month limit. The exceptions to this are:

(a) When the brand-name drug is a preferred drug on the Washington preferred drug list (PDL) (preferred brand-name drugs on the Washington PDL do not count against the limit); or

(b) When an endorsing practitioner indicates dispense as written (DAW) for a nonpreferred drug. Nonpreferred drugs do not count against the limit in these cases. However, if a nonendorsing practitioner indicates DAW for a nonpreferred drug, the nonpreferred drug counts against the limit and requires prior authorization, regardless of the DAW indication. See WAC 388-530-1290.

(3) Through TCS, MAA provides a complete drug profile review for each client whose claims exceed four brand name prescriptions in a calendar month. MAA excludes the following from the four brand name prescriptions per calendar month limit:

(a) Generic drugs; and

(b) The following drugs:

(i) Antidepressants;

(ii) Antipsychotics;

(iii) Chemotherapy;

(iv) Contraceptives;

(v) HIV;

(vi) Immunosuppressants; and

(vii) Hypoglycemia rescue agents.

(4) When a pharmacy provider submits a claim that exceeds the four-brand-name-prescriptions-per-calendar-

month limitation for a client, MAA notifies the pharmacy provider that a TCS review is required.

(5) The TCS review process includes all of the following:

(a) Pharmacy provider requirements:

(i) The pharmacy provider notifies the prescriber that the prescriber or prescriber designee must call the TCS toll-free telephone number to begin a TCS review according to subsection (2) of this section; and

(ii) If the TCS review cannot take place due to the prescriber's or prescriber designee's unavailability, the pharmacy provider has the option to dispense an emergency supply of the requested drug only when:

(A) Given in an emergency;

(B) MAA receives justification within seventy-two hours of the fill date, excluding weekends and Washington state holidays; and

(C) MAA agrees with the justification and approves the request.

(b) Prescriber requirements:

(i) When the pharmacy provider contacts the client's prescriber as described in subsection (5)(a)(i) of this section, the prescriber or prescriber designee calls the TCS toll-free telephone number to contact the MAA designee (MAA-designated clinical pharmacist) to begin a TCS review;

(ii) After the prescriber or prescriber designee and the MAA designee review the client's drug profile and discuss clinically sound options and cost effective alternative drug(s), the prescriber does one of the following:

(A) Changes the prescription to an alternate drug or preferred drug and contacts the client's pharmacy with the new prescription;

(B) Provides the MAA designee with medical justification for the requested drug and the MAA designee authorizes the drug under the provisions of medical necessity as defined in WAC 388-500-0005; or

(C) Does not agree to prescribe an alternate drug or preferred drug and does not provide medical justification for the requested drug, then:

(I) The MAA designee authorizes only a one-month supply of the requested drug with no refills and sends the initiating prescriber a copy of the client's drug profile and a therapy authorization turnaround form;

(II) The prescriber signs the therapy authorization turnaround form and returns it to the MAA designee; and

(III) Upon receipt of the therapy authorization turnaround form, the MAA designee authorizes up to twelve months of the requested drug.

(c) MAA designee responsibilities:

(i) Notifies the following by facsimile, electronic mail, or telephone call, the results of the TCS review:

(A) Prescriber; and

(B) Pharmacy provider.

(ii) Notifies MAA clinical program staff when concerns for client safety are identified during the TCS reviews. See WAC 388-530-1100(2) for how MAA determines restrictions on drug coverage based on, but not limited to, client safety.

(iii) Contacts other prescribers identified during the TCS review when opportunities to further improve the client's healthcare outcome are discovered.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1260, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.08.090, 74.04.050, 01-24-066, § 388-530-1260, filed 11/30/01, effective 1/2/02.]

WAC 388-530-1270 Mail-order services. The medical assistance administration (MAA) provides a contracted mail-order pharmacy service for client use. The mail-order contractor is selected as a result of a competitive procurement process.

(1) The contracted mail-order pharmacy service is available as an option to all medical assistance clients, subject to the:

- (a) Scope of the client's medical care program;
- (b) Availability of services from the contracted mail-order provider; and
- (c) Special terms and conditions described in subsection (2) and (3) of this section.

(2) The mail-order prescription service may not dispense medication in a quantity greater than authorized by the prescriber. (See RCW 18.64.360(5), Nonresident pharmacies.)

(3) Prescribed medications may be filled by the mail-order pharmacy service within the following restrictions:

(a) Drugs available from mail-order in no more than a ninety day supply include:

- (i) Preferred drugs (see WAC 388-530-1280);
- (ii) Generic drugs; and,
- (iii) Drugs that do not require prior authorization or expedited prior authorization (see WAC 388-530-1200 and 388-530-1250).

(b) Drugs available in no more than a thirty-four-day supply:

- (i) Controlled substances (schedules II through V); and
- (ii) Drugs requiring prior authorization or expedited prior authorization (see WAC 388-530-1200).

(c) Other pharmacy restrictions (chapter 388-530 WAC, Pharmacy services) continue to apply.

(4) The contracted mail-order pharmacy services are reimbursed at levels lower than those established for the regular outpatient pharmacy services.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1270, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.08.090, 74.09.510, and 2002 c 371 (2001-03 Revised Omnibus Operating Budget - 2002 Supp.). 03-05-043, § 388-530-1270, filed 2/13/03, effective 3/16/03.]

WAC 388-530-1280 Preferred drug list(s). This section contains the medical assistance administration's (MAA) rules for preferred drug list(s) (PDL). Under RCW 69.41.190 and 70.14.050, MAA and other state agencies cooperate in developing and maintaining preferred drug list(s).

(1) The Washington preferred drug list (PDL):

(a) Washington state contracts with evidence-based practice center(s) for systematic reviews of drug(s).

(b) The pharmacy and therapeutics (P&T) committee reviews and evaluates the safety, efficacy, and outcomes of prescribed drugs, using evidence-based information provided by the evidence-based practice center(s).

(c) The P&T committee makes recommendations to state agencies as to which drug(s) to include on the Washington PDL, under chapter 182-50 WAC.

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(d) The appointing authority makes the final selection of drugs included on the Washington PDL.

(e) Nonpreferred drugs within a therapeutic class on the Washington PDL are subject to the therapeutic interchange program (TIP) according to WAC 388-530-1290.

(2) The medical assistance administration's (MAA's) PDL. Drugs on MAA's PDL:

(a) Are not part of the Washington PDL;

(b) Are not subject to TIP; and

(c) Continue to require prior authorization when they are designated as nonpreferred.

(3) Combination drugs that are not on the Washington PDL, that are not reviewed by the evidence-based practice center(s), and that are not subject to TIP under WAC 388-530-1290, are considered for coverage according to MAA's prior authorization program.

[Statutory Authority: RCW 69.41.190, 70.14.050, and 74.08.090. 05-11-078, § 388-530-1280, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1280, filed 12/30/04, effective 1/30/05.]

WAC 388-530-1290 Therapeutic interchange program (TIP). This section contains the medical assistance administration's (MAA) rules for the endorsing practitioner therapeutic interchange program (TIP). TIP is established under RCW 69.41.190 and 70.14.050. The statutes require state-operated prescription drug programs to allow physicians and other prescribers to endorse a Washington preferred drug list (PDL) and, in most cases, requires pharmacists to automatically substitute a preferred, equivalent drug from the list.

(1) The therapeutic interchange program (TIP) applies only to drugs within therapeutic classes on the Washington PDL that are prescribed by an endorsing practitioner. TIP does not apply to other drugs that require MAA's prior authorization or to other program limitations.

(2) A practitioner who wishes to become an endorsing practitioner must specifically enroll with the health care authority (HCA) as such, under the provisions of chapter 182-50 WAC.

(3) When an endorsing practitioner writes a prescription for an MAA client for a nonpreferred drug and indicates that substitution is permitted, the pharmacist must:

(a) Dispense the preferred drug in that therapeutic class in place of the nonpreferred drug. In the event that more than one preferred drug in that therapeutic class is on the Washington PDL, dispense one of the preferred drugs in place of the nonpreferred drug; and

(b) Notify the endorsing practitioner of the specific drug and dose dispensed.

(4) When an endorsing practitioner determines that a nonpreferred drug is medically necessary, all of the following apply:

(a) The practitioner must indicate that the prescription is to be dispensed as written (DAW);

(b) The filling pharmacist dispenses the nonpreferred drug as prescribed; and

(c) MAA does not require prior authorization to dispense the nonpreferred drug.

(5) In the event the following therapeutic drug classes are on the Washington PDL, pharmacists will not substitute a

preferred drug for a nonpreferred drug in these therapeutic drug classes when the endorsing practitioner prescribes a refill (including the renewal of a previous prescription or adjustments in dosage):

- (a) Antipsychotic;
- (b) Antidepressant;
- (c) Chemotherapy;
- (d) Antiretroviral; or
- (e) Immunosuppressive.

(6) When a pharmacist fills a prescription from a nonendorsing practitioner for an MAA client and the prescription is for a nonpreferred drug, the pharmacist must obtain prior authorization from MAA or its designee to dispense the nonpreferred drug.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1290, filed 12/30/04, effective 1/30/05.]

WAC 388-530-1300 General reimbursement methodology. (1) The medical assistance administration's (MAA) total reimbursement for a prescription drug must not exceed the lowest of:

- (a) Estimated acquisition cost (EAC) plus a dispensing fee;
- (b) Maximum allowable cost (MAC) plus a dispensing fee;
- (c) Federal Upper Limit (FUL) plus a dispensing fee;
- (d) Actual acquisition cost (AAC) plus a dispensing fee for drugs purchased under section 340 B of the Public Health Service (PHS) Act and dispensed to medical assistance clients;
- (e) Automated maximum allowable cost (AMAC) plus a dispensing fee;
- (f) Certified average wholesale price (CAWP) plus a dispensing fee; or
- (g) The provider's usual and customary charge to the non-Medicaid population.

(2) MAA selects the sources for pricing information used to set EAC and MAC. These sources may include pharmaceutical wholesalers.

(3) MAA may solicit assistance from pharmacy providers, pharmacy benefit managers (PBM), other government agencies, actuaries, and/or other consultants when establishing EAC and/or MAC.

(4) MAA reimburses a pharmacy for the least costly dosage form of a drug within the same route of administration, unless the prescriber has designated a medically necessary specific dosage form.

(5) If the pharmacy provider offers a discount, rebate, promotion or other incentive which directly relates to the reduction of the price of a prescription to the individual non-Medicaid customer, the provider must similarly reduce its charge to MAA for the prescription.

(6) If a pharmacy gives a product free to the general public, the pharmacy must not submit a claim to MAA when giving the free product to a medical assistance client.

[Statutory Authority: RCW 74.08.090 and 74.09.520. 04-01-089, § 388-530-1300, filed 12/16/03, effective 1/16/04. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1300, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1300, filed 12/7/00,

effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1300, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1350 Estimated acquisition cost (EAC) methodology. (1) The medical assistance administration (MAA) determines EAC as follows:

(a) When acquisition cost data are made available to MAA by drug wholesalers:

(i) MAA determines pharmacies' acquisition costs for the top 100 single-source drugs reimbursed by MAA as measured by the total dollars paid for each drug.

(ii) Establishes the actual acquisition cost (AAC) for each product on the sample list as a percentage of the published average wholesale price (AWP), determined for that product by MAA's drug pricing file contractor.

(iii) MAA averages the percentages obtained from the sample, and that average represents the EAC.

(b) When drug wholesalers do not make acquisition cost data available to MAA, MAA may set EAC using acquisition cost information provided, or rates set, by any of the following:

- (i) Audit agencies, federal or state;
- (ii) Other state health care purchasing agencies;
- (iii) Pharmacy benefit managers;
- (iv) Individual pharmacy providers participating in MAA's programs;
- (v) Other third party payers; and/or
- (vi) Actuaries or other consultants.

(2) MAA establishes EAC as a percentage of AWP, derived by applying a discount to AWP.

(3) MAA may set EAC for specified drugs or drug categories at a percentage of AWP other than that determined in subsection (1)(a) of this section when MAA considers it necessary. MAA ends the exemption when the necessity no longer exists.

The factors MAA considers in setting a rate for a class of drugs under this subsection include, but are not limited to:

- (a) Product cost;
 - (b) MAA's documented clinical concerns; and
 - (c) MAA's budget limits.
- (4) MAA bases EAC drug reimbursement on the actual package size dispensed.

(5) MAA uses the EAC as MAA's reimbursement for a drug when the EAC is the lowest of the rates calculated under the methods listed in WAC 388-530-1300(1), or when the conditions of WAC 388-530-1400(3) are met.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1350, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1350, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1350, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1360 Certified average wholesale price (CAWP). (1) The medical assistance administration (MAA) reimburses providers the certified average wholesale price (CAWP) for selected infusion, injectable, and inhalation drugs manufactured and/or marketed by manufacturers/labelers who are subject to a consent order with the United States Department of Justice.

(2) The CAWP is determined by First Data Bank (FDB) through a survey of wholesale prices. FDB reports these

prices to states and certifies that they accurately represent the price from wholesalers to retailers for these drugs.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1360, filed 8/9/02, effective 9/9/02.]

WAC 388-530-1400 Maximum allowable cost (MAC) methodology. (1) The medical assistance administration (MAA) establishes a maximum allowable cost (MAC) for a multiple-source drug which is available from at least two manufacturers/labelers.

(2) MAA determines the MAC for a multiple-source drug by:

(a) When drug wholesalers make acquisition cost data available to MAA, MAA:

(i) Identifies what products are available from wholesalers for each MAC drug;

(ii) Determines pharmacy subscribers' approximate acquisition costs for these products;

(iii) Ranks the products in descending order by approximate acquisition cost; and

(iv) Establishes the MAC at a level which gives pharmacies access to one product from a manufacturer with a qualified rebate agreement (see WAC 388-530-1125).

(b) When drug wholesalers do not make acquisition cost data available to MAA, MAA may set a MAC for a drug in the same manner described in WAC 388-530-1350 (1)(b).

(3) The MAC established for a multiple-source drug does not apply if the written prescription identifies that a specific brand is medically necessary for a particular client. In such cases, the estimated acquisition cost (EAC) for the particular brand applies, provided prior authorization is obtained from MAA as specified under WAC 388-530-1250(5), Prior authorization.

(4) Except as provided in subsection (3) of this section, MAA reimburses providers for a multiple-source drug at the lowest of the rates calculated under the methods listed in WAC 388-530-1300(1).

(5) The MAC established for a multiple-source drug applies to all package sizes of that drug, including those identified as unit dose national drug codes (NDCs) by the manufacturer(s) of the drug.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1400, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1400, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1400, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1400, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1405 Automated maximum allowable cost (AMAC). (1) The medical assistance administration (MAA) uses the automated maximum allowable cost (AMAC) pricing methodology for multiple-source drugs that are:

(a) Not on the published maximum allowable cost (MAC) or federal upper limit (FUL) lists; and

(b) Produced by two or more manufacturers/labelers, at least one of which must have a federal drug rebate agreement.

(2) MAA establishes AMAC as a specified percentage of the published average wholesale price (AWP). MAA may use

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different percentage discounts from AWP for the estimated acquisition cost (EAC) and AMAC.

(3) MAA sets the percentage discount from AWP for AMAC reimbursement using any of the information sources identified in WAC 388-530-1350 (1)(b).

(4) MAA may set AMAC reimbursement at different percentage discounts from AWP for different multiple source drugs. MAA considers the same factors as those in WAC 388-530-1350(3).

(5) AMAC reimbursement for all products within a generic code number sequence number is at the AMAC determined for the second lowest priced product in that sequence, or the AMAC of the lowest priced drug under a federal rebate agreement.

(6) MAA recalculates AMAC each time the drug file contractor provides a pricing update to any product in a GCN sequence.

(7) Except as provided in WAC 388-530-1400(3), MAA reimburses at the lowest of the rates calculated under the methods listed in WAC 388-530-1300(1).

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1405, filed 8/9/02, effective 9/9/02.]

WAC 388-530-1410 Federal upper limit (FUL) methodology. (1) The medical assistance administration (MAA) adopts the federal upper limit (FUL) set by the Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA).

(2) MAA's maximum payment for multiple-source drugs for which CMS has set FULs will not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by MAA.

(3) Except as provided in WAC 388-530-1400(3), MAA uses the FUL as MAA's reimbursement rate for the drug when the FUL price is the lowest of the rates calculated under the methods listed in WAC 388-530-1300(1).

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1410, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1410, filed 12/7/00, effective 1/7/01.]

WAC 388-530-1425 Payment methodology for drugs purchased under the Public Health Service (PHS) Act. (1) Drugs purchased under section 340B of the Public Health Service (PHS) Act can be dispensed to medical assistance clients only by PHS-qualified health facilities. These medications must be billed using the actual acquisition cost (AAC) of the drug plus the appropriate dispensing fee.

(2) Providers dispensing drugs under this section are required to submit their valid MAA provider number(s) to the PHS Health Resources and Services Administration, Office of Pharmacy Affairs. This requirement is to ensure that claims for drugs dispensed under this section and paid by MAA are excluded from the drug rebate claims that are submitted to the manufacturers of the drugs. See WAC 388-530-1125 for information on the drug rebate program.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1425, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1425, filed 12/7/00, effective 1/7/01.]

WAC 388-530-1450 Dispensing fee determination.

(1) Subject to the provisions of WAC 388-530-1300, the medical assistance administration (MAA) pays a dispensing fee for each prescribed and covered drug.

(2) MAA does not pay a dispensing fee for nondrug items, devices, or supplies.

(3) MAA adjusts the dispensing fee by considering factors including, but not limited to:

- (a) Legislative appropriations for vendor rates;
- (b) Input from provider and/or advocacy groups;
- (c) Input from state-employed or contracted actuaries; and

(d) Dispensing fees paid by other third-party payers, including, but not limited to, health care plans and other states' Medicaid agencies.

(4) MAA uses a tiered dispensing fee system which reimburses higher volume pharmacies at a lower fee and lower volume pharmacies at a higher fee.

(5) MAA uses total annual prescription volume (both Medicaid and non-Medicaid) reported to MAA to determine each pharmacy's dispensing fee tier.

(a) A pharmacy which fills more than thirty-five thousand prescriptions annually is a high-volume pharmacy. MAA considers hospital-based pharmacies that serve both inpatient and outpatient clients as high-volume pharmacies.

(b) A pharmacy which fills between fifteen thousand one and thirty-five thousand prescriptions annually is a mid-volume pharmacy.

(c) A pharmacy which fills fifteen thousand or fewer prescriptions annually is a low-volume pharmacy.

(6) MAA determines a pharmacy's annual total prescription volume as follows:

(a) MAA sends out a prescription volume survey form to pharmacy providers during the first quarter of the calendar year;

(b) Pharmacies return completed prescription volume surveys to MAA by the date specified, typically April 15th of each year. Pharmacy providers not responding to the survey by the specified date are assigned to the high volume category;

(c) Pharmacies must include all prescriptions dispensed from the same physical location in the pharmacy's total prescription count;

(d) MAA considers prescriptions dispensed to nursing facility clients as outpatient prescriptions;

(e) Assignment to a new dispensing fee tier is effective on the first of the month, (typically May 1st of each year) following the date specified by MAA.

(7) A pharmacy may request a change in dispensing fee tier during the interval between the annual prescription volume surveys. The pharmacy must substantiate such a request with documentation showing that the pharmacy's most recent six-month dispensing data, annualized, would qualify the pharmacy for the new tier. If MAA receives the documentation by the twentieth of the month, assignment to a new dispensing fee tier is effective on the first of the following month.

(8) MAA grants general dispensing fee rate increases only when authorized by the legislature. Amounts authorized for dispensing fee increases may be distributed nonuniformly (e.g., tiered dispensing fee based upon volume).

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1450, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1450, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1450, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1500 Reimbursement for compounded prescriptions.

(1) The medical assistance administration (MAA) covers a drug ingredient used for a compounded prescription only when the manufacturer has a signed rebate agreement with the federal Department of Health and Human Services (DHHS). MAA considers bulk chemical supplies used in compounded prescriptions as non-drug items, which do not require a drug rebate agreement. MAA covers such bulk chemical supplies only as specifically approved by MAA.

(2) MAA does not cover or reimburse for coloring agents, preservatives, and flavoring agents used in compounded prescriptions except when they are necessary as a complete vehicle for compounding (e.g., simple syrup).

(3) MAA does not consider reconstitution to be compounding.

(a) MAA reimburses pharmacists for compounding drugs only if the client's drug therapy needs are unable to be met by commercially available dosage strengths and/or forms of the medically necessary drug.

(b) The pharmacist must ensure the need for the adjustment of the drug's therapeutic strength and/or form is well documented in the client's file.

(c) The pharmacist must ensure that the ingredients used in a compounded prescription are for an approved use as defined in "medically approved indication" in WAC 388-530-1050.

(4) MAA requires that each drug ingredient used for a compounded prescription be billed to MAA using its eleven-digit national drug code (NDC) number.

(5) Compounded prescriptions are reimbursed as follows:

(a) MAA allows only the lowest cost for each covered ingredient, whether that cost is determined by actual acquisition cost (AAC), estimated acquisition cost (EAC), federal upper limit (FUL), maximum allowable cost (MAC), automated maximum allowable cost (AMAC), certified average wholesale price (CAWP), or amount billed.

(b) MAA applies current prior authorization requirements to drugs used as ingredients in compounded prescriptions, except as provided under subsection (5)(c) of this section. MAA denies payment for a drug requiring prior authorization used as an ingredient in a compounded prescription when prior authorization was not obtained.

(c) MAA may designate selected drugs as not requiring prior authorization when used for compounded prescriptions, but requiring prior authorization for other uses. For the list of selected drugs, refer to MAA's prescription drug program billing instructions.

(d) MAA reimburses a dispensing fee as described under WAC 388-530-1450 for:

(i) Each covered or prior authorized drug ingredient billed separately; and

(ii) Drugs used in compounding under subsection (5)(c) of this section.

(e) MAA does not pay a separate fee for compounding time.

(6) MAA requires pharmacists to document the need for each inactive ingredient added to the compounded prescription. MAA limits reimbursement to those that meet the following criteria. To be reimbursed by MAA, each inactive ingredient must be:

- (a) A necessary component of a compounded drug; and
- (b) Listed in MAA's prescription drug program billing instructions.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1500, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-01-029, § 388-530-1500, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090, 96-21-031, § 388-530-1500, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1550 Unit dose drug delivery systems.

(1) The medical assistance administration (MAA) pays for unit dose drug delivery systems only for clients residing in nursing facilities, except as provided in subsections (7) and (8) of this section.

(2) Unit dose delivery systems may be either true or modified unit dose.

(3) MAA pays pharmacies that provide unit dose delivery service MAA's highest allowable dispensing fee for each unit dose prescription dispensed to clients in nursing facilities. MAA reimburses ingredient costs for drugs under unit dose systems as described in WAC 388-530-1500 (5)(a).

(4) MAA pays a pharmacy that dispenses drugs in bulk containers or multidose form to clients in nursing facilities the regular dispensing fee applicable to the pharmacy's total annual prescription volume tier. Drugs MAA considers not deliverable in unit dose form include, but are not limited to, liquids, creams, ointments, ophthalmic and otic solutions. MAA reimburses ingredient costs as described in WAC 388-530-1500 (5)(a).

(5) MAA pays a pharmacy that dispenses drugs prepackaged by the manufacturer in unit dose form to clients in nursing facilities the regular dispensing fee applicable under WAC 388-530-1450(5). MAA reimburses ingredient costs for drugs prepackaged by the manufacturer in unit dose form as described in WAC 388-530-1500 (5)(a).

(6) MAA limits its coverage and payment for manufacturer-designated unit dose packaging to the following conditions:

- (a) The drug is a single source drug and a multidose package for the drug is not available;
- (b) The drug is a multiple source drug but there is no other multidose package available among the drug's generic equivalents; or
- (c) The manufacturer-designated unit dose package is the most cost-effective package available or it is the least costly alternative form of the drug.

(7) MAA reimburses a pharmacy provider for manufacturer-designated unit dose drugs dispensed to clients not residing in nursing facilities only when such drugs:

- (a) Are available in the marketplace only in manufacturer-designated unit dose packaging; and
- (b) Would otherwise have been covered outpatient drugs. The unit dose dispensing fee does not apply in such

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cases. MAA pays the pharmacy the dispensing fee applicable to the pharmacy's total annual prescription volume tier.

(8) MAA may pay for unit dose delivery systems for developmentally disabled (DD) clients residing in approved community living arrangements.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1550, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-01-029, § 388-530-1550, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090, 96-21-031, § 388-530-1550, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1600 Unit dose pharmacy billing requirements. (1) To be eligible for a unit dose dispensing fee from the medical assistance administration (MAA), a pharmacy must:

(a) Notify MAA in writing of its intent to provide unit dose service;

(b) Identify the nursing facility(ies) to be served;

(c) Indicate the approximate date unit dose service to the facility(ies) will commence; and

(d) Follow department requirements for unit dose reimbursement.

(2) Under a unit dose delivery system, a pharmacy must bill only for the number of drug units actually used by the medical assistance client in the nursing facility, except as provided in subsections (3), (4), and (5) of this section. It is the unit dose pharmacy provider's responsibility to coordinate with nursing facilities to ensure that the unused drugs the pharmacy dispensed to MAA clients are returned to the pharmacy for credit.

(3) The pharmacy must submit an adjustment form or claims reversal of the charge to MAA for the cost of all unused drugs returned to the pharmacy from the nursing facility on or before the sixtieth day following the date the drug was dispensed, except as provided in subsection (5) of this section. Such adjustment must conform to the nursing facility's monthly log as described in subsection (7) of this section.

(4) MAA pays a unit dose provider a dispensing fee when a provider-packaged unit dose prescription is returned, in its entirety, to the pharmacy. A dispensing fee is not paid if the returned prescription is for a drug with a manufacturer-designated unit dose national drug code (NDC). In addition to the dispensing fee paid under this subsection, the provider may bill MAA one unit of the tablet or capsule but must credit MAA for the remainder of the ingredient costs for the returned prescription.

(5) Unit dose providers do not have to credit MAA for federally designated schedule two drugs which are returned to the pharmacy. These returned drugs must be disposed of according to federal regulations.

(6) Pharmacies must not charge clients or MAA a fee for repackaging a client's bulk medications in unit dose form. The costs of repackaging are the responsibility of the nursing facility when the repackaging is done:

(a) To conform with a nursing facility's drug delivery system; or

(b) For the nursing facility's convenience.

(7) The pharmacy must maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy must keep a monthly log for each nursing facility

served, including but not limited to the following information:

- (a) Facility name and address;
- (b) Client's name and patient identification code (PIC);
- (c) Drug name/strength;
- (d) National drug code (NDC);
- (e) Quantity and date dispensed;
- (f) Quantity and date returned;
- (g) Value of returned drugs or amount credited;
- (h) Explanation for no credit given or nonreusable returns; and

- (i) Prescription number.

(8) Upon MAA's request, the pharmacy must submit copies of the logs referred to in subsection (7) of this section.

(9) When the pharmacy submits the completed annual prescription volume survey to MAA, it must include an updated list of all nursing facilities currently served under unit dose systems.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1600, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1600, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.04.050, 74.08.090, 42 CFR 447.333 and Attachment 4.19-B, Page 2-b of the State Plan under Title XIX of the Social Security Act. 98-14-005, § 388-530-1600, filed 6/18/98, effective 7/19/98. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1600, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1625 Compliance packaging services.

(1) The medical assistance administration (MAA) reimburses pharmacies for compliance packaging services provided to clients considered at risk for adverse drug therapy outcomes. Clients who are eligible for compliance packaging services must not reside in a nursing home or other inpatient facility, and must meet (a) and either (b) or (c) of this subsection. The client must:

(a) Have one or more of the following representative disease conditions:

- (i) Alzheimer's disease;
- (ii) Blood clotting disorders;
- (iii) Cardiac arrhythmia;
- (iv) Congestive heart failure;
- (v) Depression;
- (vi) Diabetes;
- (vii) Epilepsy;
- (viii) HIV/AIDS;
- (ix) Hypertension;
- (x) Schizophrenia; or
- (xi) Tuberculosis.

(b) Concurrently consume two or more prescribed medications for chronic medical conditions, that are dosed at three or more intervals per day; or

(c) Have demonstrated a pattern of noncompliance that is potentially harmful to the client's health. The client's pattern of noncompliance with the prescribed drug regimen must be fully documented in the provider's file.

(2) Compliance packaging services include:

(a) Reusable hard plastic containers of any type (e.g., medisets); and

(b) Nonreusable compliance packaging devices (e.g., blister packs).

(3) MAA pays a filling fee and reimburses pharmacies for the compliance packaging device and/or container. The

frequency of fills and number of payable compliance packaging devices per client is subject to limits specified by MAA. MAA does not pay filling or preparation fees for blister packs.

(4) Pharmacies must use the HCFA-1500 claim form to bill MAA for compliance packaging services.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1625, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1625, filed 12/7/00, effective 1/7/01.]

WAC 388-530-1650 Reimbursement for pharmaceutical supplies. (1) The medical assistance administration (MAA) reimburses for selected covered pharmaceutical supplies that are not included in MAA's drug claim payment system, called the point-of-sale (POS) system.

(2) MAA bases reimbursement of pharmaceutical items or supplies that are not payable through the POS on MAA-published fee schedules.

(3) MAA uses any or all of the following methodologies to set the maximum allowable reimbursement rate for pharmaceutical items, devices, and supplies:

(a) A pharmacy provider's acquisition cost. Upon review of the claim, MAA may require an invoice which must show the name of the item, the manufacturer, the product description, the quantity, and the cost including any free goods associated with the invoice;

(b) Medicare's reimbursement for the item; or

(c) A specified discount off the item's list price or manufacturer's suggested retail price (MSRP).

(4) MAA does not pay a dispensing fee for nondrug items, devices, or supplies. See WAC 388-530-1450(2).

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1650, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1650, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1650, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1700 Drugs and drug-related supplies from nonpharmacy providers. The medical assistance administration (MAA) reimburses for covered drugs, supplies, and devices provided or administered by nonpharmacy providers under specified conditions.

(1) MAA reimburses actual acquisition cost (AAC) to a physician or ARNP for a covered drug (oral, topical or injectable) prepared or packaged for individual use and provided or administered to a client during an office visit. When the cost of the drug provided or administered to the client exceeds the established fee, the physician or ARNP may submit to MAA a photocopy of the invoice for the actual drug cost. The invoice must show the name of the drug, the manufacturer, the national drug code (NDC), drug strength, quantity, and cost.

(2) MAA reimburses drugs and supplies provided to clients by local health departments according to its established fee schedules.

(3) MAA does not reimburse providers for the cost of vaccines obtained through the state department of health (DOH); MAA does pay physicians and ARNPs a fee for administering the vaccine.

(4) MAA reimburses family planning clinics:

(a) For oral contraceptives, the lesser of the family planning clinic's certified full fee or MAA's maximum allowable fee per cycle of birth control pills. The certified full fee is the clinic's acquisition cost for each cycle of birth control pills, as reported annually by the clinic to DOH;

(b) For contraceptive supplies and devices, the clinic's actual acquisition cost or MAA's maximum allowable fee, whichever is specified by MAA; and

(c) For other drugs, supplies, and devices, according to MAA's established fee schedules.

(5) MAA may request family planning clinics and other nonpharmacy providers to submit an invoice for the actual cost of the drug, supply, or device billed. If an invoice is requested, the invoice must show the:

(a) Name of the drug, supply, or device;

(b) Drug or product manufacturer;

(c) NDC of the product(s);

(d) Drug strength;

(e) Product description;

(f) Quantity; and

(g) Cost, including any free goods associated with the invoice.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1700, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-029, § 388-530-1700, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1700, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1750 Drugs and pharmaceutical supplies for clients with any third-party coverage. (1) The medical assistance administration (MAA) requires pharmacy providers to meet the third party requirements of WAC 388-501-0200.

(2) Except as specified under MAA's managed care contracts, MAA does not reimburse providers for any drugs or pharmaceutical supplies provided to clients who have pharmacy benefits under MAA-contracted managed care plans. The managed care plan is responsible for payment.

(3) The following definitions apply to this section:

(a) "Closed pharmacy network" means an arrangement made by an insurer which restricts prescription coverage to an exclusive list of pharmacies. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy that is not included on the exclusive list.

(b) "Private point-of-sale (POS) authorization system" means an insurer's system, other than the MAA POS system, which requires that coverage be verified by or submitted to the insurer's agent for authorization at the time of service and at the time the prescription is filled.

(4) This subsection applies to MAA clients who have a third-party resource that is a managed care entity other than an MAA-contracted plan, or have other insurance that requires the use of "closed pharmacy networks" or "private point-of-sale authorization." MAA will not pay pharmacies for prescription drug claims until the pharmacy provider submits an explanation of benefits from the private insurance that demonstrates that the pharmacy provider has complied with the terms of the third-party's coverage.

(a) If the private insurer pays a fee based on the incident of care, the pharmacy provider must file a claim with MAA consistent with MAA's billing requirements.

(b) If the private insurer pays the pharmacy provider a monthly capitation fee for all prescription costs related to the client, the pharmacy provider must submit a claim to MAA for the amount of the client copayment, coinsurance, and/or deductible. MAA pays the provider the lesser of:

(i) The billed amount; or

(ii) MAA's maximum allowable fee for the prescription.

(5) For clients eligible for both Medicare and medical assistance, MAA reimburses providers for:

(a) An amount up to MAA's maximum allowable fee for drugs Medicare does not cover, but MAA covers; or

(b) Deductible and/or coinsurance amounts up to Medicare's or MAA's maximum allowable fee, whichever is less, for drugs Medicare and MAA cover; or

(c) Deductible and/or coinsurance amounts for clients under the qualified Medicare beneficiary (QMB) program for drugs Medicare covers but MAA does not cover.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1750, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.09.035. 00-14-071, § 388-530-1750, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1750, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1800 Requirements for pharmacy claim payment. (1) When billing the medical assistance administration (MAA) for pharmacy services, providers must:

(a) Use the appropriate department claim form or electronic billing specifications;

(b) Include the actual eleven-digit national drug code (NDC) number of the product dispensed; and

(c) Bill MAA using metric decimal quantities which is the National Council for Prescription Drug Programs (NCPDP) billing unit standard.

(2) When billing drugs requiring authorization, providers must insert the authorization number in the appropriate data field on the drug claim.

(3) When billing drugs under the expedited authorization process, providers must insert the authorization number which includes the corresponding criteria code(s) in the appropriate data field on the drug claim.

(4) Pharmacy services for clients on restriction under WAC 388-501-0135 must be prescribed by the client's primary care provider and are paid only to the client's primary pharmacy, except in cases of:

(a) Emergency;

(b) Family planning services; or

(c) Services properly referred from the client's assigned pharmacy or physician/ARNP.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1800, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-530-1800, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1800, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1850 Drug use review (DUR) board. In accordance with 42 C.F.R. 456.716, the medical assistance administration (MAA) establishes a drug use review (DUR) board (also known as the drug utilization & education (DUE) council).

(1) The DUR board:

(a) Includes health professionals who are actively practicing and licensed in the state of Washington and who have recognized knowledge and expertise in one or more of the following:

- (i) The clinically appropriate prescribing of covered outpatient drugs;
- (ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs;
- (iii) Drug use review, evaluation, and intervention; and
- (iv) Medical quality assurance.

(b) Is made up of at least one-third but not more than fifty-one percent physicians, and at least one-third pharmacists.

(2) MAA may appoint members of the pharmacy and therapeutics committee established by the health care authority (HCA) under chapter 182-50 WAC or other qualified individuals to serve as members of the DUR board.

(3) The DUR board meets periodically to:

- (a) Advise MAA on drug utilization review activities;
- (b) Review provider and patient profiles;
- (c) Recommend adoption of standards and treatment guidelines for drug therapy;
- (d) Recommend interventions targeted toward correcting drug therapy problems; and
- (e) Produce an annual report.

(4) MAA has the authority to accept or reject the recommendations of the DUR board in accordance with 42 C.F.R. 456.716(c).

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 2003 1st sp.s. c 29 § 10, 42 C.F.R. 456.716, RCW 41.05.160, 04-11-009, § 388-530-1850, filed 5/5/04, effective 6/5/04. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102, 02-17-023, § 388-530-1850, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-01-028, § 388-530-1850, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090, 96-21-031, § 388-530-1850, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1900 Drug use and claims review. (1)

The medical assistance administration's (MAA's) drug use review (DUR) consists of:

(a) A prospective drug use review (Pro-DUR) that requires all pharmacy providers to:

- (i) Obtain patient histories of allergies, idiosyncrasies, or chronic condition(s) which may relate to drug utilization;
- (ii) Screen for potential drug therapy problems; and
- (iii) Counsel the patient in accordance with existing state pharmacy laws and federal regulations; and

(b) A retrospective drug use review (Retro-DUR), in which MAA provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits.

(2) MAA performs a periodic sampling of claims to determine if drugs are appropriately dispensed and billed. If a review of the sample finds that a provider is inappropriately dispensing or billing for drugs, MAA may implement corrective action that includes, but is not limited to:

(a) Educating the provider regarding the problem practice(s);

(b) Requiring the provider to maintain specific documentation in addition to the normal documentation requirements regarding the provider's dispensing or billing actions;

(c) Recouping the payment for the drug(s); and/or

(d) Terminating the provider's core provider agreement.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1900, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102, 02-17-023, § 388-530-1900, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050, 01-01-028, § 388-530-1900, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090, 96-21-031, § 388-530-1900, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1950 Point-of-sale (POS) system/prospective drug use review (Pro-DUR). (1)

Pharmacy claims for drugs and other products listed in the medical assistance administration (MAA) drug file list and billed to MAA by national drug code (NDC) are adjudicated by the MAA point-of-sale (POS) system. Claims must be submitted for payment using the billing unit standard identified in WAC 388-530-1800.

(2) All pharmacy drug claims processed through the POS system undergo a system-facilitated prospective drug use review (Pro-DUR) screening as a complement to the Pro-DUR screening required of pharmacists.

(3) If the MAA POS system identifies a potential drug therapy problem during Pro-DUR screening, a message will alert the pharmacy provider indicating the type of potential problem.

The alerts regarding possible drug therapy problems include, but are not limited to:

- (a) Therapeutic duplication;
- (b) Duration of therapy exceeds the recommended maximum period;
- (c) Drug-to-drug interaction;
- (d) Drug disease precaution;
- (e) High dose;
- (f) Ingredient duplication;
- (g) Drug-to-client age conflict;
- (h) Drug-to-client gender conflict; or
- (i) Refill too soon.

(4) MAA provides pharmacy providers with a list of codes from which to choose in overriding MAA POS system alert messages. The override codes come from the national council for prescription drug programs (NCPDP).

(5) The dispensing pharmacist evaluates the potential drug therapy conflict and chooses one of the following:

(a) If the conflict is resolved, the pharmacy may process the claim using the applicable NCPDP override code.

(b) If the conflict is not resolved, MAA requires prior authorization. This includes all claims for which an alert message is triggered in the POS system and an NCPDP override code is not appropriate.

(6) MAA requires providers to retain documentation of the justification for the use of payment system override codes as described in subsections (4) and (5) of this section. MAA requires the documentation be retained for the same period as that described in WAC 388-502-0020.

(7) POS/Pro-DUR screening is not applicable to pharmacy claims included in the managed care capitated rate.

[Statutory Authority: RCW 74.08.090, 70.14.050, 69.41.150, 69.41.190, chapter 41.05 RCW. 05-02-044, § 388-530-1950, filed 12/30/04, effective 1/30/05. Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-1950, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-1950, filed 12/7/00, effective 1/7/01. Statutory Authority: RCW 74.08.090. 96-08-018 (Order 3960), § 388-530-1950, filed 3/26/96, effective 4/26/96.]

WAC 388-530-2050 Reimbursement for out-of-state prescriptions. (1) The medical assistance administration (MAA) reimburses out-of-state pharmacies for prescription drugs provided to an eligible client within the scope of the client's medical care program if the pharmacy:

(a) Contracts with MAA to be an enrolled provider; and
(b) Meets the same criteria MAA requires for in-state pharmacy providers.

(2) MAA considers pharmacies located in bordering areas listed in WAC 388-501-0175 the same as in-state pharmacies.

[Statutory Authority: RCW 74.09.080, 74.04.050 and 42 C.F.R. Subpart K, subsection 162.1102. 02-17-023, § 388-530-2050, filed 8/9/02, effective 9/9/02. Statutory Authority: RCW 74.08.090, 74.04.050. 01-01-028, § 388-530-2050, filed 12/7/00, effective 1/7/01; 00-01-088, § 388-530-2050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-2050, filed 10/9/96, effective 11/9/96.]

Chapter 388-531 WAC PHYSICIAN-RELATED SERVICES

WAC

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388-531-0750	Inpatient hospital physician-related services.
388-531-0800	Laboratory and pathology physician-related services.
388-531-0850	Laboratory and pathology physician-related services reimbursement.
388-531-0900	Neonatal intensive care unit (NICU) physician-related services.
388-531-0950	Office and other outpatient physician-related services.
388-531-1000	Ophthalmic physician-related services.
388-531-1050	Osteopathic manipulative treatment.
388-531-1100	Out-of-state physician services.
388-531-1150	Physician care plan oversight services.
388-531-1200	Physician office medical supplies.
388-531-1250	Physician standby services.
388-531-1300	Podiatric physician-related services.
388-531-1350	Prolonged physician-related service.
388-531-1400	Psychiatric physician-related services.
388-531-1450	Radiology physician-related services.
388-531-1500	Sleep studies.
388-531-1550	Sterilization physician-related services.
388-531-1600	Bariatric surgery.

388-531-1650	Substance abuse detoxification physician-related services.
388-531-1700	Surgical physician-related services.
388-531-1750	Transplant coverage for physician-related services.
388-531-1800	Transplant coverage—Medical criteria to receive transplants.
388-531-1850	Payment methodology for physician-related services—General and billing modifiers.
388-531-1900	Reimbursement—General requirements for physician-related services.
388-531-2000	Increased payments for physician-related services for qualified trauma cases.

WAC 388-531-0050 Physician-related services definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, apply to this chapter. Defined words and phrases are bolded the first time they are used in the text.

"Acquisition cost" means the cost of an item excluding shipping, handling, and any applicable taxes.

"Acute care" means care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status. See also WAC 246-335-015.

"Acute physical medicine and rehabilitation (PM&R)" means a comprehensive inpatient and rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four hour specialized nursing services and an intense level of specialized therapy (speech, physical, and occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 388-550-2501).

"Add-on procedure(s)" means secondary procedure(s) that are performed in addition to another procedure.

"Admitting diagnosis" means the medical condition responsible for a hospital admission, as defined by ICD-9-M diagnostic code.

"Advanced registered nurse practitioner (ARNP)" means a registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

"Aging and disability services administration (ADSA)" means the administration that administers directly or contracts for long-term care services, including but not limited to nursing facility care and home and community services. See WAC 388-71-0202.

"Allowed charges" means the maximum amount reimbursed for any procedure that is allowed by MAA.

"Anesthesia technical advisory group (ATAG)" means an advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

"Bariatric surgery" means any surgical procedure, whether open or by laparoscope, which reduces the size of the stomach with or without bypassing a portion of the small intestine and whose primary purpose is the reduction of body weight in an obese individual.

"Base anesthesia units (BAU)" means a number of anesthesia units assigned to a surgical procedure that includes the usual pre-operative, intra-operative, and post-operative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

"Bundled services" means services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

"Bundled supplies" means supplies which are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

"By report (BR)" means a method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

"Call" means a face-to-face encounter between the client and the provider resulting in the provision of services to the client.

"Cast material maximum allowable fee" means a reimbursement amount based on the average cost among suppliers for one roll of cast material.

"Centers for Medicare and Medicaid Services (CMS)" means the agency within the federal Department of Health and Human Services (DHHS) with oversight responsibility for Medicare and Medicaid programs.

"Certified registered nurse anesthetist (CRNA)" means an advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the National Certification and scope of practice.

"Children's health insurance plan (CHIP)," see chapter 388-542 WAC.

"Clinical Laboratory Improvement Amendment (CLIA)" means regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

"Conversion factors" means dollar amounts MAA uses to calculate the maximum allowable fee for physician-related services.

"Covered service" means a service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

"CPT," see "current procedural terminology."

"Critical care services" means physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such that the client's survival is jeopardized. Critical care is given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Diagnosis code" means a set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.

"Emergency medical condition(s)" means a medical condition(s) that manifests itself by acute symptoms of suffi-

cient severity so that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"Emergency services" means medical services required by and provided to a patient experiencing an emergency medical condition.

"Estimated acquisition cost (EAC)" means the department's best estimate of the price providers generally and currently pay for drugs and supplies.

"Evaluation and management (E&M) codes" means procedure codes which categorize physician services by type of service, place of service, and patient status.

"Expedited prior authorization" means the process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"Experimental" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of safety and effectiveness. See WAC 388-531-0550. A service is not "experimental" if the service:

- (1) Is generally accepted by the medical profession as effective and appropriate; and
- (2) Has been approved by the FDA or other requisite government body, if such approval is required.

"Fee-for-service" means the general payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under MAA's healthy options program or children's health insurance program (CHIP) programs.

"Flat fee" means the maximum allowable fee established by MAA for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"Geographic practice cost index (GPCI)" as defined by Medicare, means a Medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"Global surgery reimbursement," see WAC 388-531-1700.

"HCPCS Level II" means a coding system established by CMS (formerly known as the Health Care Financing Administration) to define services and procedures not included in CPT.

"Health care financing administration common procedure coding system (HCPCS)" means the name used for the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) codes made up of CPT and HCPCS level II codes.

"Health care team" means a group of health care providers involved in the care of a client.

"Hospice" means a medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"ICD-9-CM," see "International Classification of Diseases, 9th Revision, Clinical Modification."

"Informed consent" means that an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and
 (2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and

(3) Given the client a copy of the consent form; and

(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and

(5) Given the client oral information about all of the following:

(a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and

(b) Alternatives to the procedure including potential risks, benefits, and consequences; and

(c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital admission" means an admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alpha-numerical designations (coding).

"Investigational" means a term to describe a procedure, or course of treatment, which lacks sufficient scientific evidence of benefit for a particular condition. A service is not "investigational" if the service:

(1) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(2) Is supported by an overall balance of objective scientific evidence, in which the potential risks and potential benefits are examined, demonstrating the proposed service to be of greater overall benefit to the client in the particular circumstance than another, generally available service.

"Life support" means mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

"Limitation extension" means a process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MAA routinely reimburses. Limitation extensions require prior authorization.

"Maximum allowable fee" means the maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

"Medically necessary," see WAC 388-500-0005.

"Medicare physician fee schedule data base (MPFSDB)" means the official HCFA publication of the Medicare policies and RVUs for the RBRVS reimbursement program.

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"Medicare program fee schedule for physician services (MPFSPS)" means the official HCFA publication of the Medicare fees for physician services.

"Medicare clinical diagnostic laboratory fee schedule" means the fee schedule used by Medicare to reimburse for clinical diagnostic laboratory procedures in the state of Washington.

"Mentally incompetent" means a client who has been declared mentally incompetent by a federal, state, or local court.

"Modifier" means a two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting physician can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"Outpatient" means a client who is receiving medical services in other than an inpatient hospital setting.

"Peer-reviewed medical literature" means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

"Physician care plan" means a written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

"Physician standby" means physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

"Physician's current procedural terminology," see "CPT, current procedural terminology."

"PM&R," see acute physical medicine and rehabilitation.

"Podiatric service" means the diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

"Pound indicator (#)" means a symbol (#) indicating a CPT procedure code listed in MAA fee schedules that is not routinely covered.

"Preventive" means medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

"Prior authorization" means a process by which clients or providers must request and receive MAA approval for certain medical services, equipment, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

"Professional component" means the part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

"Prognosis" means the probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

"Prolonged services" means face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

"Provider," see WAC 388-500-0005.

"Radioallergosorbent test" or "RAST" means a blood test for specific allergies.

"RBRVS," see resource based relative value scale.

"RVU," see relative value unit.

"Reimbursement" means payment to a provider or other MAA-approved entity who bills according to the provisions in WAC 388-502-0100.

"Reimbursement steering committee (RSC)" means an interagency work group that establishes and maintains RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, MAA, and department of labor and industries.

"Relative value guide (RVG)" means a system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

"Relative value unit (RVU)" means a unit which is based on the resources required to perform an individual service or intervention.

"Resource based relative value scale (RBRVS)" means a scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"RBRVS RVU" means a measure of the resources required to perform an individual service or intervention. It is set by Medicare based on three components - physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

"RSC RVU" means a unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

"Stat laboratory charges" means charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

"Sterile tray" means a tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by HCFA to be nonroutine and reimbursed separately.

"Technical advisory group (TAG)" means an advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the health care authority, MAA, and department of labor and industries.

"Technical component" means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reim-

bursement that recognizes the equipment cost and technician time.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-059, § 388-531-0050, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-081, § 388-531-0050, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090. 03-06-049, § 388-531-0050, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0050, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0100 Scope of coverage for physician-related services—General and administrative. (1) The department covers medical services, equipment, and supplies when they are:

(a) Within the scope of an eligible client's medical assistance program. Refer to WAC 388-501-0060 and 388-501-0065; and

(b) Medically necessary as defined in WAC 388-500-0005.

(2) The department evaluates a request for a service that is in a covered category under the provisions of WAC 388-501-0165.

(3) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 388-501-0169.

(4) The department covers the following physician-related services, subject to the conditions in subsections (1), (2), and (3) of this section:

- (a) Allergen immunotherapy services;
- (b) Anesthesia services;
- (c) Dialysis and end stage renal disease services (refer to chapter 388-540 WAC);
- (d) Emergency physician services;
- (e) ENT (ear, nose, and throat) related services;
- (f) Early and periodic screening, diagnosis, and treatment (EPSDT) services (refer to WAC 388-534-0100);
- (g) Family planning services (refer to chapter 388-532 WAC);
- (h) Hospital inpatient services (refer to chapter 388-550 WAC);
- (i) Maternity care, delivery, and newborn care services (refer to chapter 388-533 WAC);
- (j) Office visits;
- (k) Vision-related services, refer to chapter 388-544 WAC;
- (l) Osteopathic treatment services;
- (m) Pathology and laboratory services;
- (n) Psychiatry and other rehabilitation services (refer to chapter 388-550 WAC);
- (o) Podiatry services;
- (p) Primary care services;
- (q) Psychiatric services, provided by a psychiatrist;
- (r) Pulmonary and respiratory services;
- (s) Radiology services;
- (t) Surgical services;
- (u) Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects from birth, illness, or physical trauma, or for mastectomy reconstruction for post cancer treatment; and
- (v) Other outpatient physician services.

(5) The department covers physical examinations for medical assistance clients only when the physical examination is one or more of the following:

(a) A screening exam covered by the EPSDT program (see WAC 388-534-0100);

(b) An annual exam for clients of the division of developmental disabilities; or

(c) A screening pap smear, mammogram, or prostate exam.

(6) By providing covered services to a client eligible for a medical assistance program, a provider who has signed an agreement with the department accepts the department's rules and fees as outlined in the agreement, which includes federal and state law and regulations, billing instructions, and department issuances.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-531-0100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0100, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0150 Noncovered physician-related services—General and administrative. (1) Except as provided in WAC 388-531-0100 and subsection (2) of this section, MAA does not cover the following:

(a) Acupuncture, massage, or massage therapy;

(b) Any service specifically excluded by statute;

(c) Care, testing, or treatment of infertility, frigidity, or impotency. This includes procedures for donor ovum, sperm, womb, and reversal of vasectomy or tubal ligation;

(d) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to trauma, birth defect, or illness;

(e) Experimental or investigational services, procedures, treatments, devices, drugs, or application of associated services, except when the individual factors of an individual client's condition justify a determination of medical necessity under WAC 388-501-0165;

(f) Hair transplantation;

(g) Marital counseling or sex therapy;

(h) More costly services when MAA determines that less costly, equally effective services are available;

(i) Vision-related services listed as noncovered in chapter 388-544 WAC;

(j) Payment for body parts, including organs, tissues, bones and blood, except as allowed in WAC 388-531-1750;

(k) Physician-supplied medication, except those drugs administered by the physician in the physician's office;

(l) Physical examinations or routine checkups, except as provided in WAC 388-531-0100;

(m) Routine foot care. This does not include clients who have a medical condition that affects the feet, such as diabetes or arteriosclerosis obliterans. Routine foot care includes, but is not limited to:

(i) Treatment of mycotic disease;

(ii) Removal of warts, corns, or calluses;

(iii) Trimming of nails and other hygiene care; or

(iv) Treatment of flat feet;

(n) Except as provided in WAC 388-531-1600, weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for

the purpose of weight reduction, or the application of associated services.

(o) Nonmedical equipment; and

(p) Nonemergent admissions and associated services to out-of-state hospitals or noncontracted hospitals in contract areas.

(2) MAA covers excluded services listed in (1) of this subsection if those services are mandated under and provided to a client who is eligible for one of the following:

(a) The EPSDT program;

(b) A Medicaid program for qualified **Medicare** beneficiaries (QMBs); or

(c) A waiver program.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-12-022, § 388-531-0150, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0150, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0200 Physician-related services requiring prior authorization. (1) MAA requires **prior authorization** for certain services. Prior authorization includes **expedited prior authorization (EPA)** and **limitation extension (LE)**. See WAC 388-501-0165.

(2) The EPA process is designed to eliminate the need for telephone prior authorization for selected admissions and procedures.

(a) The provider must create an authorization number using the process explained in MAA's physician-related billing instructions.

(b) Upon request, the provider must provide supporting clinical documentation to MAA showing how the authorization number was created.

(c) Selected nonemergent admissions to contract hospitals require EPA. These are identified in MAA billing instructions.

(d) Procedures requiring expedited prior authorization include, but are not limited to, the following:

(i) Bladder repair;

(ii) Hysterectomy for clients age forty-five and younger, except with a diagnosis of cancer(s) of the female reproductive system;

(iii) Outpatient magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA);

(iv) Reduction mammoplasties/mastectomy for gynecomastia; and

(v) Strabismus surgery for clients eighteen years of age and older.

(3) MAA evaluates new technologies under the procedures in WAC 388-531-0550. These require prior authorization.

(4) Prior authorization is required for the following:

(a) Abdominoplasty;

(b) All inpatient hospital stays for **acute physical medicine and rehabilitation (PM&R)**;

(c) Cochlear implants, which also:

(i) For coverage, must be performed in an ambulatory surgery center (ASC) or an inpatient or outpatient hospital facility; and

(ii) For reimbursement, must have the invoice attached to the claim;

(d) Diagnosis and treatment of eating disorders for clients twenty-one years of age and older;

- (e) Osteopathic manipulative therapy in excess of MAA's published limits;
 - (f) Panniculectomy;
 - (g) Bariatric surgery (see WAC 388-531-1600); and
 - (h) Vagus nerve stimulator insertion, which also:
 - (i) For coverage, must be performed in an inpatient or outpatient hospital facility; and
 - (ii) For reimbursement, must have the invoice attached to the claim.
- (5) MAA may require a second opinion and/or consultation before authorizing any elective surgical procedure.
- (6) Children six year of age and younger do not require authorization for hospitalization.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-12-022, § 388-531-0200, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0200, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0250 Who can provide and bill for physician-related services. (1) The following enrolled providers are eligible to provide and bill for physician-related medical services which they provide to eligible clients:

- (a) Advanced registered nurse practitioners (ARNP);
- (b) Federally qualified health centers (FQHCs);
- (c) Health departments;
- (d) Hospitals currently licensed by the department of health;
- (e) Independent (outside) laboratories **CLIA** certified to perform tests. See WAC 388-531-0800;
- (f) Licensed radiology facilities;
- (g) Medicare-certified ambulatory surgery centers;
- (h) Medicare-certified rural health clinics;
- (i) Providers who have a signed agreement with MAA to provide screening services to eligible persons in the EPSDT program;
- (j) Registered nurse first assistants (RNFA); and
- (k) Persons currently licensed by the state of Washington department of health to practice any of the following:
 - (i) Dentistry (refer to chapter 388-535 WAC);
 - (ii) Medicine and osteopathy;
 - (iii) Nursing;
 - (iv) Optometry; or
 - (v) Podiatry.

(2) MAA does not reimburse for services performed by any of the following practitioners:

- (a) Acupuncturists;
- (b) Christian Science practitioners or theological healers;
- (c) Counselors;
- (d) Herbalists;
- (e) Homeopaths;
- (f) Massage therapists as licensed by the Washington state department of health;
- (g) Naturopaths;
- (h) Sanipractors;
- (i) Those who have a master's degree in social work (MSW), except those employed by an FQHC or who have prior authorization to evaluate a client for bariatric surgery;
- (j) Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010; or
- (k) Any other licensed practitioners providing services which the practitioner is not:

- (i) Licensed to provide; and
 - (ii) Trained to provide.
- (3) MAA reimburses practitioners listed in subsection (2) of this section for physician-related services if those services are mandated by, and provided to, clients who are eligible for one of the following:
- (a) The EPSDT program;
 - (b) A Medicaid program for qualified Medicare beneficiaries (QMB); or
 - (c) A waiver program.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-12-022, § 388-531-0250, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0250, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0300 Anesthesia providers and covered physician-related services. MAA bases coverage of anesthesia services on Medicare policies and the following rules:

(1) MAA reimburses providers for covered anesthesia services performed by:

- (a) Anesthesiologists;
- (b) **Certified registered nurse anesthetists (CRNAs);**
- (c) Oral surgeons with a special agreement with MAA to provide anesthesia services; and
- (d) Other providers who have a special agreement with MAA to provide anesthesia services.

(2) MAA covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

- (a) Computerized tomography (CT);
- (b) Dental procedures;
- (c) Electroconvulsive therapy; and
- (d) Magnetic resonance imaging (MRI).

(3) MAA covers anesthesia services provided for any of the following:

- (a) Dental restorations and/or extractions;
- (b) Maternity per subsection (9) of this section. See WAC 388-531-1550 for information about sterilization/hysterectomy anesthesia;
- (c) Pain management per subsection (5) of this section;
- (d) Radiological services as listed in WAC 388-531-1450; and
- (e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

- (a) Perform a pre-anesthetic examination and evaluation;
- (b) Prescribe the anesthesia plan;
- (c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) MAA does not allow the anesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by Medicare instructions.

(6) MAA requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, MAA reimburses the base anesthesia units (BAU) for the major procedure only.

(b) MAA does not reimburse the attending surgeon for anesthesia services.

(c) When more than one anesthesia provider is present on a case, MAA reimburses as follows:

(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive fifty percent of the allowed amount.

(ii) For anesthesia provided by a team, MAA limits reimbursement to one hundred percent of the total allowed reimbursement for the service.

(8) Pain management:

(a) MAA pays CRNAs or anesthesiologists for pain management services.

(b) MAA allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) MAA does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC 388-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter 388-533 WAC for more information about maternity-related services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0300, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0350 Anesthesia services—Reimbursement for physician-related services. (1) MAA reimburses anesthesia services on the basis of base anesthesia units (BAU) plus time.

(2) MAA calculates payment for anesthesia by adding the BAU to the time units and multiplying that sum by the conversion factor. The formula used in the calculation is: $(BAU \times \text{fifteen}) + \text{time}) \times (\text{conversion factor divided by fifteen}) = \text{reimbursement}$.

(3) MAA obtains BAU values from the relative value guide (RVG), and updates them annually. MAA and/or the anesthesia technical advisory group (ATAG) members estab-

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lish the base units for procedures for which anesthesia is appropriate but do not have BAUs established by RVSP and are not defined as add-on.

(4) MAA determines a budget neutral anesthesia conversion factor by:

(a) Determining the BAUs, time units, and expenditures for a **base period** for the provided procedure. Then,

(b) Adding the latest BAU RVSP to the time units for the base period to obtain an estimate of the new time unit for the procedure. Then,

(c) Multiplying the time units obtained in (b) of this subsection for the new period by a conversion factor to obtain estimated expenditures. Then,

(d) Comparing the expenditures obtained in (c) of this subsection with base period expenditure levels obtained in (a) of this subsection. Then,

(e) Adjusting the dollar amount for the anesthesia conversion factor and the projected time units at the new BAUs equals the allocated amount determined in (a) of this subsection.

(5) MAA calculates anesthesia time units as follows:

(a) One minute equals one unit.

(b) The total time is calculated to the next whole minute.

(c) Anesthesia time begins when the anesthesiologist, surgeon, or CRNA begins physically preparing the client for the induction of anesthesia; this must take place in the operating room or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be added together as long as there is continuous monitoring. Examples of this include, but are not limited to, the following:

(i) The time a client spends in an anesthesia induction room; or

(ii) The time a client spends under the care of an operating room nurse during a surgical procedure.

(d) Anesthesia time ends when the anesthesiologist, surgeon, or CRNA is no longer in constant attendance (i.e., when the client can be safely placed under post-operative supervision).

(6) MAA changes anesthesia **conversion factors** if the legislature grants a vendor rate increase, or other increase, and if the effective date of that increase is not the same as MAA's annual update.

(7) If the legislatively authorized vendor rate increase or other increase becomes effective at the same time as MAA's annual update, MAA applies the increase after calculating the budget-neutral conversion factor.

(8) When more than one surgical procedure is performed at the same operative session, MAA uses the BAU of the major procedure to determine anesthesia **allowed charges**. MAA reimburses add-on procedures as defined by CPT only for the time spent on the add-on procedure that is in addition to the time spent on the major procedure.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0350, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0400 Client responsibility for reimbursement for physician-related services. Clients may be responsible to reimburse the provider, as described under WAC 388-501-0100, for services that are not covered under the client's medical care program. Clients whose care is provided under CHIP may be responsible for copayments as out-

lined in chapter 388-542 WAC. Also, see WAC 388-502-0160, Billing the client.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0400, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0450 Critical care—Physician-related services. (1) MAA reimburses the following physicians for critical care services:

(a) The attending physician who assumes responsibility for the care of a client during a life-threatening episode;

(b) More than one physician if the services provided involve multiple organ systems; or

(c) Only one physician for services provided in the emergency room.

(2) MAA reimburses preoperative and postoperative critical care in addition to a **global surgical package** when all the following apply:

(a) The client is critically ill and the physician is engaged in work directly related to the individual client's care, whether that time is spent at the immediate bedside or elsewhere on the floor;

(b) The critical injury or illness acutely impairs one or more vital organ systems such that the client's survival is jeopardized;

(c) The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and

(d) The provider uses any necessary, appropriate modifier when billing MAA.

(3) MAA limits payment for critical care services to a maximum of three hours per day, per client.

(4) MAA does not pay separately for certain services performed during a critical care period when the services are provided on a per hour basis. These services include, but are not limited to, the following:

(a) Analysis of information data stored in computers (e.g., ECG, blood pressure, hematologic data);

(b) Blood draw for a specimen;

(c) Blood gases;

(d) Cardiac output measurement;

(e) Chest X rays;

(f) Gastric intubation;

(g) Pulse oximetry;

(h) Temporary transcutaneous pacing;

(i) Vascular access procedures; and

(j) Ventilator management.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0450, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0500 Emergency physician-related services. (1) MAA reimburses for E&M services provided in the hospital emergency department to clients who arrive for immediate medical attention.

(2) MAA reimburses emergency physician services only when provided by physicians assigned to the hospital emergency department or the physicians on **call** to cover the hospital emergency department.

(3) MAA pays a provider who is called back to the emergency room at a different time on the same day to attend a return visit the same client. When this results in multiple claims on the same day, the time of each encounter must be clearly indicated on the claim.

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(4) MAA does not pay emergency room physicians for **hospital admission** charges or additional service charges.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0550 Experimental and investigational services. (1) When MAA makes a determination as to whether a proposed service is experimental or investigational, MAA follows the procedures in this section. The policies and procedures and any criteria for making decisions are available upon request.

(2) The determination of whether a service is experimental and/or investigational is subject to a case-by-case review under the provisions of WAC 388-501-0165 which relate to medical necessity. MAA also considers the following:

(a) Evidence in **peer-reviewed medical literature**, as defined in WAC 388-531-0050, and pre-clinical and clinical data reported to the National Institute of Health and/or the National Cancer Institute, concerning the probability of the service maintaining or significantly improving the enrollee's length or quality of life, or ability to function, and whether the benefits of the service or treatment are outweighed by the risks of death or serious complications;

(b) Whether evidence indicates the service or treatment is more likely than not to be as beneficial as existing conventional treatment alternatives for the treatment of the condition in question;

(c) Whether the service or treatment is generally used or generally accepted for treatment of the condition in the United States;

(d) Whether the service or treatment is under continuing scientific testing and research;

(e) Whether the service or treatment shows a demonstrable benefit for the condition;

(f) Whether the service or treatment is safe and efficacious;

(g) Whether the service or treatment will result in greater benefits for the condition than another generally available service; and

(h) If approval is required by a regulating agency, such as the Food and Drug Administration, whether such approval has been given before the date of service.

(3) MAA applies consistently across clients with the same medical condition and health status, the criteria to determine whether a service is experimental. A service or treatment that is not experimental for one client with a particular medical condition is not determined to be experimental for another enrollee with the same medical condition and health status. A service that is experimental for one client with a particular medical condition is not necessarily experimental for another, and subsequent individual determinations must consider any new or additional evidence not considered in prior determinations.

(4) MAA does not determine a service or treatment to be experimental or investigational solely because it is under clinical investigation when there is sufficient evidence in peer-reviewed medical literature to draw conclusions, and the evidence indicates the service or treatment will probably be of greater overall benefit to the client in question than another generally available service.

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(5) All determinations that a proposed service or treatment is "experimental" or "investigation" are subject to the review and approval of a physician who is:

(a) Licensed under chapter 18.57 RCW or an osteopath licensed under chapter 18.71 RCW;

(b) Designated by MAA's medical director to issue such approvals; and

(c) Available to consult with the client's treating physician by telephone.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0550, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0600 HIV/AIDS Counseling and testing as physician-related services. MAA covers one pre- and one post-HIV/AIDS counseling/testing session per client each time the client is tested for HIV/AIDS.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0600, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0650 Hospital physician-related services not requiring authorization when provided in MAA-approved centers of excellence or hospitals authorized to provide the specific services. MAA covers the following services without prior authorization when provided in MAA-approved centers of excellence. MAA issues periodic publications listing centers of excellence. These services include the following:

(1) All transplant procedures specified in WAC 388-550-1900;

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400. See also WAC 388-531-0700;

(3) Sleep studies including but not limited to polysomnograms for clients one year of age and older. MAA allows sleep studies only in outpatient hospital settings as described under WAC 388-550-6350. See also WAC 388-531-1500; and

(4) Diabetes education, in a DOH-approved facility, per WAC 388-550-6300.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-12-022, § 388-531-0650, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-0650, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0700 Inpatient chronic pain management physician-related services. (1) MAA covers inpatient chronic pain management services only when the services are obtained through an MAA-approved chronic pain facility.

(2) A client qualifies for inpatient chronic pain management services when all of the following apply:

(a) The client has had chronic pain for at least three months, that has not improved with conservative treatment, including tests and therapies;

(b) At least six months have passed since a previous surgical procedure was done in relation to the pain problem; and

(c) Clients with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs or alcohol for six months.

(3) For chronic pain management, MAA limits coverage to only one inpatient hospital stay per client's lifetime, up to a maximum of twenty-one days.

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(4) MAA reimburses for only the chronic pain management services and procedures that are listed in the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0700, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0750 Inpatient hospital physician-related services. (1) MAA separately reimburses the attending provider for inpatient hospital professional services rendered by the attending provider during the surgical follow-up period only if the services are performed for an emergency condition or a diagnosis that is unrelated to the inpatient stay.

(2) MAA reimburses for only one inpatient hospital call per client, per day for the same or related diagnoses. If a call is included in the **global surgery reimbursement**, MAA does not reimburse separately.

(3) MAA reimburses a hospital admission related to a planned surgery through the global fee for surgery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0750, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0800 Laboratory and pathology physician-related services. (1) MAA reimburses providers for laboratory services only when:

(a) The provider is certified according to Title XVII of the Social Security Act (Medicare), if required; and

(b) The provider has a clinical laboratory improvement amendment (CLIA) certificate and identification number.

(2) MAA includes a handling, packaging, and mailing fee in the reimbursement for lab tests and does not reimburse these separately.

(3) MAA reimburses only one blood drawing fee per client, per day. MAA allows additional reimbursement for an independent laboratory when it goes to a nursing facility or a private home to obtain a specimen.

(4) MAA reimburses only one catheterization for collection of a urine specimen per client, per day.

(5) MAA reimburses automated multichannel tests done alone or as a group, as follows:

(a) The provider must bill a panel if all individual tests are performed. If not all tests are performed, the provider must bill individual tests.

(b) If the provider bills one automated multichannel test, MAA reimburses the test at the individual procedure code rate, or the internal code maximum allowable fee, whichever is lower.

(c) Tests may be performed in a facility that owns or leases automated multichannel testing equipment. The facility may be any of the following:

(i) A clinic;

(ii) A hospital laboratory;

(iii) An independent laboratory; or

(iv) A physician's office.

(6) MAA allows a **STAT** fee in addition to the maximum allowable fee when a laboratory procedure is performed STAT.

(a) MAA reimburses STAT charges for only those procedures identified by the clinical laboratory advisory council as appropriate to be performed STAT.

(b) Tests generated in the emergency room do not automatically justify a STAT order, the physician must specifically order the tests as STAT.

(c) Refer to the fee schedule for a list of STAT procedures.

(7) MAA reimburses for drug screen charges only when medically necessary and when ordered by a physician as part of a total medical evaluation.

(8) MAA does not reimburse for drug screens for clients in the division of alcohol and substance abuse (DASA)-contracted methadone treatment programs. These are reimbursed through a contract issued by DASA.

(9) MAA does not cover for drug screens to monitor any of the following:

(a) Program compliance in either a residential or outpatient drug or alcohol treatment program;

(b) Drug or alcohol abuse by a client when the screen is performed by a provider in private practice setting; or

(c) Suspected drug use by clients in a residential setting, such as a group home.

(10) MAA may require a drug or alcohol screen in order to determine a client's suitability for a specific test.

(11) An independent laboratory must bill MAA directly. MAA does not reimburse a medical practitioner for services referred to or performed by an independent laboratory.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0800, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0850 Laboratory and pathology physician-related services reimbursement. (1) MAA pays for clinical diagnostic laboratory procedures based on the **Medicare clinical diagnostic laboratory fee schedule (MCDLF)** for the state of Washington. MAA obtains information used to update fee schedule regulations from Program Memorandum and Regional Medicare Letters as published by HCFA.

(2) MAA updates budget-neutral fees each July by:

(a) Determining the units of service and expenditures for a base period. Then,

(b) Determining in total the ratio of current MAA fees to existing Medicare fees. Then,

(c) Determining new MAA fees by adjusting the new Medicare fee by the ratio. Then,

(d) Multiplying the units of service by the new MAA fee to obtain total estimated expenditures. Then,

(e) Comparing the expenditures in subsection (14)(d) of this section to the base period expenditures. Then,

(f) Adjusting the new ratio until estimated expenditures equals the base period amount.

(3) MAA calculates maximum allowable fees (MAF) by:

(a) Calculating fees using methodology described in subsection (2) of this section for procedure codes that have an applicable Medicare clinical diagnostic laboratory fee (MCDLF).

(b) Establishing **RSC** fees for procedure codes that have no applicable MCDLF.

(c) Establishing maximum allowable fees, or "**flat fees**" for procedure codes that have no applicable MCDLF or RSC fees. MAA updates flat fee reimbursement only when authorized by the legislature.

(d) MAA reimbursement for clinical laboratory diagnostic procedures does not exceed the regional MCDLF schedule.

(4) MAA increases fees if the legislature grants a vendor rate increase or other increase. If the legislatively authorized increase becomes effective at the same time as MAA's annual update, MAA applies the increase after calculating budget-neutral fees.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0850, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0900 Neonatal intensive care unit (NICU) physician-related services. (1) MAA pays the physician directing the care of a neonate or infant in an NICU, for NICU services.

(2) NICU services include, but are not limited to, any of the following:

(a) Patient management;

(b) Monitoring and treatment of the neonate, including nutritional, metabolic and hematologic maintenance;

(c) Parent counseling; and

(d) Personal direct supervision by the **health care team** of activities required for diagnosis, treatment, and supportive care of the patient.

(3) Payment for NICU care begins with the date of admission to the NICU.

(4) MAA reimburses a provider for only one NICU service per client, per day.

(5) A provider may bill for NICU services in addition to **prolonged services** and newborn resuscitation when the provider is present at the delivery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0900, filed 12/6/00, effective 1/6/01.]

WAC 388-531-0950 Office and other outpatient physician-related services. (1) MAA reimburses for the following:

(a) Two calls per month for routine medical conditions for a client residing in a nursing facility; and

(b) One call per noninstitutionalized client, per day, for an individual physician, except for valid call-backs to the emergency room per WAC 388-531-0500.

(2) The provider must provide justification based on medical necessity at the time of billing for visits in excess of subsection (1) of this section.

(3) See physician billing instructions for procedures that are included in the office call and cannot be billed separately.

(4) Using selected diagnosis codes, MAA reimburses the provider at the appropriate level of physician office call for history and physical procedures in conjunction with dental surgery services performed in an outpatient setting.

(5) MAA may reimburse providers for injection procedures and/or injectable drug products only when:

(a) The injectable drug is administered during an office visit; and

(b) The injectable drug used is from office stock and purchased by the provider from a pharmacist or drug manufacturer as described in WAC 388-530-1200.

(6) MAA does not reimburse a prescribing provider for a drug when a pharmacist dispenses the drug.

(7) MAA does not reimburse the prescribing provider for an immunization when the immunization material is received from the department of health; MAA does reimburse an administrative fee. If the immunization is given in a health department and is the only service provided, MAA reimburses a minimum E&M service.

(8) MAA reimburses immunizations at **estimated acquisition costs (EAC)** when the immunizations are not part of the vaccine for children program. MAA reimburses a separate administration fee for these immunizations. Covered immunizations are listed in the fee schedule.

(9) MAA reimburses therapeutic and diagnostic injections subject to certain limitations as follows:

(a) MAA does not pay separately for the administration of intra-arterial and intravenous therapeutic or diagnostic injections provided in conjunction with intravenous infusion therapy services. MAA does pay separately for the administration of these injections when they are provided on the same day as an E&M service. MAA does not pay separately an administrative fee for injectables when both E&M and infusion therapy services are provided on the same day. MAA reimburses separately for the drug(s).

(b) MAA does not pay separately for subcutaneous or intramuscular administration of antibiotic injections provided on the same day as an E&M service. If the injection is the only service provided, MAA pays an administrative fee. MAA reimburses separately for the drug.

(c) MAA reimburses injectable drugs at **acquisition cost**. The provider must document the name, strength, and dosage of the drug and retain that information in the client's file. The provider must provide an invoice when requested by MAA. This subsection does not apply to drugs used for chemotherapy; see subsection (11) in this section for chemotherapy drugs.

(d) The provider must submit a manufacturer's invoice to document the name, strength, and dosage on the claim form when billing MAA for the following drugs:

(i) Classified drugs where the billed charge to MAA is over one thousand, one hundred dollars; and

(ii) Unclassified drugs where the billed charge to MAA is over one hundred dollars. This does not apply to unclassified antineoplastic drugs.

(10) MAA reimburses allergen immunotherapy only as follows:

(a) Antigen/antigen preparation codes are reimbursed per dose.

(b) When a single client is expected to use all the doses in a multiple dose vial, the provider may bill the total number of doses in the vial at the time the first dose from the vial is used. When remaining doses of a multiple dose vial are injected at subsequent times, MAA reimburses the injection service (administration fee) only.

(c) When a multiple dose vial is used for more than one client, the provider must bill the total number of doses provided to each client out of the multiple dose vial.

(d) MAA covers the antigen, the antigen preparation, and an administration fee.

(e) MAA reimburses a provider separately for an E&M service if there is a diagnosis for conditions unrelated to allergen immunotherapy.

(f) MAA reimburses for **RAST** testing when the physician has written documentation in the client's record indicating that previous skin testing failed and was negative.

(11) MAA reimburses for chemotherapy drugs:

(a) Administered in the physician's office only when:

(i) The physician personally supervises the E&M services furnished by office medical staff; and

(ii) The medical record reflects the physician's active participation in or management of course of treatment.

(b) At established maximum allowable fees that are based on the Medicare pricing method for calculating the estimated acquisition cost (EAC), or maximum allowable cost (MAC) when generics are available;

(c) For unclassified antineoplastic drugs, the provider must submit the following information on the claim form:

(i) The name of the drug used;

(ii) The dosage and strength used; and

(iii) The national drug code (NCD).

(12) Notwithstanding the provisions of this section, MAA reserves the option of determining drug pricing for any particular drug based on the best evidence available to MAA, or other good and sufficient reasons (e.g., fairness/equity, budget), regarding the actual cost, after discounts and promotions, paid by typical providers nationally or in Washington state.

(13) MAA may request an invoice as necessary.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-0950, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1000 Ophthalmic physician-related services. Refer to chapter 388-544 WAC for ophthalmic and vision-related services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1000, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1050 Osteopathic manipulative treatment. (1) MAA reimburses osteopathic manipulative therapy (OMT) only when OMT is provided by an osteopathic physician licensed under chapter 18.71 RCW.

(2) MAA reimburses OMT only when the provider bills using the appropriate CPT codes that involve the number of body regions involved.

(3) MAA allows an osteopathic physician to bill MAA for an E&M service in addition to the OMT when one of the following apply:

(a) The physician diagnoses the condition requiring manipulative therapy and provides it during the same visit;

(b) The existing related diagnosis or condition fails to respond to manipulative therapy or the condition significantly changes or intensifies, requiring E&M services beyond those included in the manipulation codes; or

(c) The physician treats the client during the same encounter for an unrelated condition that does not require manipulative therapy.

(4) MAA limits reimbursement for manipulations to ten per client, per calendar year. Reimbursement for each manipulation includes a brief evaluation as well as the manipulation.

(5) MAA does not reimburse for physical therapy services performed by osteopathic physicians.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1050, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1100 Out-of-state physician services.

(1) MAA covers medical services provided to eligible clients who are temporarily located outside the state, subject to the provisions of this chapter and WAC 388-501-0180.

(2) Out-of-state border areas as described under WAC 388-501-0175 are not subject to out-of-state limitations. MAA considers physicians in border areas as providers in the state of Washington.

(3) In order to be eligible for reimbursement, out-of-state physicians must meet all criteria for, and must comply with all procedures required of in-state physicians, in addition to other requirements of this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1100, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1150 Physician care plan oversight services. (1) MAA covers **physician care plan** oversight services only when:

(a) A physician provides the service; and

(b) The client is served by a home health agency, a nursing facility, or a **hospice**.

(2) MAA reimburses for physician care plan oversight services when both of the following apply:

(a) The facility/agency has established a plan of care; and

(b) The physician spends thirty or more minutes per calendar month providing oversight for the client's care.

(3) MAA reimburses only one physician per client, per month, for physician care plan oversight services.

(4) MAA reimburses for physician care plan oversight services during the global surgical reimbursement period only when the care plan oversight is unrelated to the surgery.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1150, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1200 Physician office medical supplies. (1) Refer to RBRVS billing instructions for a list of:

(a) Supplies that are a routine part of office or other outpatient procedures and that cannot be billed separately; and

(b) Supplies that can be billed separately and that MAA considers nonroutine to office or outpatient procedures.

(2) MAA reimburses at acquisition cost certain supplies under fifty dollars that do not have a maximum allowable fee listed in the fee schedule. The provider must retain invoices for these items and make them available to MAA upon request.

(3) Providers must submit invoices for items costing fifty dollars or more.

(4) MAA reimburses for **sterile tray** for certain surgical services only. Refer to the fee schedule for a list of covered items.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1200, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1250 Physician standby services. (1) MAA reimburses **physician standby** services only when the standby physician does not provide care or service to other clients during this period, and either:

(a) The services are provided in conjunction with newborn care history and examination, or result in an admission to a neonatal intensive care unit on the same day; or

(b) A physician requests another physician to stand by, resulting in the prolonged attendance by the second physician without face-to-face client contact.

(2) MAA does not reimburse physician standby services when any of the following occur:

(a) The standby ends in a surgery or procedure included in a global surgical reimbursement;

(b) The standby period is less than thirty minutes; or

(c) Time is spent proctoring another physician.

(3) One unit of physician standby service equals thirty minutes. MAA reimburses subsequent periods of physician standby service only when full thirty minutes of standby is provided for each unit billed. MAA rounds down fractions of a thirty-minute time unit.

(4) The provider must clearly document the need for physician standby services in the client's medical record.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1250, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1300 Podiatric physician-related services. (1) MAA covers podiatric services as listed in this section when provided by any of the following:

(a) A medical doctor;

(b) A doctor of osteopathy; or

(c) A podiatric physician.

(2) MAA reimburses for the following:

(a) Nonroutine foot care when a medical condition that affects the feet (such as diabetes or arteriosclerosis obliterans) requires that any of the providers in subsection (1) of this section perform such care;

(b) One treatment in a sixty-day period for debridement of nails. MAA covers additional treatments in this period if documented in the client's medical record as being medically necessary;

(c) Impression casting. MAA includes ninety-day follow-up care in the reimbursement;

(d) A surgical procedure performed on the ankle or foot, requiring a local nerve block, and performed by a qualified provider. MAA does not reimburse separately for the anesthesia, but includes it in the reimbursement for the procedure; and

(e) Custom fitted and/or custom molded orthotic devices:

(i) MAA's fee for the orthotic device includes reimbursement for a biomechanical evaluation (an evaluation of the foot that includes various measurements and manipulations necessary for the fitting of an orthotic device); and

(ii) MAA includes an E&M fee reimbursement in addition to an orthotic fee reimbursement if the E&M services are justified and well documented in the client's medical record.

(3) MAA does not reimburse podiatrists for any of the following radiology services:

(a) X rays for soft tissue diagnosis;

(b) Bilateral X rays for a unilateral condition;

(c) X rays in excess of two views;

(d) X rays that are ordered before the client is examined;

or

(e) X rays for any part of the body other than the foot or ankle.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1300, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1350 Prolonged physician-related service. (1) MAA reimburses prolonged services based on established Medicare guidelines. The services provided may or may not be continuous. The services provided must meet both of the following:

(a) Consist of face-to-face contact between the physician and the client; and

(b) Be provided with other services.

(2) MAA allows reimbursement for a prolonged service procedure in addition to an E&M procedure or consultation, up to three hours per client, per diagnosis, per day, subject to other limitations in the CPT codes that may be used. The applicable CPT codes are indicated in the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1350, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1400 Psychiatric physician-related services. (1) MAA limits psychotherapy to one hour per day, per client, up to a total of twelve hours per calendar year. This includes family or group psychotherapy. Psychotherapy must be provided by a psychiatrist in the office, in the client's home, or in a nursing facility.

(2) MAA reimburses only one hospital call for direct psychiatric client care, per client, per day. Psychiatrists must bill the total time spent on direct psychiatric client care during each visit. Making rounds is considered direct client care and includes any one of the following:

(a) Brief (up to one hour), individual psychotherapy;

(b) Family/group therapy;

(c) Electroconvulsive therapy; or

(d) Pharmacologic management.

(3) MAA reimburses psychiatrists for either hospital care or psychotherapy, but not for both on the same day.

(4) MAA reimburses psychiatrists for a medical physical examination in the hospital in addition to a psychiatric diagnostic or evaluation interview examination.

(5) MAA reimburses only one psychiatric diagnostic interview examination in a calendar year unless a significant change in the client's circumstances renders an additional evaluation medically necessary.

(6) MAA requires psychiatrists to use hospital E&M codes when billing for daily rounds.

(7) MAA does not cover for psychiatric sleep therapy.

(8) Medication adjustment is the only psychiatric service for which MAA reimburses psychiatric ARNPs.

(9) MAA reimburses for one interactive or insight oriented call per client, per day, in an office or outpatient setting. Individual psychotherapy, interactive services may be billed only for clients age twenty and younger.

(10) DSHS providers must comply with chapters 275-55 and 275-57 WAC for hospital inpatient psychiatric admissions, and must follow rules adopted by the division of mental health or the appropriate regional support network (RSN). MAA does not reimburse for those psychiatric services that are eligible for reimbursement under those agencies.

(2007 Ed.)

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1400, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1450 Radiology physician-related services. (1) MAA reimburses radiology services subject to the limitations in this section and under WAC 388-531-0300.

(2) MAA does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Clients receiving these injections must have one or more of the following conditions:

(a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;

(b) A history of asthma or allergy;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

(d) Generalized severe debilitation;

(e) Sickle cell disease;

(f) Pre-existing renal insufficiency; and/or

(g) Other clinical situations where use of any media except LOCM would constitute a danger to the health of the client.

(3) MAA reimburse separately for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures. Providers must submit invoices for these procedures when requested by MAA, and reimbursement is at acquisition cost.

(4) MAA reimburses general anesthesia for radiology procedures. See WAC 388-531-0300.

(5) MAA reimburses radiology procedures in combination with other procedures according to the rules for multiple surgeries. See WAC 388-531-1700. The procedures must meet all of the following conditions:

(a) Performed on the same day;

(b) Performed on the same client; and

(c) Performed by the same physician or more than one member of the same group practice.

(6) MAA reimburses consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate **professional component** modifier.

(7) MAA reimburses for portable X-ray services furnished in the client's home or in nursing facilities, limited to the following:

(a) Chest or abdominal films that do not involve the use of contract media;

(b) Diagnostic mammograms; and

(c) Skeletal films involving extremities, pelvis, vertebral column or skull.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1450, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1500 Sleep studies. (1) MAA covers sleep studies only when all of the following apply:

(a) The study is done to establish a diagnosis of narcolepsy or of sleep apnea;

(b) The study is done only at an MAA-approved sleep study center that meets the standards and conditions in subsections (2), (3), and (4) of this section; and

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(c) An ENT consultation has been done for a client under ten years of age.

(2) In order to become an MAA-approved sleep study center, a sleep lab must send MAA verification of both of the following:

(a) Sleep lab accreditation by the American Academy of Sleep Medicine; and

(b) Physician's Board Certification by the American Board of Sleep Medicine.

(3) Registered polysomnograph technicians (PSGT) must meet the accreditation standards of the American Academy of Sleep Medicine.

(4) When a sleep lab changes directors, MAA requires the provider to submit accreditation for the new director. If an accredited director moves to a facility that MAA has not approved, the provider must submit certification for the facility.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-1500, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1550 Sterilization physician-related services. (1) For purposes of this section, sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. A hysterectomy is a surgical procedure or operation for the purpose of removing the uterus. Hysterectomy results in sterilization, but MAA does not cover hysterectomy performed solely for that purpose. Both hysterectomy and sterilization procedures require the use of specific consent forms.

STERILIZATION

(2) MAA covers sterilization when all of the following apply:

(a) The client is at least eighteen years of age at the time consent is signed;

(b) The client is a mentally competent individual;

(c) The client has voluntarily given **informed consent** in accordance with all the requirements defined in this subsection; and

(d) At least thirty days, but not more than one hundred eighty days, have passed between the date the client gave informed consent and the date of the sterilization.

(3) MAA does not require the thirty-day waiting period, but does require at least a seventy-two hour waiting period, for sterilization in the following circumstances:

(a) At the time of premature delivery, the client gave consent at least thirty days before the expected date of delivery. The expected date of delivery must be documented on the consent form;

(b) For emergency abdominal surgery, the nature of the emergency must be described on the consent form.

(4) MAA waives the thirty-day consent waiting period for sterilization when the client requests that sterilization be performed at the time of delivery, and completes a sterilization consent form. One of the following circumstances must apply:

(a) The client became eligible for **medical assistance** during the last month of pregnancy;

(b) The client did not obtain medical care until the last month of pregnancy; or

(c) The client was a substance abuser during pregnancy, but is not using alcohol or illegal drugs at the time of delivery.

(5) MAA does not accept informed consent obtained when the client is in any of the following conditions:

(a) In labor or childbirth;

(b) Seeking to obtain or obtaining an abortion; or

(c) Under the influence of alcohol or other substances that affect the client's state of awareness.

(6) MAA has certain consent requirements that the provider must meet before MAA reimburses sterilization of a **mentally incompetent** or institutionalized client. MAA requires both of the following:

(a) A court order; and

(b) A sterilization consent form signed by the legal guardian, sent to MAA at least thirty days prior to the procedure.

(7) MAA reimburses epidural anesthesia in excess of the six-hour limit for sterilization procedures that are performed in conjunction with or immediately following a delivery. MAA determines total billable units by:

(a) Adding the time for the sterilization procedure to the time for the delivery; and

(b) Determining the total billable units by adding together the delivery BAUs, the delivery time, and the sterilization time.

(c) The provider cannot bill separately for the BAUs for the sterilization procedure.

(8) The physician identified in the "consent to sterilization" section of the DSHS-approved sterilization consent form must be the same physician who completes the "physician's statement" section and performs the sterilization procedure. If a different physician performs the sterilization procedure, the client must sign and date a new consent form at the time of the procedure that indicates the name of the physician performing the operation under the "consent for sterilization" section. This modified consent must be attached to the original consent form when the provider bills MAA.

(9) MAA reimburses all attending providers for the sterilization procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. MAA reimburses after the procedure is completed.

HYSTERECTOMY

(10) Hysterectomies performed for medical reasons may require expedited prior authorization as explained in WAC 388-531-0200(2).

(11) MAA reimburses hysterectomy without prior authorization in either of the following circumstances:

(a) The client has been diagnosed with cancer(s) of the female reproductive organs; and/or

(b) The client is forty-six years of age or older.

(12) MAA reimburses all attending providers for the hysterectomy procedure only when the provider submits an appropriate, completed DSHS-approved consent form with the claim for reimbursement. If a prior authorization number is necessary for the procedure, it must be on the claim. MAA reimburses after the procedure is completed.

[Statutory Authority: RCW 74.08.090, 74.09.520, 01-01-012, § 388-531-1550, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1600 Bariatric surgery. (1) The department covers medically necessary bariatric surgery for eligible clients.

(2) Bariatric surgery must be performed in a hospital with a bariatric surgery program, and the hospital must be:

(a) Located in the state of Washington or approved border cities (see WAC 388-501-0175); and

(b) Meet the requirements of WAC 388-550-2301.

(3) If bariatric surgery is requested or prescribed under the EPSDT program, the department evaluates it as a covered service under EPSDT's standard of coverage that requires the service to be:

(a) Medically necessary;

(b) Safe and effective; and

(c) Not experimental.

(4) The department authorizes payment for bariatric surgery and bariatric surgery-related services in three stages:

(a) Stage one—Initial assessment of client;

(b) Stage two—Evaluations for bariatric surgery and successful completion of a weight loss regimen; and

(c) Stage three—Bariatric surgery.

Stage one—Initial assessment

(5) Any department-enrolled provider who is licensed to practice medicine in the state of Washington may examine a client requesting bariatric surgery to ascertain if the client meets the criteria listed in subsection (6) of this section.

(6) The client meets the preliminary conditions of stage one when:

(a) The client is between twenty-one and fifty-nine years of age;

(b) The client has a body mass index (BMI) of thirty-five or greater;

(c) The client is not pregnant. (Pregnancy within the first two years following bariatric surgery is not recommended. When applicable, a family planning consultation is highly recommended prior to bariatric surgery);

(d) The client is diagnosed with one of the following:

(i) Diabetes mellitus;

(ii) Degenerative joint disease of a major weight bearing joint(s) (the client must be a candidate for joint replacement surgery if weight loss is achieved); or

(iii) Other rare comorbid conditions (such as pseudo tumor cerebri) in which there is medical evidence that bariatric surgery is medically necessary and that the benefits of bariatric surgery outweigh the risk of surgical mortality; and

(e) The client has an absence of other medical conditions such as multiple sclerosis (MS) that would increase the client's risk of surgical mortality or morbidity from bariatric surgery.

(7) If a client meets the criteria in subsection (6) of this section, the provider must request prior authorization from the department before referring the client to stage two of the bariatric surgery authorization process. The provider must attach a medical report to the request for prior authorization with supporting documentation that the client meets the stage one criteria in subsections (5) and (6) of this section.

(8) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the provisions of WAC 388-501-0165 and 388-501-0169.

Stage two—Evaluations for bariatric surgery and successful completion of a weight loss regimen

(9) After receiving prior authorization from the department to begin stage two of the bariatric surgery authorization process, the client must:

(a) Undergo a comprehensive psychosocial evaluation performed by a psychiatrist, licensed psychiatric ARNP, or licensed independent social worker with a minimum of two years postmasters' experience in a mental health setting. Upon completion, the results of the evaluation must be forwarded to the department. The comprehensive psychosocial evaluation must include:

(i) An assessment of the client's mental status or illness to:

(A) Evaluate the client for the presence of substance abuse problems or psychiatric illness which would preclude the client from participating in presurgical dietary requirements or postsurgical lifestyle changes; and

(B) If applicable, document that the client has been successfully treated for psychiatric illness and has been stabilized for at least six months and/or has been rehabilitated and is free from any drug and/or alcohol abuse and has been drug and/or alcohol free for a period of at least one year.

(ii) An assessment and certification of the client's ability to comply with the postoperative requirements such as life-long required dietary changes and regular follow-up.

(b) Undergo an internal medicine evaluation performed by an internist to assess the client's preoperative condition and mortality risk. Upon completion, the internist must forward the results of the evaluation to the department.

(c) Undergo a surgical evaluation by the surgeon who will perform the bariatric surgery (see subsection (13) of this section for surgeon requirements). Upon completion, the surgeon must forward the results of the surgical evaluation to the department and to the licensed medical provider who is supervising the client's weight loss regimen (refer to WAC 388-531-1600 (9)(d)(ii)).

(d) Under the supervision of a licensed medical provider, the client must participate in a weight loss regimen prior to surgery. The client must, within one hundred and eighty days from the date of the department's stage one authorization, lose at least five percent of his or her initial body weight. If the client does not meet this weight loss requirement within one hundred and eighty days from the date of the department's initial authorization, the department will cancel the authorization. The client or the client's provider must reapply for prior authorization from the department to restart stage two. For the purpose of this section, "initial body weight" means the client's weight at the first evaluation appointment.

(i) The purpose of the weight loss regimen is to help the client achieve the required five percent loss of initial body weight prior to surgery and to demonstrate the client's ability to adhere to the radical and lifelong behavior changes and strict diet that are required after bariatric surgery.

(ii) The weight loss regimen must:

(A) Be supervised by a licensed medical provider who has a core provider agreement with the department;

(B) Include monthly visits to the medical provider;

(C) Include counseling twice a month by a registered dietician referred to by the treating provider or surgeon; and

(D) Be at least six months in duration.

(iii) Documentation of the following requirements must be retained in the client's medical file. Copies of the documentation must be forwarded to the department upon completion of stage two. The department will evaluate the documentation and authorize the client for bariatric surgery if the stage two requirements were successfully completed.

(A) The provider must document the client's compliance in keeping scheduled appointments and the client's progress toward weight loss by serial weight recordings. Clients must lose at least five percent loss of initial body weight and must maintain the five percent weight loss until surgery;

(B) For diabetic clients, the provider must document the efforts in diabetic control or stabilization;

(C) The registered dietician must document the client's compliance (or noncompliance) in keeping scheduled appointments, and the client's weight loss progress;

(D) The client must keep a journal of active participation in the medically structured weight loss regimen including the activities under (d)(iii)(A), (d)(iii)(B) if appropriate, and (d)(iii)(C) of this subsection.

(10) If the client fails to complete all of the requirements of subsection (9) of this section, the department will not authorize stage three—Bariatric surgery.

(11) If the client is unable to meet all of the stage two criteria, the client or the client's provider must reapply for prior authorization from the department to re-enter stage two.

Stage three—Bariatric surgery

(12) The department may withdraw authorization of payment for bariatric surgery at any time up to the actual surgery if the department determines that the client is not complying with the requirements of this section.

(13) A surgeon who performs bariatric surgery for medical assistance clients must:

(a) Have a signed core provider agreement with the department;

(b) Have a valid medical license in the state of Washington; and

(c) Be affiliated with a bariatric surgery program that meets the requirements of WAC 388-550-2301.

(14) For hospital requirements for stage three—Bariatric surgery, see WAC 388-530-2301.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-531-1600, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520. 05-12-022, § 388-531-1600, filed 5/20/05, effective 6/20/05; 01-01-012, § 388-531-1600, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1650 Substance abuse detoxification physician-related services. (1) MAA covers physician services for three-day alcohol detoxification or five-day drug detoxification services for a client eligible for medical care program services in an MAA-enrolled hospital-based detoxification center.

(2) MAA covers treatment in programs certified under chapter 388-805 WAC or its successor.

(3) MAA covers detoxification and medical stabilization services to chemically using pregnant (CUP) women for up to twenty-seven days in an inpatient hospital setting.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-081, § 388-531-1650, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1650, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1700 Surgical physician-related services. (1) MAA's global surgical reimbursement for all covered surgeries includes all of the following:

(a) The operation itself;

(b) Postoperative dressing changes, including:

(i) Local incision care and removal of operative packs;

(ii) Removal of cutaneous sutures, staples, lines, wire, tubes, drains, and splints;

(iii) Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; or

(iv) Change and removal of tracheostomy tubes.

(c) All additional medical or surgical services required because of complications that do not require additional operating room procedures.

(2) MAA's global surgical reimbursement for major surgeries, includes all of the following:

(a) Preoperative visits, in or out of the hospital, beginning on the day before surgery; and

(b) Services by the primary surgeon, in or out of the hospital, during a standard ninety-day postoperative period.

(3) MAA's global surgical reimbursement for minor surgeries includes all of the following:

(a) Preoperative visits beginning on the day of surgery; and

(b) Follow-up care for zero or ten days, depending on the procedure.

(4) When a second physician provides follow-up services for minor procedures performed in hospital emergency departments, MAA does not include these services in the global surgical reimbursement. The physician may bill these services separately.

(5) MAA's global surgical reimbursement for multiple surgical procedures is as follows:

(a) Payment for multiple surgeries performed on the same client on the same day equals one hundred percent of MAA's allowed fee for the highest value procedure. Then,

(b) For additional surgical procedures, payment equals fifty percent of MAA's allowed fee for each procedure.

(6) MAA allows separate reimbursement for any of the following:

(a) The initial evaluation or consultation;

(b) Preoperative visits more than one day before the surgery;

(c) Postoperative visits for problems unrelated to the surgery; and

(d) Postoperative visits for services that are not included in the normal course of treatment for the surgery.

(7) MAA's reimbursement for endoscopy is as follows:

(a) The global surgical reimbursement fee includes follow-up care for zero or ten days, depending on the procedure.

(b) Multiple surgery rules apply when a provider bills multiple endoscopies from different endoscopy groups. See subsection (4) of this section.

(c) When a physician performs more than one endoscopy procedure from the same group on the same day, MAA pays the full amount of the procedure with the highest maximum allowable fee.

(d) MAA pays the procedure with the second highest maximum allowable fee at the maximum allowable fee minus

the base diagnostic endoscopy procedure's maximum allowed amount.

(e) MAA does not pay when payment for other codes within an endoscopy group is less than the base code.

(8) MAA restricts reimbursement for surgery assists to selected procedures as follows:

(a) MAA applies multiple surgery reimbursement rules for surgery assists apply. See subsection (4) of this section.

(b) Surgery assists are reimbursed at twenty percent of the maximum allowable fee for the surgical procedure.

(c) A surgical assist fee for a registered nurse first assistant (RNFA) is reimbursed if the nurse has been assigned a provider number.

(d) A provider must use a modifier on the claim with the procedure code to identify surgery assist.

(9) MAA bases payment splits between preoperative, intraoperative, and postoperative services on Medicare determinations for given surgical procedures or range of procedures. MAA pays any procedure that does not have an established Medicare payment split according to a split of ten percent - eighty percent - ten percent respectively.

(10) For preoperative and postoperative critical care services provided during a global period refer to WAC 388-531-0450.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1700, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1750 Transplant coverage for physician-related services. MAA covers transplants when performed in an MAA-approved center of excellence. See WAC 388-550-1900 for information regarding transplant coverage.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1750, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1800 Transplant coverage—Medical criteria to receive transplants. See WAC 388-550-2000 for information about medical criteria to receive transplants.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1800, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1850 Payment methodology for physician-related services—General and billing modifiers.

GENERAL PAYMENT METHODOLOGY

(1) MAA bases the payment methodology for most physician-related services on Medicare's RBRVS. MAA obtains information used to update MAA's RBRVS from the MPFSPS.

(2) MAA updates and revises the following RBRVS areas each January prior to MAA's annual update.

(3) MAA determines a budget-neutral conversion factor (CF) for each RBRVS update, by:

(a) Determining the units of service and expenditures for a **base period**. Then,

(b) Applying the latest Medicare RVU obtained from the MPFSDB, as published in the MPFSPS, and GCPI changes to obtain projected units of service for the new period. Then,

(c) Multiplying the projected units of service by conversion factors to obtain estimated expenditures. Then,

(d) Comparing expenditures obtained in (c) of this subsection with base period expenditure levels.

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(e) Adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) MAA calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable Medicare RVUs, the three components (practice, malpractice, and work) of the RVU are:

(i) Each multiplied by the statewide GPCI. Then,

(ii) The sum of these products is multiplied by the applicable conversion factor. The resulting RVUs are known as RBRVS RVUs.

(b) For procedure codes that have no applicable Medicare RVUs, RSC RVUs are established in the following way:

(i) When there are three RSC RVU components (practice, malpractice, and work):

(A) Each component is multiplied by the statewide GPCI. Then,

(B) The sum of these products is multiplied by the applicable conversion factor.

(ii) When the RSC RVUs have just one component, the RVU is not GPCI adjusted and the RVU is multiplied by the applicable conversion factor.

(c) For procedure codes with no RBRVS or RSC RVUs, MAA establishes maximum allowable fees, also known as "flat" fees.

(i) MAA does not use the conversion factor for these codes.

(ii) MAA updates flat fee reimbursement only when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) Immunization codes are reimbursed at EAC. (See WAC 388-530-1050 for explanation of EAC.) When the provider receives immunization materials from the department of health, MAA pays the provider a flat fee only for administering the immunization.

(B) A **cast material maximum allowable fee** is set using an average of wholesale or distributor prices for cast materials.

(iii) Other supplies are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs)).

(d) For procedure codes with no RVU or maximum allowable fee, MAA reimburses "by report." By report codes are reimbursed at a percentage of the amount billed for the service.

(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.

(f) MAA reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established.

(5) The **technical advisory group** reviews RBRVS changes.

(6) MAA also makes fee schedule changes when the legislature grants a vendor rate increase and the effective date of that increase is not the same as MAA's annual update.

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(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, MAA applies the increase after calculating budget-neutral fees. MAA pays providers a higher reimbursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) MAA does not allow separate reimbursement for bundled services. However, MAA allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.

(9) Variations of payment methodology which are specific to particular services and which differ from the general payment methodology described in this section are included in the sections dealing with those particular services.

CPT/HCFA MODIFIERS

(10) A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.

(11) Certain services and procedures require modifiers in order for MAA to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1850, filed 12/6/00, effective 1/6/01.]

WAC 388-531-1900 Reimbursement—General requirements for physician-related services. (1) MAA reimburses physicians and related providers for covered services provided to eligible clients on a fee-for-service basis, subject to the exceptions, restrictions, and other limitations listed in this chapter and other published issuances.

(2) In order to be reimbursed, physicians must bill MAA according to the conditions of payment under WAC 388-501-0150 and other issuances.

(3) MAA does not separately reimburse certain administrative costs or services. MAA considers these costs to be included in the reimbursement. These costs and services include the following:

- (a) Delinquent payment fees;
- (b) Educational supplies;
- (c) Mileage;
- (d) Missed or canceled appointments;
- (e) Reports, client charts, insurance forms, copying expenses;
- (f) Service charges;
- (g) Take home drugs; and
- (h) Telephoning (e.g., for prescription refills).

(4) MAA does not routinely pay for procedure codes which have a "#" indicator in the fee schedule. MAA reviews these codes for conformance to Medicaid program policy only as an exception to policy or as a limitation extension. See WAC 388-501-0160 and 388-501-0165.

[Statutory Authority: RCW 74.08.090, 74.09.520. 01-01-012, § 388-531-1900, filed 12/6/00, effective 1/6/01.]

WAC 388-531-2000 Increased payments for physician-related services for qualified trauma cases. (1) The department's trauma care fund (TCF) is an amount that is leg-

islatively appropriated to DSHS each biennium for the purpose of increasing the department's payment to eligible physicians and other clinical providers for providing qualified trauma services to Medicaid, general assistance-unemployable (GA-U), and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) fee-for-service clients. Claims for trauma care provided to clients enrolled in the department's managed care programs are not eligible for increased payments from the TCF.

(2) Beginning with services provided after June 30, 2003, the department makes increased payments from the TCF to physicians and other clinical providers who provide trauma services to Medicaid, GA-U, and ADATSA clients, subject to the provisions in this section. A provider is eligible to receive increased payments from the TCF for trauma services provided to a GA-U or ADATSA client during the client's certification period only. See WAC 388-416-0010.

(3) The department makes increased payments from the TCF to physicians and other clinical providers who:

- (a) Are on the designated trauma services response team of any department of health (DOH)-designated trauma service center;
- (b) Meet the provider requirements in this section and other applicable WAC;
- (c) Meet the billing requirements in this section and other applicable WAC; and
- (d) Submit all information the department requires to ensure trauma services are being provided.

(4) Except as described in subsection (5) of this section and subject to the limitations listed, the department makes increased payments from the TCF to physicians and other eligible clinical providers:

(a) For only those trauma services that are designated by the department as "qualified." These qualified services must be provided to eligible fee-for-service Medicaid, GA-U, and ADATSA clients. Qualified trauma services include care provided within six months of the date of injury for surgical procedures related to the injury if the surgical procedures were planned during the initial acute episode of injury.

(b) For hospital-based services only.

(c) Only for trauma cases that meet the injury severity score (ISS) (a summary rating system for traumatic anatomic injuries) of:

- (i) Thirteen or greater for an adult trauma patient (a client age fifteen or older); or
- (ii) Nine or greater for a pediatric trauma patient (a client younger than age fifteen).

(d) On a per-client basis in any DOH designated trauma service center.

(e) At a rate of two and one-half times the current department fee-for-service rate for qualified trauma services, subject to the following:

(i) The department monitors the increased payments from the TCF during each state fiscal year (SFY) and makes necessary adjustments to the rate to ensure that total payments from the TCF for the biennium will not exceed the legislative appropriation for that biennium.

(ii) Laboratory and pathology charges are not eligible for increased payments from the TCF. (See subsection (6)(b) of this section.)

(5) When a trauma case is transferred from one hospital to another, the department makes increased payments from the TCF to physicians and other eligible clinical providers, according to the ISS score as follows:

(a) If the transferred case meets or exceeds the appropriate ISS threshold described in subsection (4)(c) of this section, eligible providers who furnish qualified trauma services in both the transferring and receiving hospitals are eligible for increased payments from the TCF.

(b) If the transferred case is below the ISS threshold described in subsection (4)(c) of this section, only the eligible providers who furnish qualified trauma services in the receiving hospital are eligible for increased payments from the TCF.

(6) The department distributes increased payments from the TCF only:

(a) When eligible trauma claims are submitted with the appropriate trauma indicator within the time frames specified by the department; and

(b) On a per-claim basis. Each qualifying trauma service and/or procedure on the physician's claim or other clinical provider's claim is paid at the department's current fee-for-service rate, multiplied by an increased TCF payment rate that is based on the appropriate rate described in subsection (4)(e) of this section. Charges for laboratory and pathology services and/or procedures are not eligible for increased payments from the TCF and are paid at the department's current fee-for-service rate.

(7) For purposes of the increased payments from the TCF to physicians and other eligible clinical providers, all of the following apply:

(a) The department may consider a request for a claim adjustment submitted by a provider only if the claim is received by the department within one year from the date of the initial trauma service;

(b) The department does not allow any carryover of liabilities for an increased payment from the TCF after a date specified by the department as the last date to make adjustments to a trauma claim for an SFY. WAC 388-502-0150(7) does not apply in this case;

(c) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(d) The total amount of increased payments from the TCF disbursed to providers by the department in a biennium cannot exceed the amount appropriated by the legislature for that biennium. The department has the authority to take whatever actions are needed to ensure the department stays within the current TCF appropriation (see subsection (4)(e)(i) of this section).

[Statutory Authority: RCW 74.08.090, 74.09.500, 05-20-050, § 388-531-2000, filed 9/30/05, effective 10/31/05; 04-19-113, § 388-531-2000, filed 9/21/04, effective 10/22/04.]

Chapter 388-532 WAC

REPRODUCTIVE HEALTH/FAMILY PLANNING ONLY/TAKE CHARGE

WAC

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REPRODUCTIVE HEALTH SERVICES

WAC 388-532-001 Reproductive health services—

Purpose. The department of social and health services (DSHS) defines reproductive health services as those services that:

(1) Assist clients to avoid illness, disease, and disability related to reproductive health;

(2) Provide related and appropriate, medically necessary care when needed; and

(3) Assist clients to make informed decisions about using medically safe and effective methods of family planning.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-001, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-001, filed 2/6/04, effective 3/8/04.]

WAC 388-532-050 Reproductive health services—

Definitions. The following definitions and those found in WAC 388-500-005, Medical definitions, apply to this chapter.

"Complication"—A condition occurring subsequent to and directly arising from the family planning services received under the rules of this chapter.

"Contraception"—Preventing pregnancy through the use of contraceptives.

"Contraceptive"—A device, drug, product, method, or surgical intervention used to prevent pregnancy.

"Department"—The department of social and health services.

"Department-approved family planning provider"—A physician, advanced registered nurse practitioner (ARNP), or clinic that has:

- Agreed to the requirements of WAC 388-532-110;
- Signed a core provider agreement with the department;
- Assigned a unique family planning provider number by the department; and
- Signed a special agreement that allows the provider to bill for family planning laboratory services provided to cli-

ents enrolled in a department-managed care plan through an independent laboratory certified through the Clinical Laboratory Improvements Act (CLIA).

"Family planning services"—Medically safe and effective medical care, educational services, and/or contraceptives that enable individuals to plan and space the number of children and avoid unintended pregnancies.

"Medical identification card"—The document the department uses to identify a client's eligibility for a medical program.

"Natural family planning"—Also known as fertility awareness method, means methods such as observing, recording, and interpreting the natural signs and symptoms associated with the menstrual cycle to identify the fertile days of the menstrual cycle and avoid unintended pregnancies.

"Over-the-counter (OTC)"—See WAC 388-530-1050 for definition.

"Sexually transmitted disease infection (STD-I)"—Is a disease or infection acquired as a result of sexual contact.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-050, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-050, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-050, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800. 00-14-066, § 388-532-050, filed 7/5/00, effective 8/5/00.]

WAC 388-532-100 Reproductive health services—Client eligibility. (1) The department covers limited reproductive health services for clients eligible for the following medical assistance programs:

- (a) Children's health insurance program (CHIP);
- (b) Categorically needy program (CNP);
- (c) General assistance unemployable (GAU);
- (d) Limited casualty program-medically needy program (LCP-MNP); and
- (e) Alcohol and Drug Abuse Treatment and Support Act (ADATSA).

(2) Clients enrolled in a department managed care plan may self-refer outside their plan for family planning services (excluding sterilizations for clients twenty-one years of age or older), abortions, and STD-I services to any of the following:

- (a) A department-approved family planning provider;
- (b) A department-contracted local health department/STD-I clinic; or
- (c) A department-contracted pharmacy for:
 - (i) Over-the-counter contraceptive supplies;
 - (ii) Contraceptives and STD-I related prescriptions from a department-approved family planning provider or department-contracted local health department/STD-I clinic.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-100, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-100, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-100, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800. 00-14-066, § 388-532-100, filed 7/5/00, effective 8/5/00.]

WAC 388-532-110 Reproductive health services—Provider requirements. To be reimbursed by the department for reproductive health services provided to eligible cli-

ents, physicians, ARNPs, licensed midwives, and department-approved family planning providers must:

(1) Meet the requirements in chapter 388-502 WAC, Administration of medical programs—Provider rules;

(2) Provide only those services that are within the scope of their licenses;

(3) Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter (OTC) birth control supplies and related medical services;

(4) Provide medical services related to FDA-approved prescription birth control methods and OTC birth control supplies upon request;

(5) Supply or prescribe FDA-approved prescription birth control methods and OTC birth control supplies upon request; and

(6) Refer the client to an appropriate provider if unable to meet the requirements of subsections (3), (4), and (5) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-110, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-110, filed 2/6/04, effective 3/8/04.]

WAC 388-532-120 Reproductive health—Covered services. In addition to those services listed in WAC 388-531-0100 Physician's related services, the department covers the following reproductive health services:

(1) Services for women

(a) Cervical, vaginal, and breast cancer screening examination once per year as medically necessary.

(b) Food and Drug Administration (FDA) approved prescription contraception methods as identified in chapter 388-530 WAC, Pharmacy services.

(c) Over-the-counter (OTC) contraceptives, drugs and supplies (as described in chapter 388-530 WAC, Pharmacy services).

(d) Sterilization procedures that meet the requirements of WAC 388-531-1550, if it is:

(i) Requested by the client; and

(ii) Performed in an appropriate setting for the procedure.

(e) Screening and treatment for sexually transmitted diseases-infections (STD-I), including laboratory tests and procedures.

(f) Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

(g) Mammograms for clients forty years of age and older, once per year;

(h) Colposcopy and related medically necessary follow-up services;

(i) Maternity-related services as described in chapter 388-533 WAC; and

(j) Abortion.

(2) Services for men

(a) Office visits where the primary focus and diagnosis is contraceptive management and/or there is a medical concern;

(b) Over-the-counter (OTC) contraceptives, drugs and supplies (as described in chapter 388-530 WAC, Pharmacy services).

(c) Sterilization procedures that meet the requirements of WAC 388-531-1550(1), if it is:

- (i) Requested by the client; and
- (ii) Performed in an appropriate setting for the procedure.

(d) Screening and treatment for sexually transmitted diseases-infections (STD-I), including laboratory tests and procedures.

(e) Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

(f) Prostate cancer screenings for men who are fifty years of age and older, once per year.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-120, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-120, filed 2/6/04, effective 3/8/04.]

WAC 388-532-130 Reproductive health—Noncovered services. Noncovered reproductive health services are the same as shown in WAC 388-531-0150, Noncovered physician-related services—General and administrative.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-130, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-130, filed 2/6/04, effective 3/8/04.]

WAC 388-532-140 Reproductive health services—Reimbursement and payment limitations. (1) The department reimburses providers for covered reproductive health services using the department's published fee schedules.

(2) When a client enrolled in a department-approved managed care plan self-refers outside the plan to either a department-approved family planning provider or a department-contracted local health department STD-I clinic for family planning or STD-I services, all laboratory services must be billed through the family planning provider.

(3) When a client enrolled in a department managed care plan obtains family planning or STD-I services from a department-approved family planning provider or a department-contracted local health department/STD-I clinic which has a contract with the managed care plan, those services must be billed directly to the managed care plan.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-140, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-140, filed 2/6/04, effective 3/8/04.]

FAMILY PLANNING ONLY PROGRAM

WAC 388-532-500 Family planning only program—Purpose. The purpose of the family planning only program is to provide family planning services at the end of a pregnancy to women who received medical assistance benefits during their pregnancy. The primary goal of the family planning only program is to prevent an unintended, subsequent pregnancy. Women receive this benefit automatically regardless of how or when the pregnancy ends. This ten-month benefit follows the department's sixty-day postpregnancy coverage. Men are not eligible for the family planning only program.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-500, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-500, filed 2/6/04, effective 3/8/04.]

WAC 388-532-505 Family planning only program—Definitions. The following definition and those found in

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WAC 388-500-005, Medical definitions and WAC 388-532-050, apply to the family planning only program.

"Family planning only program"—The program that provides an additional ten months of family planning services to eligible women who have just ended a pregnancy or completed a delivery. This benefit follows the sixty-day postpregnancy coverage for women who received medical assistance benefits during the pregnancy. This program's coverage is strictly limited to family planning services.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-505, filed 11/30/05, effective 12/31/05.]

WAC 388-532-510 Family planning only program—Client eligibility. A woman is eligible for family planning only services if:

(1) She received medical assistance benefits during her pregnancy; or

(2) She is determined eligible for a retroactive period as defined in WAC 388-500-0005 covering the end of the pregnancy.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-510, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-510, filed 2/6/04, effective 3/8/04.]

WAC 388-532-520 Family planning only program—Provider requirements. To be reimbursed by the department for services provided to clients eligible for the family planning only program, physicians, ARNPs, and/or department-approved family planning providers must:

(1) Meet the requirements in chapter 388-502 WAC, Administration of medical programs—Provider rules;

(2) Provide only those services that are within the scope of their licenses;

(3) Educate clients on Food and Drug Administration (FDA)-approved prescription birth control methods and over-the-counter birth control supplies and related medical services;

(4) Provide medical services related to FDA-approved prescription birth control methods and over-the-counter birth control supplies upon request;

(5) Supply or prescribe FDA-approved prescription birth control methods and over-the-counter birth control supplies upon request; and

(6) Refer the client to an appropriate provider if unable to meet the requirements of subsections (3), (4), and (5) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-520, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-520, filed 2/6/04, effective 3/8/04.]

WAC 388-532-530 Family planning only program—Covered services. The department covers the following services under the family planning only program:

(1) Gynecological examination that may include a cervical and vaginal cancer screening examination, one per year when it is:

(a) Provided according to the current standard of care; and

(b) Conducted at the time of an office visit with a primary focus and diagnosis of family planning.

(2) Food and Drug Administration (FDA) approved prescription contraception methods meeting the requirements of chapter 388-530 WAC, Pharmacy services.

(3) Over-the-counter (OTC) contraceptive, drugs and supplies (as described in chapter 388-530 WAC, Pharmacy services).

(4) Sterilization procedure that meets the requirements of WAC 388-531-1550, if it is:

- (a) Requested by the client; and
- (b) Performed in an appropriate setting for the procedure.

(5) Screening and treatment for sexually transmitted diseases-infections (STD-I), including laboratory test and procedures only when the screening and treatment is:

(a) Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning; and

(b) Medically necessary for the client to safely, effectively, and successfully use, or to continue to use, her chosen contraceptive method.

(6) Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-530, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-530, filed 2/6/04, effective 3/8/04.]

WAC 388-532-540 Family planning only program—Noncovered services. Medical services are not covered under the family planning only program unless those services are:

(1) Performed in relation to a primary focus and diagnosis of family planning; and

(2) Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-540, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-540, filed 2/6/04, effective 3/8/04.]

WAC 388-532-550 Family planning only program—Reimbursement and payment limitations. (1) The department limits reimbursement under the family planning only program to visits and services that:

(a) Have a primary focus and diagnosis of family planning as determined by a qualified licensed medical practitioner; and

(b) Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, her chosen contraceptive method.

(2) The department reimburses providers for covered family planning only services using the department's published fee schedules.

(3) The department does not cover inpatient services under the family planning only program. However, inpatient charges may be incurred as a result of complications arising directly from a covered family planning service. If this happens, providers of family planning-related inpatient services that are not otherwise covered by third parties or other medical assistance programs must submit to the department a complete report of the circumstances and conditions that caused the need for the inpatient services.

[Title 388 WAC—p. 1004]

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-550, filed 11/30/05, effective 12/31/05; 04-05-011, § 388-532-550, filed 2/6/04, effective 3/8/04.]

TAKE CHARGE PROGRAM

WAC 388-532-700 TAKE CHARGE program—Purpose. TAKE CHARGE is a five-year family planning demonstration and research program. The purpose of the TAKE CHARGE program is to make family planning services available to men and women with incomes at or below two hundred percent of the federal poverty level. TAKE CHARGE is approved by the federal government under a Medicaid program waiver and runs from July 1, 2001, through June 30, 2006 (unless terminated or extended prior to June 30, 2006). See WAC 388-532-710 for a definition of TAKE CHARGE.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-700, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-700, filed 10/8/02, effective 11/8/02.]

WAC 388-532-710 TAKE CHARGE program—Definitions. The following definitions and those found in WAC 388-500-0005 medical definitions and WAC 388-532-050 apply to the medical assistance administration's (MAA's) TAKE CHARGE program.

"Ancillary services"—Those family planning services provided to TAKE CHARGE clients by MAA's contracted providers who are not TAKE CHARGE providers. These services include, but are not limited to, family planning pharmacy services, family planning laboratory services and sterilization surgical services.

"Application assistance"—The process a TAKE CHARGE provider follows in helping a client to complete and submit an application to MAA for the TAKE CHARGE program.

"Education, counseling and risk reduction intervention" or "ECRR"—A stand alone department-designated service, specifically intended for clients at higher risk of contraceptive failure, that strengthen a client's decision-making skills to make the best choice of contraceptive method and reduce the risk of unintended pregnancy. ECRR services must include:

(1) Helping the client critically evaluate which contraceptive method is most acceptable and can be used most effectively by her/him.

(2) Assessing and addressing other client personal considerations, risk factors (including sexually transmitted infections), and behaviors that impact her/his use of contraception.

(3) Facilitating a discussion of the male role in successful use of chosen contraceptive method, as appropriate.

(4) Facilitating contingency planning (the back-up method) regarding the chosen contraceptive method, including planning for emergency contraception.

(5) Scheduling a follow-up appointment as medically necessary for birth control evaluation for the safe, effective and successful use of the client's chosen contraceptive method and to reinforce positive contraceptive and other self protective behaviors.

(6) If no contraceptive method is chosen, discussing the likelihood of a pregnancy and helping the client assess

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his/her emotional, physical, and financial readiness for pregnancy and/or parenting.

"Intensive follow-up services" or "IFS"—Those supplemental services specified in some TAKE CHARGE provider contracts that support clients in the successful use of contraceptive methods. Department-selected TAKE CHARGE providers perform IFS as part of the research component of the TAKE CHARGE program (see WAC 388-532-730 (1)(f)).

"TAKE CHARGE"—The department's five-year demonstration and research program approved by the federal government under a Medicaid program waiver to provide family planning services.

"TAKE CHARGE provider"—A provider who is approved by the department to participate in TAKE CHARGE by:

- (1) Being a department-approved family planning provider; and
- (2) Having a supplemental TAKE CHARGE agreement to provide TAKE CHARGE family planning services to eligible clients under the terms of the federally approved Medicaid waiver for the TAKE CHARGE program.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-710, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-710, filed 10/8/02, effective 11/8/02.]

WAC 388-532-720 TAKE CHARGE program—Eligibility. (1) The TAKE CHARGE program is for men and women. To be eligible for the TAKE CHARGE program, an applicant must:

- (a) Be a United States citizen, U.S. National, or "qualified alien" as described in chapter 388-424 WAC;
- (b) Be a resident of the state of Washington as described in WAC 388-468-0005;
- (c) Have income at or below two hundred percent of the federal poverty level as described in WAC 388-478-0075;
- (d) Apply voluntarily for family planning services with a TAKE CHARGE provider; and
- (e) Need family planning services but have:
 - (i) No family planning coverage through another medical assistance program; or
 - (ii) Family planning coverage that does not cover one hundred percent of the applicant's chosen birth control.

(2) A client who is currently pregnant or sterilized is not eligible for TAKE CHARGE.

(3) A client is authorized for TAKE CHARGE coverage for one year from the date the department determines eligibility or for the duration of the demonstration and research program as long as the criteria in subsection (1) and (2) of this section continue to be met. Upon reapplication for TAKE CHARGE by the client, the department may renew the coverage for additional periods of up to one year each, or for the duration of the demonstration and research program, whichever is shorter.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-720, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-532-720, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-720, filed 10/8/02, effective 11/8/02.]

WAC 388-532-730 TAKE CHARGE program—Provider requirements. (1) A TAKE CHARGE provider must:

(a) Be a department-approved family planning provider as described in WAC 388-532-050;

(b) Sign the supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE demonstration and research program according to the department's TAKE CHARGE program guidelines;

(c) Participate in the department's specialized training for the TAKE CHARGE demonstration and research program prior to providing TAKE CHARGE services. Providers must assure that each individual responsible for providing TAKE CHARGE services is trained on all aspects of the TAKE CHARGE program;

(d) Comply with the required general department and TAKE CHARGE provider policies, procedures, and administrative practices as detailed in the department's billing instructions and provide referral information to clients regarding available and affordable nonfamily planning primary care services; and

(e) If requested by the department, participate in the research and evaluation component of the TAKE CHARGE demonstration and research program. If selected by the department for the research and evaluation component, the provider must accept assignment to either:

(i) A randomly selected group of providers that give intensive follow-up service (IFS) to TAKE CHARGE clients under a TAKE CHARGE research component client services contract. See WAC 388-532-740(2) for a related limitation; or

(ii) A randomly selected control group of providers subject to a TAKE CHARGE research component client services contract.

(2) Department providers (e.g., pharmacies, laboratories, surgeons performing sterilization procedures) who are not TAKE CHARGE providers may furnish family planning ancillary services, as defined in this chapter, to eligible TAKE CHARGE clients. The department reimburses for these services under the rules and fee schedules applicable to the specific services provided under the department's other programs.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-730, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-730, filed 10/8/02, effective 11/8/02.]

WAC 388-532-740 TAKE CHARGE program—Covered services. (1) The department covers the following TAKE CHARGE services for men and women:

(a) One session of application assistance per client, per year;

(b) Food and Drug Administration (FDA) approved prescription and nonprescription contraceptives as provided in chapter 388-530 WAC;

(c) Over-the-counter (OTC) contraceptives, drugs, and supplies (as described in chapter 388-538, Pharmacy services);

(d) Gynecological examination that may include a cervical and vaginal cancer screening exam, one per year when it is:

(i) Provided according to the current standard of care; and

(ii) Conducted at the time of an office visit with a primary focus and diagnosis of family planning.

(e) Education, counseling, and risk reduction (ECRR) intervention, specifically intended for clients at higher risk of contraceptive failure, that have identified or demonstrated risks of unintended pregnancy. MAA limits ECRR as follows:

(i) For women at risk of unintended pregnancy, limited to one ECRR service every ten months;

(ii) For men whose sexual partner is at risk of unintended pregnancy, limited to one ECRR service every twelve months;

(iii) Must be a minimum of thirty minutes in duration;

(iv) Must be appropriate and individualized to the client's needs, age, language, cultural background, risk behaviors, sexual orientation, and psychosocial history;

(v) Must be provided by one of the following TAKE CHARGE trained providers:

(A) An advanced registered nurse practitioner (ARNP);

(B) Registered nurse (RN), licensed practical nurse (LPN);

(C) Physician or physician's assistant (PA); or

(D) A trained and experienced health educator or medical assistant when used for assisting and augmenting the above listed clinicians.

(vi) Must be documented in the client's chart with detailed information that would allow for a well-informed follow-up visit;

(vii) A client who does not have identified or demonstrated risks of unintended pregnancy and who is not at increased risk of contraceptive failure is not eligible for ECRR.

(f) Sterilization procedure that meets the requirements of WAC 388-531-1550, if the service is:

(i) Requested by the TAKE CHARGE client; and

(ii) Performed in an appropriate setting for the procedure.

(g) Screening and treatment for sexually transmitted diseases-infections (STD-I), including laboratory tests and procedures, only when the screening and treatment is:

(i) Performed in conjunction with an office visit that has a primary focus and diagnosis of family planning; and

(ii) Medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.

(h) Education and supplies for FDA-approved contraceptives, natural family planning and abstinence.

(2) The department covers intensive follow-up services (IFS) for certain clients as part of the research component of the TAKE CHARGE demonstration and research program. Only those clients served by the department's randomly selected research sites receive IFS (see WAC 388-532-730 (1)(e)(i)). The specific elements of IFS are negotiated with each research site.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-740, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-740, filed 10/8/02, effective 11/8/02.]

WAC 388-532-750 TAKE CHARGE program—Non-covered services. The department does not cover medical

services under the TAKE CHARGE program unless those services are:

(1) Performed in relation to a primary focus and diagnosis of family planning; and

(2) Medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-750, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-750, filed 10/8/02, effective 11/8/02.]

WAC 388-532-760 TAKE CHARGE program—Documentation requirements. In addition to the documentation requirements in WAC 388-502-0020, TAKE CHARGE providers must keep the following records:

(1) TAKE CHARGE preapplication worksheet form(s) and application(s);

(2) Signed supplemental TAKE CHARGE agreement to participate in the TAKE CHARGE program;

(3) Documentation of the department's specialized TAKE CHARGE training and/or in-house in-service TAKE CHARGE training for each individual responsible for providing TAKE CHARGE.

(4) Chart notes that reflect the primary focus and diagnosis of the visit was family planning;

(5) Contraceptive methods discussed with the client;

(6) Notes on any discussions of emergency contraception and needed prescription(s);

(7) The client's plan for the contraceptive method to be used, or the reason for no contraceptive method and plan;

(8) Documentation of the education, counseling and risk reduction (ECRR) service, if provided, including all of the required components as defined in WAC 388-532-710 with sufficient detail that allows for follow-up;

(9) Documentation of referrals to or from other providers;

(10) A form signed by the client authorizing release of information for referral purposes, as necessary; and

(11) If applicable, a copy of the completed DSHS sterilization consent form [DSHS 13-364 - available for download at <http://www.dshs.wa.gov/msa/forms/eforms.html>] (see WAC 388-531-1550).

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-760, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-760, filed 10/8/02, effective 11/8/02.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 388-532-780 TAKE CHARGE program—Reimbursement and payment limitations. (1) The department limits reimbursement under the TAKE CHARGE program to those services that:

(a) Have a primary focus and diagnosis of family planning as determined by a qualified licensed medical practitioner; and

(b) Are medically necessary for the client to safely, effectively, and successfully use, or continue to use, his or her chosen contraceptive method.

(2) The department reimburses providers for covered TAKE CHARGE services according to the department's published TAKE CHARGE fee schedule.

(3)(3) The department limits reimbursement for TAKE CHARGE intensive follow-up services (IFS) to those randomly selected research sites described in WAC 388-532-740(2). See WAC 388-532-730 (1)(e)(i) for related information.

(4) Federally qualified health centers (FQHCs), rural health centers (RHCs), and Indian health providers who choose to become TAKE CHARGE providers must bill the department for TAKE CHARGE services without regard to their special rates and fee schedules. The department does not reimburse FQHCs, RHCs or Indian health providers under the encounter rate structure for TAKE CHARGE services.

(5) The department requires TAKE CHARGE providers to meet the billing requirements of WAC 388-502-0150 (billing time limits). In addition, all final billings and billing adjustments related to the TAKE CHARGE program must be completed no later than June 30, 2008, or no later than two years after the demonstration and research program terminates, whichever occurs first. The department will not accept new billings or billing adjustments that increase expenditures for the TAKE CHARGE program after the cut-off date in this subsection.

(6) The department does not cover inpatient services under the TAKE CHARGE program. However, inpatient charges may be incurred as a result of complications arising directly from a covered TAKE CHARGE service. If this happens, providers of TAKE CHARGE related inpatient services that are not otherwise covered by third parties or other medical assistance programs must submit to the department a complete report of the circumstances and conditions that caused the need for inpatient services for the department to consider payment under WAC 388-501-0165.

(7) The department requires a provider under WAC 388-501-0200 to seek timely reimbursement from a third party when a client has available third party resources. The exceptions to this requirement are described under WAC 388-501-0200 (2) and (3) and 388-532-790.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-780, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-780, filed 10/8/02, effective 11/8/02.]

WAC 388-532-790 TAKE CHARGE program—Good cause exemption from billing third party insurance. (1) TAKE CHARGE applicants who are either adolescents or young adults and who depend on their parents' medical insurance, or individuals who are domestic violence victims may request an exemption of available third party family planning coverage due to "good cause." Under the TAKE CHARGE program, "good cause" means that use of the third party coverage would violate his or her privacy because the third party:

(a) Routinely or randomly sends verification of services to the third party subscriber and that subscriber is other than the applicant; and/or

(b) Requires the applicant to use a primary care provider who is likely to report the applicant's request for family planning services to another party.

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(2) If subsection (1)(a) or (1)(b) of this section applies, the applicant is considered for TAKE CHARGE without regard to the available third party family planning coverage.

[Statutory Authority: RCW 74.08.090, 74.09.520, and 74.09.800. 05-24-032, § 388-532-790, filed 11/30/05, effective 12/31/05. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.800, and SSB 5968, 1999 c 392 § 2(12). 02-21-021, § 388-532-790, filed 10/8/02, effective 11/8/02.]

Chapter 388-533 WAC MATERNITY-RELATED SERVICES

WAC

388-533-0300 Enhanced benefits for pregnant women.

MATERNITY SUPPORT SERVICES

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388-533-0315 Maternity support services—Definitions.
388-533-0320 Maternity support services—Client eligibility.
388-533-0325 Maternity support services—Provider requirements.
388-533-0330 Maternity support services—Covered services.
388-533-0340 Maternity support services—Noncovered services.
388-533-0345 Maternity support services—Reimbursement.

INFANT CASE MANAGEMENT SERVICES

388-533-0360 Infant case management—Purpose.
388-533-0365 Infant case management—Definitions.
388-533-0370 Infant case management—Eligibility.
388-533-0375 Infant case management—Provider requirements.
388-533-0380 Infant case management—Covered services.
388-533-0385 Infant case management—Noncovered services.
388-533-0386 Infant case management services—Reimbursement.
388-533-0390 Childbirth education classes (CBE).
388-533-0400 Maternity care and newborn delivery.
388-533-0600 Planned home births and births in birthing centers.
388-533-0701 Chemical-using pregnant (CUP) women program—Purpose.
388-533-0710 Chemical-using pregnant (CUP) women program—Client eligibility.
388-533-0720 Chemical-using pregnant (CUP) women program—Provider requirements.
388-533-0730 Chemical-using pregnant (CUP) women program—Covered services.
388-533-1000 First steps child care program.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-533-0350 Maternity case management. [Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-533-0350, filed 11/16/00, effective 12/17/00.] Repealed by 04-13-049, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910.
388-533-0500 Planned home births—Pilot project. [Statutory Authority: RCW 74.08.090, 00-24-054, § 388-533-0500, filed 11/30/00, effective 12/31/00.] Repealed by 05-01-065, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.760, and 74.09.770.

WAC 388-533-0300 Enhanced benefits for pregnant women. Pursuant to the 1989 Maternity Care Access Act, also known as First Steps, the medical assistance administration (MAA) provides enhanced services to eligible women during and after their pregnancy. The enhanced services include:

(1) Maternity support services (see WAC 388-533-0310 through 388-533-0345);

(2) Infant case management services (see WAC 388-533-0360 through 388-533-0386);

(3) Alcohol and drug assessment and treatment services (see WAC 388-533-0701);

(4) Childbirth education classes (see WAC 388-533-0390); and

[Title 388 WAC—p. 1007]

(5) Childcare services (see WAC 388-533-1000).

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0300, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 74.09.770, and 74.09.800. 00-14-068, § 388-533-0300, filed 7/5/00, effective 8/5/00.]

MATERNITY SUPPORT SERVICES

WAC 388-533-0310 Maternity support services—

Purpose. The integrated maternity support services (MSS) program provides enhanced preventive health and education services to eligible pregnant women and their families during the maternity cycle. The purpose of the enhanced services is to improve birth outcomes and respond to clients' individual risks and needs. MSS is collaboratively managed by the department of health and the medical assistance administration. This MSS program combines the previous MSS and maternity case management programs.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0310, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0315 Maternity support services—

Definitions. The following definitions and those found in WAC 388-500-0005 apply to the maternity support services (MSS) program.

"Advocacy"—For the purposes of the MSS program, means actions taken to support the parent(s) in accessing needed services or goods and helping the parent(s) to develop skills to access services.

"Assurances document"—A signed agreement documenting that the provider understands and agrees to maintain certain required program elements; and to work toward integrating other specifically recommended practices. Also referred to as the MSS/ICM assurances document.

"Basic health messages"—For the purposes of the MSS program, means the preventative health education messages designed to promote healthy pregnancies, healthy newborns and healthy parenting during the first year of life.

"Case management"—For the purposes of the MSS program, means services to assist individuals who are eligible under the Medicaid state plan, to gain access to needed medical, social, educational, and other services.

"Childbirth education classes (CBE)"—A series of educational sessions offered in a group setting and led by an approved instructor to prepare a pregnant woman and her support person for an upcoming childbirth.

"Childcare"

"DASA (division of alcohol and substance abuse)"—Childcare for women attending DASA-funded outpatient alcohol or drug treatment services that may be provided through the treatment facility.

"First Steps"—Childcare funded through the First Steps Program for the care of children of pregnant or postpregnant women who are attending appointments for Medicaid-covered services, pregnant women on physician ordered bed rest, and for visits to the neonatal intensive care unit (NICU) after delivery.

"Community and family health (CFH)"—Refers to the division within the state department of health whose mission is to improve the health and well-being of Washington

residents with a special focus on infants, children, youth, pregnant woman, and prospective parents.

"Consultation"—For the purposes of the MSS program, means the practice of conferring with other professionals to share knowledge and problem solve with the intent of providing the best possible care to clients.

"Core services"—For the purposes of the MSS program, means the services that provide the framework for interdisciplinary, client-centered maternity support services and infant case management. These services include: Client screening, basic health messages, basic linkages, and minimum interventions.

"Department of health (DOH)"—The agency whose mission is to protect and improve the health of people in Washington state.

"Department of social and health services (DSHS)"—The state agency that administers social and health services programs for the state of Washington.

"First Steps"—The 1989 Maternity Care Access Act, known as First Steps. This program provides enhanced maternity care for pregnant and postpregnant women, and health care for infants. The program is managed collaboratively by DSHS and DOH. First Steps maternity care consists of obstetrical care, maternity support services, childbirth education classes, and infant case management.

"First Steps Childcare"—See childcare.

"Home visit"—For the purposes of the MSS program, means services delivered in the client's place of residence or other setting as described in the medical assistance administration's published MSS/ICM billing instructions.

"Infant case management (ICM)"—A program that provides case management services to eligible high-risk infants and their families. Eligibility for ICM may be established at the end of the maternity cycle and up to the infant's first birthday.

"Interagency agreement"—A written letter of agreement between two agencies for the exchange of referrals or service provision (e.g., a written agreement in letter format that agrees to an exchange of referrals or services for MSS/ICM clients).

"Interdisciplinary team"—Members from different professions and occupations that work closely together and communicate frequently to optimize care for the client (pregnant woman and infant). Each team member contributes specialized knowledge, skills and experience to support and augment the contributions of the other team members.

"Linkages"—Networking and/or collaboration between agencies in order to assure proper referral of clients and avoid duplication of services.

"Maternal and infant health (MIH)"—A section within the state department of health. MIH works collaboratively with DSHS to provide clinical consultation, oversight and monitoring of the MSS/ICM programs.

"Maternity cycle"—An eligibility period for maternity support services that begins during pregnancy and continues to the end of the month in which the sixtieth-day postpregnancy occurs.

"Maternity support services (MSS)"—Preventive health services for pregnant/postpregnant women including: Professional observation, assessment, education, intervention and counseling. MSS services are provided by an interdisciplinary

plinary team consisting of at minimum, a community health nurse, a nutritionist, and a behavioral health specialist. Additional MSS services may be provided by community health workers.

"Medical assistance administration (MAA)"—The administration within DSHS authorized to administer medical assistance programs.

"Minimum interventions"—Defined levels of client assessment, education, intervention and outcome evaluation for specific risk factors found in client screening for MSS/ICM services, or identified during ongoing services.

"Performance measure"—An indicator used to measure the results of a focused intervention or initiative.

"Risk factors"—The biopsychosocial factors that could lead to negative pregnancy or parenting outcomes. The MSS/ICM program design identifies specific risk factors and corresponding minimum interventions.

"Service plan"—The written plan of care that must be developed and maintained throughout the eligibility period for each client in the MSS/ICM programs.

"Staff"—For the purposes of the MSS program, means the personnel employed by providers.

"Unit of service"—Fifteen minutes of one-to-one service delivered face-to-face.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0315, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0320 Maternity support services—Client eligibility. (1) To be eligible for maternity support services (MSS), a client must be:

(a) Covered under one of the following medical assistance administration programs:

(i) Categorically needy program (CNP);

(ii) Categorically needy program—Children's health insurance program; (CNP-Children's health insurance program); or

(iii) Categorically needy program—Emergency medical only (CNP-Emergency medical only); and

(b) Pregnant or still within the maternity cycle.

(2) Clients meeting the eligibility criteria in WAC 388-533-0320(1) who are enrolled in an MAA managed care plan, are eligible for MSS services outside their plan. MSS services delivered outside the managed care plan are reimbursed on a fee-for-service basis and subject to the same program rules as apply to nonmanaged care clients.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0320, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0325 Maternity support services—Provider requirements. (1) Services under this program are provided only by approved maternity support services (MSS)/infant case management (ICM) providers. Representatives from the medical assistance administration (MAA) and the department of health (DOH) recruit and approve providers using the following criteria:

(a) Services are to be delivered in area of geographic need as determined by MAA/DOH; and

(b) Providers must:

(i) Deliver both MSS and ICM services;

(ii) Provide services in both office and home visit settings; and

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(iii) Assure maintenance of staffing requirements and delivery of core services according to program design.

(2) To participate in the MSS program, a provider must:

(a) Comply with the clinical supervision/clinical consultation guidelines as required in the assurances document;

(b) Notify the appropriate state discipline-specific consultant when a staff person joins or leaves a designated position;

(c) Ensure that all newly hired staff receive an orientation to First Steps as soon as possible, but no later than sixty days from the hire date;

(d) Refer clients who may need chemical dependency assessment and/or treatment to a provider contracted with the division of alcohol and substance abuse (DASA) (see chapter 440-22 WAC);

(e) Authorize First Steps childcare for the MSS client as appropriate to facilitate MSS and First Step objectives (see WAC 388-533-1000 for rules governing First Steps childcare);

(f) Complete and document case conferencing activities.

(3) To be reimbursed by MAA for MSS, providers must:

(a) Meet the requirements in chapter 388-502 WAC, Administration of medical programs—Providers rules;

(b) Have a completed, approved MSS/ICM assurance document, signed by an officer or employee qualified to sign on behalf of the provider, on file with MAA;

(c) Meet the DOH/MAA requirements for a qualified MSS interdisciplinary team as prescribed in the assurances document;

(d) Ensure that staff meet the minimum qualifications for the MSS rules they perform; and

(e) Submit billings as instructed in MAA's published MSS/ICM billing instructions.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0325, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0330 Maternity support services—Covered services. (1) The medical assistance administration (MAA) covers services under the maternity support services (MSS) program subject to the restrictions and limitations in this section and other applicable published WAC.

(2) Covered services include:

(a) Community health nursing visits;

(b) Nutrition visits;

(c) Behavioral health visits; and

(d) Community health worker visits under the direction of a professional member of the team.

(3) The services listed in WAC 388-533-0330(2) are covered under this program only when the services are:

(a) Documented in the client's record;

(b) Provided on an individual basis in a face-to-face encounter;

(c) Delivered by a qualified staff person acting within her/his area of expertise; and

(d) Used for the purposes of the MSS program to provide:

(i) Risk screening;

(ii) Education that relates to improving pregnancy and parenting outcomes;

(iii) Brief counseling;

(iv) Interventions for identified risk factors;

- (v) Basic health messages;
- (vi) Referral and linkages to other services; or
- (vii) Family planning screening.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0330, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0340 Maternity support services—Noncovered services. (1) The following are considered non-covered services under the MSS program. Any service:

- (a) Not within the scope of the program;
- (b) Not listed in WAC 388-533-0330; or
- (c) Any service provided by staff not qualified to deliver the service.

(2) The department evaluates requests for services listed as noncovered under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-533-0340, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0340, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0345 Maternity support services—Reimbursement. Services provided under the maternity support services (MSS) program are reimbursed on a fee-for-service basis subject to the following limitations:

- (1) MAA reimburses under this program only for services billed using approved procedure codes and modifiers as identified in MAA's published MSS/ICM billing instructions;
- (2) MAA reimburses MSS services in units of time with one unit being equal to fifteen minutes of service;
- (3) MAA reimburses a maximum of:
 - (a) Six units per client, per day for any combination of office or home visits;
 - (b) Sixty total units per client, from all disciplines, over the maternity cycle;
 - (c) A one-time-only fee per client for the family planning performance measure; and
 - (d) A one-time-only fee per client per pregnancy for the tobacco cessation performance measure.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0345, filed 6/10/04, effective 7/11/04.]

INFANT CASE MANAGEMENT SERVICES

WAC 388-533-0360 Infant case management—Purpose. The infant case management (ICM) program serves high-risk infants and their families. The goal of ICM is to improve self-sufficiency of the parent(s) in gaining access to needed medical, social, educational, and other services (SSA 1915(g)).

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0360, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0365 Infant case management—Definitions. The following definitions and those found in WAC 388-500-0005, Medical definitions and 388-533-0315, Maternity support services definitions apply to this section:

"Infant case management (ICM)"—The program that provides case management services to eligible high-risk infants and their families. Eligibility for ICM may be established at the end of the maternity cycle up to the end of the month of the baby's first birthday.

[Title 388 WAC—p. 1010]

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0365, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0370 Infant case management—Eligibility. (1) To be eligible for infant case management (ICM):

- (a) The infant must be covered under one of the medical programs listed in WAC 388-533-0320 (1)(a) of this chapter;
- (b) The parent(s) must need assistance in accessing or providing care for the infant; and
- (c) At least one or more of the following criteria exists:
 - (i) The parent(s) are unable to care for infant specifically due to at least one of the following:
 - (A) Incarceration of the mother within the last year;
 - (B) Low functioning ability (e.g., needs repeated instructions, not attuned to infant cues, leaves infant with inappropriate caregivers, parent has the equivalent of less than an eighth grade education);
 - (C) Unstable mental health issue (regardless of whether the mental health issue is being treated or not);
 - (D) Physical impairment;
 - (E) Infant's mother is experiencing postpregnancy depression or mood disorder or has a history of depression/mood disorder;
 - (F) Infant's parent(s) are unable to access resources due to age (nineteen years of age or younger);
 - (G) Social isolation (e.g., family is new to the community, parent(s) do not have a support system, family moves frequently, lack of supportive living environment);
 - (H) Inability to access resources due to language or cultural barrier.
 - (ii) The infant's safety is a concern specifically due to at least one of the following:
 - (A) Domestic or family violence in present or past relationship that keeps the parent(s) feeling unsafe;
 - (B) Substance abuse by the infant's mother and/or father that is impacting ability to parent;
 - (C) Secondhand smoke exposure to the infant;
 - (D) Child protective service involvement within the last year or mother/father had parental rights terminated in the past;
 - (E) Unstable living situation (e.g., homelessness, couch surfing, unsafe conditions, no cooking facilities, heat, or water).
 - (iii) The infant's health is a concern specifically due to at least one of the following:
 - (A) Low birth weight—less than five and one half pounds;
 - (B) Premature birth—less than thirty-seven weeks gestation;
 - (C) Failure to thrive (e.g., baby is not gaining weight, significant feeding difficulty, no eye contact, or baby is listless);
 - (D) Multiple births (twins, triplets, etc.);
 - (E) Excessive fussiness or infant has irregular sleeping patterns (e.g., parent(s)' sleep deprivation, exhaustion and/or need for respite childcare);
 - (F) Infant has an identified medical problem or disability.
- (2) Clients meeting the eligibility criteria in WAC 388-533-0370(1) who are enrolled in an MAA managed care plan are eligible for ICM services outside their plan. ICM services

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delivered outside the managed care plan are reimbursed on a fee-for-service basis and subject to the same program rules as apply to nonmanaged care clients.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0370, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0375 Infant case management—Provider requirements. (1) Services under this program are provided only by approved integrated maternity support services (MSS)/infant case management (ICM) providers. Representatives from the department of health (DOH) and the department of social and health services' (DSHS) medical assistance administration (MAA) recruit and approve providers using the following criteria:

- (a) Services are to be delivered in area of geographic need as determined by MAA/DOH; and
- (b) Provider must:
 - (i) Deliver both MSS and ICM services;
 - (ii) Provide services in both office and home visit settings; and

- (iii) Assure maintenance of staffing requirements and delivery of service according to program design.

(2) To participate in the ICM program, a provider must:

- (a) Comply with the clinical supervision/clinical guidelines as prescribed in the assurances document;
- (b) Notify the MAA program manager when there is a staff change in a designated position;

- (c) Ensure that all newly hired staff receive an orientation to First Steps services as soon as possible, but not later than sixty days from the hire date; and

- (d) Submit billings as instructed in MAA's published MSS/ICM billing instructions.

(3) To be reimbursed by MAA for ICM, a provider must:

- (a) Meet the requirements in chapter 388-502 WAC, Administration of medical programs—Providers rules;

- (b) Have a completed, approved MSS/ICM assurances document, signed by an officer or employee qualified to sign on behalf of the provider, on file with MAA; and

- (c) Ensure that staff meet the minimum qualifications for the ICM roles they perform.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0375, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0380 Infant case management—Covered services. (1) The medical assistance administration (MAA) covers services under the infant case management (ICM) program subject to the restrictions and limitations in this section and other applicable published WAC.

(2) The ICM program reimburses approved providers for case management including:

- (a) Assessing risk and need;
- (b) Reviewing and updating the infant and parent(s) service plan;
- (c) Referring and linking the client to other agencies; and
- (d) Advocating for the client with other agencies.

(3) The case management activities listed in WAC 388-533-0380(2) are covered under the ICM program only when:

- (a) Documented in the client's record;
- (b) Provided on an individual basis in a face-to-face encounter;

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- (c) Performed by a qualified staff person acting within her/his area of expertise; and

- (d) Provided according to program design as described in the MSS/ICM assurances document.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0380, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0385 Infant case management—Non-covered services. (1) The following services are noncovered under the infant case management (ICM) program:

- (a) Any direct delivery of services other than case management activities listed in WAC 388-533-0380(2); and

- (b) Any service provided by staff not qualified to deliver the service.

(2) The department evaluates requests for services listed as noncovered under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-533-0385, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0385, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0386 Infant case management services—Reimbursement. The medical assistance administration (MAA) reimburses for infant case management (ICM) services on a fee-for-service basis subject to the following terms and limitations:

- (1) ICM is reimbursed in units of service with one unit being equal to fifteen minutes of service;

- (2) MAA reimburses:

- (a) No more than six ICM units per month, per client; and

- (b) No more than forty ICM units total per client through the end of the month of the baby's first birthday; and

- (c) Only for services billed using the approved ICM procedure code and modifier identified in MAA's published MSS/ICM billing instructions.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0386, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0390 Childbirth education classes (CBE). (1) Purpose. The childbirth education services described in this section are intended to help prepare the pregnant client and her support person for labor and delivery.

(2) Definitions. The following definitions apply to WAC 388-533-0390:

- (a) Approved instructor—A childbirth instructor meeting specific criteria set by the Washington department of health (DOH) maternal and infant health section and approved by the DOH health education consultant to provide childbirth education to pregnant clients.

- (b) Childbirth education classes (CBE)—A series of educational sessions offered in a group setting; with a minimum of eight hours of instruction and led by an approved instructor to prepare a pregnant woman and her support person for an upcoming childbirth.

- (c) Social services payment systems (SSPS)—The payment method used by the department of social and health services (DSHS) for certain social services and independent providers.

(3) Client eligibility. Childbirth education classes under WAC 388-533-0390 are available to women who are:

- (a) Pregnant; and
- (b) Covered under one of the following medical assistance administration (MAA) programs:
 - (i) Categorically needy program (CNP);
 - (ii) Categorically needy program—Children's health insurance program; (CNP-Children's health insurance program); or
 - (iii) Categorically needy program emergency medical only (CNP-Emergency medical only).
- (4) Provider requirements. A childbirth educator providing services under WAC 388-533-0390 must:
 - (a) Be an approved CBE provider (individual or agency) with an assigned SSPS/CBE billing number, and a signed program assurances document on file with MAA;
 - (b) Deliver CBE services in group sessions;
 - (c) Bill the medical assistance administration (MAA):
 - (i) Using the assigned SSPS/CBE billing number; and
 - (ii) According to the form and instruction requirements in MAA's CBE billing instructions; and
 - (d) Accept the MAA fee as final and complete payment for a client.
- (5) Covered services. MAA covers childbirth education when the instruction is:
 - (a) Provided to clients eligible under WAC 388-533-0390(3);
 - (b) Delivered in group sessions with a minimum of eight hours of instruction; and
 - (c) Delivered according to a curriculum approved by the MAA/DOH program managers.
- (6) Noncovered services. The following are considered noncovered services under childbirth education:
 - (a) Any services beyond the scope of CBE; and
 - (b) Any education about childbirth that is provided during a one-to-one home or office visit. (CBE provided in a one-to-one home or office visit must be billed according to WAC 388-533-0340 and 388-533-0345, Maternity support services rules.)
- (7) Reimbursement. MAA reimburses CBE services subject to the following terms and limitations:
 - (a) Reimbursement:
 - (i) Is limited to one series per client, per pregnancy;
 - (ii) Must be for the clients specifically enrolled in the session; and
 - (iii) Includes all classes, core materials, publications and educational materials provided throughout the class series. (MAA clients must receive the same materials as are offered to other attendees.)
 - (b) A client must attend at least one CBE session in order for the provider to be reimbursed for the CBE services to the client.

[Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.910. 04-13-049, § 388-533-0390, filed 6/10/04, effective 7/11/04.]

WAC 388-533-0400 Maternity care and newborn delivery. (1) The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter.

- (a) **"Birthing center"** means a specialized facility licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC.
- (b) **"Bundled services"** means services integral to the major procedure that are included in the fee for the major pro-

cedure. Under this chapter, certain services which are customarily bundled must be billed separately (unbundled) when the services are provided by different providers.

(c) **"Facility fee"** means the portion of MAA's payment for the hospital or birthing center charges. This does not include MAA's payment for the professional fee defined below.

(d) **"Global fee"** means the fee MAA pays for total obstetrical care. Total obstetrical care includes all bundled antepartum care, delivery services and postpartum care.

(e) **"High-risk"** pregnancy means any pregnancy that poses a significant risk of a poor birth outcome.

(f) **"Professional fee"** means the portion of MAA's payment for services that rely on the provider's professional skill or training, or the part of the reimbursement that recognizes the provider's cognitive skill. (See WAC 388-531-1850 for reimbursement methodology.)

(2) MAA covers full scope medical maternity care and newborn delivery services to fee-for-service clients who qualify for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-462-0015 for client eligibility). Clients enrolled in an MAA managed care plan must receive all medical maternity care and newborn delivery services through the plan. See subsection (20) of this section for client eligibility limitations for smoking cessation counseling provided as part of antepartum care services.

(3) MAA does not provide maternity care and delivery services to its clients who are eligible for:

- (a) Family planning only (a pregnant client under this program should be referred to the local community services office for eligibility review); or
- (b) Any other program not listed in this section.

(4) MAA requires providers of maternity care and newborn delivery services to meet all of the following. Providers must:

- (a) Be currently licensed by the state of Washington's department of health (DOH) and/or department of licensing;
- (b) Have signed core provider agreements with MAA;
- (c) Be practicing within the scope of their licensure; and
- (d) Have valid certifications from the appropriate federal or state agency, if such is required to provide these services (e.g., federally qualified health centers (FQHCs), laboratories certified through the Clinical Laboratory Improvement Amendment (CLIA), etc.).

(5) MAA covers total obstetrical care services (paid under a global fee). Total obstetrical care includes all of the following:

- (a) Routine antepartum care that begins in any trimester of a pregnancy;
- (b) Delivery (intrapartum care/birth) services; and
- (c) Postpartum care. This includes family planning counseling.

(6) When an eligible client receives all the services listed in subsection (5) of this section from one provider, MAA pays that provider a global obstetrical fee.

(7) When an eligible client receives services from more than one provider, MAA pays each provider for the services furnished. The separate services that MAA pays appear in subsection (5) of this section.

(8) MAA pays for antepartum care services in one of the following two ways:

- (a) Under a global fee; or
- (b) Under antepartum care fees.

(9) MAA's fees for antepartum care include all of the following:

- (a) Completing an initial and any subsequent patient history;
- (b) Completing all physical examinations;
- (c) Recording and tracking the client's weight and blood pressure;
- (d) Recording fetal heart tones;
- (e) Performing a routine chemical urinalysis (including all urine dipstick tests); and
- (f) Providing maternity counseling.

(10) MAA covers certain antepartum services in addition to the bundled services listed in subsection (9) of this section. MAA pays separately for any of the following:

(a) An enhanced prenatal management fee (a fee for medically necessary increased prenatal monitoring). MAA provides a list of diagnoses and/or conditions that MAA identifies as justifying more frequent monitoring visits. MAA pays for either (a) or (b) of this subsection, but not both;

(b) A prenatal management fee for "high-risk" maternity clients. This fee is payable to either a physician or a certified nurse midwife. MAA pays for either (a) or (b) of this subsection, but not both;

(c) Necessary prenatal laboratory tests except routine chemical urinalysis, including all urine dipstick tests, as described in subsection (9)(e) of this section; and/or

(d) Treatment of medical problems that are not related to the pregnancy. MAA pays these fees to physicians or advanced registered nurse practitioners (ARNP).

(11) MAA covers high-risk pregnancies. MAA considers a pregnant client to have a high-risk pregnancy when the client:

- (a) Has any high-risk medical condition (whether or not it is related to the pregnancy); or
- (b) Has a diagnosis of multiple births.

(12) MAA covers delivery services for clients with high-risk pregnancies, described in subsection (11) of this section, when the delivery services are provided in a hospital.

(13) MAA pays a facility fee for delivery services in the following settings:

- (a) Inpatient hospital; or
- (b) Birthing centers.

(14) MAA pays a professional fee for delivery services in the following settings:

(a) Hospitals, to a provider who meets the criteria in subsection (4) of this section and who has privileges in the hospital;

- (b) Planned home births and birthing centers.

(15) MAA covers hospital delivery services for an eligible client as defined in subsection (2) of this section. MAA's bundled payment for the professional fee for hospital delivery services include:

- (a) The admissions history and physical examination; and
- (b) The management of uncomplicated labor (intrapartum care); and
- (c) The vaginal delivery of the newborn (with or without episiotomy or forceps); or
- (d) Cesarean delivery of the newborn.

(16) MAA pays only a labor management fee to a provider who begins intrapartum care and unanticipated medical complications prevent that provider from following through with the birthing services.

(17) In addition to MAA's payment for professional services in subsection (15) of this section, MAA may pay separately for services provided by any of the following professional staff:

(a) A stand-by physician in cases of high risk delivery and/or newborn resuscitation;

(b) A physician assistant or registered nurse "first assist" when delivery is by cesarean section;

(c) A physician, (ARNP), or licensed midwife for newborn examination as the delivery setting allows; and/or

(d) An obstetrician/gynecologist specialist for external cephalic version and consultation.

(18) In addition to the professional delivery services fee in subsection (15) or the global/total fees (i.e., those that include the hospital delivery services) in subsections (5) and (6) of this section, MAA allows additional fees for any of the following:

(a) High-risk vaginal delivery;

(b) Multiple vaginal births. MAA's typical payment covers delivery of the first child. For each subsequent child, MAA pays at fifty percent of the provider's usual and customary charge, up to MAA's maximum allowable fee; or

(c) High-risk cesarean section delivery.

(19) MAA does not pay separately for any of the following:

(a) More than one child delivered by cesarean section during a surgery. MAA's cesarean section surgery fee covers one or multiple surgical births;

(b) Postoperative care for cesarean section births. This is included in the surgical fee. Postoperative care is not the same as or part of postpartum care.

(20) In addition to the services listed in subsection (10) of this section, MAA covers counseling for tobacco dependency for eligible pregnant women through two months post-pregnancy. This service is commonly referred to as smoking cessation education or counseling.

(a) MAA covers smoking cessation counseling for only those fee-for-service clients who are eligible for categorically needy (CN) scope of care. See (f) of this subsection for limitations on prescribing pharmacotherapy for eligible CN clients. Clients enrolled in managed care may participate in a smoking cessation program through their plan.

(b) MAA pays a fee to certain providers who include smoking cessation counseling as part of an antepartum care visit or a postpregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination). MAA pays only the following providers for smoking cessation counseling:

(i) Physicians;

(ii) Physician assistants (PA) working under the guidance and billing under the provider number of a physician;

(iii) ARNPs, including certified nurse midwives (CNM); and

(iv) Licensed midwives (LM).

(c) MAA covers one smoking cessation counseling session per client, per day, up to ten sessions per client, per pregnancy. The provider must keep written documentation in the

client's file for each session. The documentation must reflect the information in (e) of this subsection.

(d) MAA covers two levels of counseling. Counseling levels are:

(i) Basic counseling (fifteen minutes), which includes (e)(i), (ii), and (iii) of this subsection; and

(ii) Intensive counseling (thirty minutes), which includes the entirety of (e) of this subsection.

(e) Smoking cessation counseling consists of providing information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps (refer to MAA's physician-related services billing instructions and births and birthing centers billing instructions for specific counseling suggestions and billing requirements):

(i) Asking the client about her smoking status;

(ii) Advising the client to stop smoking;

(iii) Assessing the client's willingness to set a quit date;

(iv) Assisting the client to stop smoking, which includes developing a written quit plan with a quit date. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy as needed (see (f) of this subsection); and

(v) Arranging to track the progress of the client's attempt to stop smoking.

(f) A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment is appropriate for the client. MAA covers certain pharmacotherapy for smoking cessation as follows:

(i) MAA covers Zyban™ only;

(ii) The product must meet the rebate requirements described in WAC 388-530-1125;

(iii) The product must be prescribed by a physician, ARNP, or physician assistant;

(iv) The client for whom the product is prescribed must be eighteen years of age or older;

(v) The pharmacy provider must obtain prior authorization from MAA when filling the prescription for pharmacotherapy; and

(vi) The prescribing provider must include both of the following on the client's prescription:

(A) The client's estimated or actual delivery date; and

(B) Indication the client is participating in smoking cessation counseling.

(g) MAA's payment for smoking cessation counseling is subject to postpay review. See WAC 388-502-0230, Provider review and appeal, and WAC 388-502-0240, Audits and the audit appeal process for contractors/providers, for information regarding review and appeal processes for providers.

[Statutory Authority: RCW 74.08.090, 74.09.760, and 74.09.770. 05-01-065, § 388-533-0400, filed 12/8/04, effective 1/8/05; 02-07-043, § 388-533-0400, filed 3/13/02, effective 4/13/02. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. 00-23-052, § 388-533-0400, filed 11/13/00, effective 12/14/00.]

WAC 388-533-0600 Planned home births and births in birthing centers. (1) MAA covers planned home births and births in birthing centers for its clients when the client and the maternity care provider choose to have a home birth or to give birth in an MAA-approved birthing center and the client:

(a) Is eligible for CN or MN scope of care (see WAC 388-533-400(2));

(b) Has a MAA-approved medical provider who has accepted responsibility for the planned home birth or birth in birthing center as provided in this section;

(c) Is expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome); and

(d) Passes MAA's risk screening criteria. MAA provides these risk-screening criteria to qualified medical services providers.

(2) MAA approves only the following provider types to provide MAA-covered planned home births and births in birthing centers:

(a) Physicians licensed under chapters 18.57 or 18.71 RCW;

(b) Nurse midwives licensed under chapter 18.79 RCW; and

(c) Midwives licensed under chapter 18.50 RCW.

(3) Each participating birthing center must:

(a) Be licensed as a childbirth center by the department of health (DOH) under chapter 246-349 WAC;

(b) Be specifically approved by MAA to provide birthing center services;

(c) Have a valid core provider agreement with MAA; and

(d) Maintain standards of care required by DOH for licensure.

(4) MAA suspends or terminates the core provider agreement of a birthing center if it fails to maintain DOH standards cited in subsection (3) of this section.

(5) Home birth or birthing center providers must:

(a) Obtain from the client a signed consent form in advance of the birth;

(b) Follow MAA's risk screening criteria and consult with and/or refer the client or newborn to a physician or hospital when medically appropriate;

(c) Have current, written, and appropriate plans for consultation, emergency transfer and transport of a client and/or newborn to a hospital;

(d) Make appropriate referral of the newborn for pediatric care and medically necessary follow-up care;

(e) Inform parents of the benefits of a newborn screening test and offer to send the newborn's blood sample to the department of health for testing; and

(f) Have evidence of current cardiopulmonary resuscitation (CPR) training for:

(i) Adult CPR; and

(ii) Neonatal resuscitation.

(6) Planned home providers must:

(a) Provide medically necessary equipment, supplies, and medications for each client;

(b) Have arrangements for twenty-four hour per day coverage;

(c) Have documentation of contact with local area emergency medical services to determine the level of response capability in the area; and

(d) Participate in a formal, state-sanctioned, quality assurance/improvement program or professional liability review process (e.g., Joint Underwriting Association (JUA), Midwives Association of Washington State (MAWS), etc.).

(7) MAA does not cover planned home births or births in birthing centers for women identified with any of the following conditions:

- (a) Previous cesarean section;
- (b) Current alcohol and/or drug addiction or abuse;
- (c) Significant hematological disorders/coagulopathies;
- (d) History of deep venous thromboses or pulmonary embolism;
- (e) Cardiovascular disease causing functional impairment;
- (f) Chronic hypertension;
- (g) Significant endocrine disorders including pre-existing diabetes (type I or type II);
- (h) Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests;
- (i) Isoimmunization, including evidence of Rh sensitization/platelet sensitization;
- (j) Neurologic disorders or active seizure disorders;
- (k) Pulmonary disease;
- (l) Renal disease;
- (m) Collagen-vascular diseases;
- (n) Current severe psychiatric illness;
- (o) Cancer affecting site of delivery;
- (p) Known multiple gestation;
- (q) Known breech presentation in labor with delivery not imminent; or
- (r) Other significant deviations from normal as assessed by the provider.

[Statutory Authority: RCW 74.08.090, 74.09.760, and 74.09.770. 05-01-065, § 388-533-0600, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.760 through 74.09.800. 00-23-052, § 388-533-0600, filed 11/13/00, effective 12/14/00.]

WAC 388-533-0701 Chemical-using pregnant (CUP) women program—Purpose. The chemical-using pregnant (CUP) women program provides immediate access to medical care in a hospital setting to chemical-using or chemical-dependent pregnant women and their fetuses. The purpose of the immediate access to medical care is to reduce harm to and improve birth outcomes for mothers and their fetuses by preventing obstetric and prenatal complications related to chemical dependency.

[Statutory Authority: RCW 74.08.090, 74.09.800. 04-11-008, § 388-533-701 (codified as WAC 388-533-0701), filed 5/5/04, effective 6/5/04.]

WAC 388-533-0710 Chemical-using pregnant (CUP) women program—Client eligibility. (1) To be eligible for the chemical-using pregnant (CUP) women program, a woman must meet all of the following conditions:

- (a) Be pregnant; and
- (b) Be eligible for Medicaid.
- (2) Clients meeting the eligibility criteria in WAC 388-533-0710(1) who are enrolled in an MAA managed care plan are eligible for CUP services outside their plan, except Washington Medicaid integration partnership clients. CUP services delivered outside the managed care plan are reimbursed and subject to the same program rules as apply to nonmanaged care clients.
- (3) Clients receiving three-day or five-day detoxification services through the department are not eligible for the CUP women program.

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[Statutory Authority: RCW 74.08.090 and 74.09.800. 05-08-061, § 388-533-0710, filed 3/31/05, effective 5/1/05; 04-11-008, § 388-533-710 (codified as WAC 388-533-0710), filed 5/5/04, effective 6/5/04.]

WAC 388-533-0720 Chemical-using pregnant (CUP) women program—Provider requirements. (1) The medical assistance administration (MAA) pays only those providers who:

- (a) Have been approved by MAA to provide chemical-using pregnant (CUP) women program services;
- (b) Have been certified as chemical dependency service providers by the division of alcohol and substance abuse (DASA) as prescribed in chapter 388-805 WAC;
- (c) Meet the hospital standards prescribed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
- (d) Meet the general provider requirements in chapter 388-502 WAC; and
- (e) Are not licensed as an institution for mental disease (IMD) under Centers for Medicare and Medicaid (CMS) criteria.

(2) CUP women program service providers are required to:

- (a) Report any changes in their certification, level of care, or program operations to the MAA CUP women program manager;
- (b) Have written policies and procedures that include a working statement describing the purpose and methods of treatment for chemical-using/abusing pregnant women;
- (c) Provide guidelines and resources for current medical treatment methods by specific drug and/or alcohol type;
- (d) Have linkages with state and community providers to ensure a working knowledge exists of current medical and substance abuse resources; and
- (e) Ensure that a chemical dependency assessment of the client has been completed:
 - (i) By a chemical dependency professional as defined in chapter 246-811 WAC;
 - (ii) Using the latest criteria of the American Society of Addiction Medicine (ASAM); and
 - (iii) No earlier than six months before, and no later than five days after, the client's admission to the CUP women program.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 05-08-061, § 388-533-0720, filed 3/31/05, effective 5/1/05; 04-11-008, § 388-533-720 (codified as WAC 388-533-0720), filed 5/5/04, effective 6/5/04.]

WAC 388-533-0730 Chemical-using pregnant (CUP) women program—Covered services. (1) The medical assistance administration (MAA) pays for the following covered services for a pregnant client and her fetus under the chemical-using pregnant (CUP) women program:

- (a) Primary acute detoxification/medical stabilization;
- (b) Secondary subacute detoxification/medical stabilization; and
- (c) Rehabilitation treatment and services as determined by the provider.
- (2) The maximum length of treatment per inpatient stay that MAA will pay for is twenty-six days, unless additional days have been preauthorized by the MAA CUP women program manager.

(3) If a client's pregnancy ends before inpatient treatment is completed, a provider may continue the client's treatment through the twenty-sixth day.

[Statutory Authority: RCW 74.08.090 and 74.09.800. 05-08-061, § 388-533-0730, filed 3/31/05, effective 5/1/05; 04-11-008, § 388-533-730 (codified as WAC 388-533-0730), filed 5/5/04, effective 6/5/04.]

WAC 388-533-1000 First steps child care program.

The purpose of the first steps child care program is to fund child care for children so that their pregnant or postpregnant mothers can access prenatal care or other medical assistance administration (MAA)-covered services.

(1) For the purposes of this section, the following terms and definitions apply:

(a) **"Background check central unit (BCCU)"** means the centralized unit established by the department of social and health services (DSHS) that performs background checks as directed by the Washington state legislature.

(b) **"Finding"** means an action taken by the department of social and health services (DSHS) that shows an individual or entity has been found by the department to have abused, neglected, exploited or abandoned a vulnerable person. Findings reported by DSHS or the background check central unit (BCCU) or both are limited to official findings that have been established through legal due process or an administrative hearing process or both.

(c) **"First steps agency"** means an entity, public or private, that is contracted with the medical assistance administration (MAA) to provide first steps program services.

(d) **"MAA first steps child care authorizers"** or **"authorizers"** means the individuals eligible to authorize first steps child care through the first steps child care program. Authorizers include maternity support services (MSS) professional/paraprofessional agency staff members, community services office (CSO) social workers or designated staff members, and other MAA-designated professional/paraprofessional persons.

(e) **"MAA first steps child care coordinator or designee"** means the individual designated by MAA to review special needs requests for first steps child care through the first steps child care program.

(f) **"MAA first steps child care program manager"** means the individual designated by MAA to review all background check cases identified by the background check central unit (BCCU) as "needing further review."

(g) **"Postpregnancy"** means the period of time after the pregnancy ends (includes live birth, still birth, miscarriage, or pregnancy termination) through the end of the month that includes the sixtieth day from the end of the pregnancy.

(2) First steps child care is available for the children of either a managed care or fee-for-service client. Subject to the restrictions and limitations listed in this section, a client is eligible to receive first steps child care for her children if she:

(a) Meets one of the following criteria:

(i) Is pregnant; or

(ii) Is within the postpregnancy period.

(b) Is currently eligible under one of the following programs:

(i) Categorically needy program (CNP);

(ii) CNP - emergency medical only; or

(iii) Children's health insurance program (CHIP).

(c) Requires one or more of the covered services listed in subsection (4) and (5) of this section;

(d) Demonstrates a need for child care; and

(e) Shows that no other child care resources are available.

(3) The following persons are eligible to authorize first steps child care, subject to the restrictions and limitations in this chapter and other WAC:

(a) Maternity support services (MSS) professional/paraprofessional agency staff members. See WAC 388-533-0300 (3) and (7);

(b) Community services office (CSO) social workers or designated staff members; and

(c) Other MAA-designated professional/paraprofessional persons.

(4) First steps child care may be authorized for a client's child(ren) during the client's pregnancy or postpregnancy period when the client pursues any of the following covered services for herself or her newborn children:

(a) Childbirth education classes;

(b) Delivery/birth (during the mother's hospitalization);

(c) Dental care;

(d) Hospital procedures;

(e) Laboratory tests;

(f) Maternity support services (MSS) visits, including nursing, social work, nutrition, and community health worker visits;

(g) Medical visits; and

(h) Family planning services.

(5) First steps child care authorized for a client's child(ren) for the following special needs requires approval by the MAA first steps child care coordinator or designee prior to providing the child care (see subsection (6) of this section for the prior approval process):

(a) Bedrest for the pregnant client for any of the following reasons:

(i) Preterm labor, with evidence of cervical change or very high risk clinically or historically for preterm delivery;

(ii) Incompetent cervix;

(iii) Bleeding (abruption, placenta previa, etc.);

(iv) Preterm ruptured membranes;

(v) Intrauterine growth restriction;

(vi) Oligohydramnios;

(vii) Multiple gestations; or

(viii) Other reasons if the obstetrical provider provides a complete clinical description of the client's circumstance (this special request for bedrest must be faxed to the MAA first steps child care coordinator or designee).

(b) The newborn(s) is in a neonatal intensive care unit (NICU) and the parent(s) is visiting the NICU.

(6) The prior approval process for a request for first steps child care for either of the reasons stated in subsection (5) of this section is as follows:

(a) The authorizer completes appropriate sections of the first steps child care billing form (DSHS 14-316) and submits the form to the MAA first steps child care coordinator or designee.

(i) If bedrest is required for a pregnant client due to one of the reasons listed in subsection (5)(a) of this section, the authorizer documents in the client's file the reason for the

bedrest and that the prenatal caregiver has verified that bedrest is necessary; or

(ii) If the reason for the request is to enable a parent(s) to visit the newborn(s) in a NICU, the authorizer documents in the client's file that hospital staff member has verified the parent(s) is visiting the newborn(s) regularly.

(b) The MAA first steps child care coordinator or designee:

(i) Approves the special needs request and signs and dates the first steps child care billing form (DSHS 14-316) in the appropriate section and returns the form to the authorizer; or

(ii) Informs the authorizer in writing if the request is denied and payment will not be made.

(7) MAA pays for authorized first steps child care when provided by any of the following, subject to the limitations and restrictions listed:

(a) A licensed child care home, center, facility, or foster home; and

(b) A friend, neighbor, or relative, other than those listed in subsection (8) of this section, who is unlicensed and:

(i) Has qualified based on a background check conducted prior to providing the child care (see subsection (9) of this section for information on the background check process);

(ii) Is eighteen years of age or older;

(iii) Has a valid social security number; and

(iv) Is authorized to work in the United States.

(8) The following individuals are not eligible to provide first steps child care:

(a) The spouse of the client.

(b) The partner of the client if the client and her partner share the same residence.

(c) The father of the pregnant client's unborn child(ren).

(d) The father of the client's other children(ren).

(e) A parent or stepparent of the client.

(f) A parent or stepparent of the client's spouse.

(g) A parent or stepparent of the client's partner if the client and her partner share the same residence.

(h) An older child(ren) of the:

(i) Client;

(ii) Client's spouse; or

(iii) Client's partner if the client and her partner share the same residence.

(i) An unlicensed child care provider:

(i) Whose background check is pending; or

(ii) Who was disqualified due to the background check.

(j) Any person under age eighteen.

(9) Each unlicensed individual child care provider who a client chooses to be a first steps child care provider is subject to a background check under RCW 43.20A.710 and 74.15.030. First steps child care will not be authorized by a first steps child care authorizer, or paid by MAA, until MAA's background check has been completed on the unlicensed child care provider. Each unlicensed first steps child care provider is subject to a new background check every two years from the date of the first background check.

(a) MAA's background check process includes all of the following:

(i) The unlicensed child care provider completes and signs the first steps child care background check form and gives it to the client. The client returns it to a first steps child

care authorizer who submits it to BCCU. The child care provider's signature on the first steps child care background check form authorizes the department's BCCU to perform the background check.

(ii) BCCU performs a background check on the individual and notifies the appropriate first steps agency or CSO of the results. The first steps child care authorizer notifies both the client and child care provider of one of the following results:

(A) "No known record" (means the individual may provide first steps child care);

(B) "Disqualifying record" (means the individual may not provide first steps child care); or

(C) "Record" (means the individual has a criminal record that needs further review).

For cases needing further review, MAA:

(I) Follows the criteria described in this subsection to determine if the individual may or may not provide first steps child care; and

(II) Notifies the first steps agency or CSO, in writing, of the decision.

(b) The department's background check of unlicensed child care providers may include a review of:

(i) Records of criminal convictions and pending criminal charges as reported by the Washington state patrol (WSP);

(ii) Department findings of abuse, neglect, exploitation, and/or abandonment of children or vulnerable adults; and

(iii) Disciplinary board final decisions.

(c) The department's background check may include a review of law enforcement records of convictions and pending charges in other states or locations when the need for further information is indicated by:

(i) A person's prior residences;

(ii) Reports from credible community sources; or

(iii) An identification number indicating the subject has a record on file with the Federal Bureau of Investigation.

(d) For the purpose of conducting criminal history portions of background checks as required by chapters 43.20A and 74.15 RCW, the department:

(i) Considers only a person's convictions and pending charges; and

(ii) Does not solicit or use as the sole basis for disqualification, information about:

(A) Arrests not resulting in charges; and

(B) Dismissed charges.

(e) In certain situations, MAA may find an individual with conviction(s) to be eligible to provide child care to children through the first steps child care program if:

(i) A conviction for any crime listed in WAC 388-06-0180 occurred more than five years from the date of the first steps child care request; or

(ii) A conviction was for a crime other than those listed in WAC 388-06-0180; and

(iii) MAA uses the criteria in subsection (f) of this section and determines the individual qualifies to provide child care.

(f) When an individual's convictions for a crime meet the conditions in (e)(i) and (ii) of this subsection, MAA may review an individual's background to determine character, suitability and competence to have unsupervised access to children using the following factors:

(i) The amount of time that has passed since the finding or conviction;

(ii) The seriousness of the crime that led to the finding or conviction;

(iii) The number and types of other convictions in the individual's background;

(iv) The individual's age at the time of finding or conviction;

(v) Documentation indicating successful completion of all court-ordered programs and restitution;

(vi) The individual's behavior since the finding or conviction; and

(vii) The vulnerability of the children for whom care is needed.

(g) MAA considers findings or criminal charges that are pending to carry the same weight as a finding or conviction. The individual may provide proof to MAA that the charge has been dropped or there was an acquittal.

(h) MAA does not consider a crime a conviction if a pardon is granted or a court of law expunges or vacates the conviction.

(i) An MAA first steps child care program manager reviews all cases that are identified as "record," and reports the final decision to the first steps agency staff. The first steps agency staff notifies the client and the designated child care provider of the results.

(10) A client who does not agree with a department decision regarding first steps child care program services has a right to a fair hearing under chapter 388-02 WAC. After receiving a request for a fair hearing, MAA may request additional information from the client or the department. After MAA reviews the available information, the result may be:

(a) A reversal of the initial department decision;

(b) Resolution of the client's issue(s); or

(c) A fair hearing conducted per chapter 388-02 WAC.

(11) To be a client who is authorized to receive first steps child care for her child(ren) receives the following forms from a first steps child care authorizer and gives the forms to the child care provider:

(a) First steps child care billing form (DSHS 14-316);

(b) W-9 Form (request for taxpayer identification number and certification); and

(c) A first steps child care (MAA) background authorization form (DSHS 15-253) if the child care provider is unlicensed.

(12) To be paid for providing first steps child care, an authorized child care provider must, within ninety days of the first date the child care is provided:

(a) Complete, sign, and date the appropriate sections of the first steps child care billing form (DSHS 14-316);

(b) Complete an original W-9 Form (the W-9 is completed only once for MAA files unless the information changes); and

(c) Mail (or give) the original completed first steps child care billing form (DSHS 14-316) and W-9 Form (both forms must have the individual's original signature) to:

(i) The first steps authorizer, who submits them to MAA; or

(ii) The client and the client mails (or gives) the forms to the first steps authorizer, who submits them to MAA.

(13) MAA sets payment for first steps child care services at a maximum dollar amount per hour from legislatively appropriated funds. Payment is subject to any exceptions, restrictions, or other limitations listed in this section and other WAC. MAA pays the child care provider directly for first steps child care services when the client and the client's designated first steps child care provider meet all the criteria in this section.

[Statutory Authority: RCW 74.08.090, 74.09.800, 03-19-010, § 388-533-1000, filed 9/4/03, effective 10/5/03; 01-15-008, § 388-533-1000, filed 7/6/01, effective 8/6/01.]

Chapter 388-534 WAC

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

WAC

388-534-0100

EPSDT.

388-534-0200

Enhanced payments for EPSDT screens for children receiving foster care placement services from the department of social and health services (DSHS).

WAC 388-534-0100 EPSDT. (1) Persons who are eligible for Medicaid are eligible for coverage through the early and periodic screening, diagnosis, and treatment (EPSDT) program up through the day before their twenty-first birthday.

(2) Access and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B which were in effect as of January 1, 1998.

(a) The standard for coverage for EPSDT is that the services, treatment or other measures are:

(i) Medically necessary;

(ii) Safe and effective; and

(iii) Not experimental.

(b) EPSDT services are exempt from specific coverage or service limitations which are imposed on the rest of the CN and MN program. Examples of service limits which do not apply to the EPSDT program are the specific numerical limits in WAC 388-545-300, 388-545-500, and 388-545-700.

(c) Services not otherwise covered under the Medicaid program are available to children under EPSDT. The services, treatments and other measures which are available include but are not limited to:

(i) Nutritional counseling;

(ii) Chiropractic care;

(iii) Orthodontics; and

(iv) Occupational therapy (not otherwise covered under the MN program).

(d) Prior authorization and referral requirements are imposed on medical service providers under EPSDT. Such requirements are designed as tools for determining that a service, treatment or other measure meets the standards in subsection (2)(a) of this section.

(3) Transportation requirements of 42 CFR 441, Subpart B are met through a contract with transportation brokers throughout the state.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 42 C.F.R., Part 441, Subpart B, 02-07-016, § 388-534-0100, filed 3/8/02, effective 4/8/02. Statutory Authority: RCW 74.08.090, 01-02-076, § 388-534-0100, filed 12/29/00, effective 1/29/01. 00-11-183, recodified as § 388-534-0100, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-86-027, filed

7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090, 90-12-061 (Order 3019), § 388-86-027, filed 5/31/90, effective 7/1/90; 82-01-001 (Order 1725), § 388-86-027, filed 12/3/81; 81-10-015 (Order 1647), § 388-86-027, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-027, filed 10/9/80; 79-12-047 (Order 1457), § 388-86-027, filed 11/26/79; Order 1112, § 388-86-027, filed 4/15/76; Order 738, § 388-86-027, filed 11/22/72.]

WAC 388-534-0200 Enhanced payments for EPSDT screens for children receiving foster care placement services from the department of social and health services (DSHS). The medical assistance administration (MAA) reimburses providers an enhanced flat fee for EPSDT screens provided to children receiving certain foster care placement services from the department of social and health services (DSHS). See MAA's EPSDT billing instructions for specific billing code requirements and the fee.

(1) For the purposes of this section, foster care is defined as twenty-four hour per day, temporary, substitute care for a child:

(a) Placed away from the child's parents or guardians in licensed, paid, out-of-home care; and

(b) For whom the department or a licensed or certified child placing agency has placement and care responsibility.

(2) MAA pays an enhanced flat fee to the providers listed in subsection (3) of this section for EPSDT screens provided to only those children receiving foster care placement services from DSHS.

(3) The following providers are eligible to perform EPSDT screens and bill MAA the enhanced rate for children receiving foster care placement services from DSHS:

(a) EPSDT clinics;

(b) Physicians;

(c) Advanced registered nurse practitioners (ARNPs);

(d) Physician assistants (PAs) working under the guidance and MAA provider number of a physician;

(e) Nurses specially trained through the department of health (DOH) to perform EPSDT screens; and

(f) Registered nurses working under the guidance and MAA provider number of a physician or ARNP.

(4) In order to be paid an enhanced fee, services furnished by the providers listed in subsection (3) of this section must meet the federal requirements for EPSDT screens at 42 CFR Part 441 Subpart B, which were in effect as of December 1, 2001.

(5) The provider must retain documentation of the EPSDT screens in the client's medical file. The provider must use the DSHS Well Child Exam forms or provide equivalent information. DSHS Well Child Exam forms are available at no charge by sending a request in writing or by fax to:

DSHS Warehouse
P.O. Box 45816
Olympia, WA. 98504-5816
fax: 360-664-0597

(6) MAA conducts evaluations of client files and payments made under this program. MAA may recover the enhanced payment amount when:

(a) The client was not receiving foster care placement services from DSHS as defined in subsection (1) of this section when the EPSDT screen was provided; or

(b) Documentation was not in the client's medical file (see subsection (5) of this section).

(2007 Ed.)

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 42 C.F.R., Part 441, Subpart B. 02-07-016, § 388-534-0200, filed 3/8/02, effective 4/8/02.]

Chapter 388-535 WAC

DENTAL-RELATED SERVICES

WAC

GENERAL

388-535-1050	Dental-related definitions.
388-535-1060	Clients who are eligible for dental-related services.
388-535-1065	Coverage limits for dental-related services provided under state-only funded programs.
388-535-1070	Dental-related services provider information.
388-535-1080	Covered dental-related services—Children.
388-535-1100	Dental-related services not covered—Children.
388-535-1200	Dental-related services requiring prior authorization—Children.
388-535-1220	Obtaining prior authorization for dental-related services—Children.
388-535-1230	Crowns for children.
388-535-1240	Dentures, partial dentures, and overdentures for children.

ABCD DENTAL PROGRAM

388-535-1245	Access to baby and child dentistry (ABCD) program.
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ADULTS' DENTAL-RELATED SERVICES

388-535-1255	Covered dental-related services—Adults.
388-535-1265	Dental-related services not covered—Adults.
388-535-1270	Dental-related services requiring prior authorization—Adults.
388-535-1280	Obtaining prior authorization for dental-related services—Adults.
388-535-1290	Dentures and partial dentures for adults.

PAYMENT

388-535-1350	Payment methodology for dental-related services.
388-535-1400	Payment for dental-related services.
388-535-1450	Payment for denture laboratory services.
388-535-1500	Payment for dental-related hospital services.
388-535-1550	Payment for dental care provided out-of-state.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-535-1000	Dental-related services—Scope of coverage. [Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1000, filed 12/6/95, effective 1/6/96.] Repealed by 99-07-023, filed 3/10/99, effective 4/10/99. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225.
388-535-1010	Dental-related program introduction. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1010, filed 3/10/99, effective 4/10/99.] Repealed by 02-13-074, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225.
388-535-1120	Coverage limits for dental-related services provided under state-only funded programs. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1120, filed 6/14/02, effective 7/15/02.] Repealed by 03-19-080, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191.
388-535-1150	Becoming a DSHS dental provider. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1150, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1150, filed 12/6/95, effective 1/6/96.] Repealed by 02-13-074, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035,

- 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225.
- 388-535-1250 Orthodontic coverage for DSHS children. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1250, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1250, filed 12/6/95, effective 1/6/96.] Repealed by 02-01-050, filed 12/11/01, effective 1/11/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225.
- 388-535-1260 Dental-related limits of state-only funded programs. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1260, filed 3/10/99, effective 4/10/99.] Repealed by 02-13-074, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225.
- 388-535-1300 Access to baby and child dentistry (ABCD) program. [Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1300, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1300, filed 12/6/95, effective 1/6/96.] Repealed by 02-11-136, filed 5/21/02, effective 6/21/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and .225. Later promulgation, see WAC 388-535-1245.

GENERAL

WAC 388-535-1050 Dental-related definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter. The medical assistance administration (MAA) also uses dental definitions found in the American Dental Association's Current Dental Terminology (CDT) and the American Medical Association's Physician's Current Procedural Terminology (CPT). Where there is any discrepancy between the CDT or CPT and this section, this section prevails. (CPT is a trademark of the American Medical Association.)

"Access to baby and child dentistry (ABCD)" is a program to increase access to dental services in targeted areas for Medicaid eligible infants, toddlers, and preschoolers up through the age of five. See WAC 388-535-1300 for specific information.

"American Dental Association (ADA)" is a national organization for dental professionals and dental societies.

"Adult" for the general purposes of the medical assistance administration's (MAA) dental program, means a client twenty-one years of age or older (MAA's payment structure changes at age nineteen, which affects specific program services provided to adults or children).

"Anterior" means teeth and tissue in the front of the mouth.

(1) **"Mandibular anterior teeth"** - incisors and canines: Permanent teeth twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven; and primary teeth M, N, O, P, Q, and R.

(2) **"Maxillary anterior teeth"** - incisors and canines: Permanent teeth six, seven, eight, nine, ten, and eleven; and primary teeth C, D, E, G, and H.

"Asymptomatic" means having or producing no symptoms.

"Base metal" means dental alloy containing little or no precious metals.

"Behavior management" means using the assistance of one additional dental professional staff to manage the behavior of a developmentally disabled client or a client age eighteen or younger to facilitate the delivery of dental treatment.

"By report" - a method of reimbursement in which MAA determines the amount it will pay for a service when the rate for that service is not included in MAA's published fee schedules. Upon request the provider must submit a "report" which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Caries" means tooth decay through the enamel or decay of the root surface.

"Child" for the general purposes of the medical assistance administration's (MAA) dental program, means a client twenty years of age or younger. (MAA's payment structure changes at age nineteen, which affects specific program services provided to children or adults.)

"Comprehensive oral evaluation" means a thorough evaluation and recording of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

"Conscious sedation" is a drug-induced depression of consciousness during which clients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained.

"Core buildup" refers to building up of clinical crowns, including pins.

"Coronal" is the portion of a tooth that is covered by enamel, and is separated from the root or roots by a slightly constricted region, known as the cemento-enamel junction.

"Coronal polishing" is a procedure limited to the removal of plaque and stain from exposed tooth surfaces.

"Crown" means a restoration covering or replacing the major part, or the whole of, the clinical crown of a tooth.

"Current dental terminology (CDT)" a systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

"Current procedural terminology (CPT)" means a description of medical procedures and is available from the American Medical Association of Chicago, Illinois.

"Decay" is a term for caries or carious lesions and means decomposition of tooth structure.

"Deep sedation" is a drug-induced depression of consciousness during which a client cannot be easily aroused, ventilatory function may be impaired, but the client responds to repeated or painful stimulation.

"Dental general anesthesia" see "general anesthesia."

"Dentures" means an artificial replacement for natural teeth and adjacent tissues, and includes complete dentures, immediate dentures, overdentures, and partial dentures.

"Endodontic" means disease and injuries to the pulp requiring root canal therapy and related follow-up.

"EPSDT" means the department's early and periodic screening, diagnosis, and treatment program for clients twenty years of age and younger as described in chapter 388-534 WAC.

"Extraction" see **"simple extraction"** and **"surgical extraction."**

"Flowable composite resin" is a low viscosity resin that is used in cervical lesions and other small, low stress bearing restorations.

"Fluoride varnish or gel" means a substance containing dental fluoride, applied to teeth.

"General anesthesia" is a drug-induced loss of consciousness during which clients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Clients may require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"High noble metal" means a dental alloy containing at least sixty percent pure gold.

"Limited oral evaluation" means an evaluation limited to a specific oral health condition or problem. Typically a client receiving this type of evaluation has a dental emergency, such as trauma or acute infection.

"Limited visual oral assessment" means a screening of the hard and soft tissues in the mouth.

"Major bone grafts" means a transplant of solid bone tissue(s).

"Medically necessary" see WAC 388-500-0005.

"Minor bone grafts" means a transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs.

"Noble metal" means a dental alloy containing at least twenty-five percent but less than sixty percent pure gold.

"Oral evaluation" see **"comprehensive oral evaluation."**

"Oral hygiene instruction" means instruction for home oral hygiene care, such as tooth brushing techniques or flossing.

"Oral prophylaxis" means the preventive dental procedure of scaling and polishing which includes removal of calculus, soft deposits, plaque, and stains from teeth and tooth implants.

"Partials" or **"partial dentures"** means a removable appliance replacing one or more missing teeth in one arch, and receiving its support and retention from both the underlying tissues and some or all of the remaining teeth.

"Periodic oral evaluation" means an evaluation performed on a patient of record to determine any changes in the client's dental or medical status since a previous comprehensive or periodic evaluation. This includes a periodontal charting at least once per year.

"Periodontal maintenance" means a procedure for clients who have previously been treated for periodontal disease and starts after completion of active (surgical or nonsurgical) periodontal therapy. It includes removal of the supra and subgingival microbial flora and calculus from teeth and tooth implants.

"Periodontal scaling and root planing" means instrumentation of the crown and root surfaces of the teeth or tooth implants to remove plaque, calculus, microbial flora, and bacterial toxins.

"Posterior" means teeth and tissue towards the back of the mouth.

(1) **"Mandibular posterior teeth"** - molars and premolars: Permanent teeth seventeen, eighteen, nineteen, twenty, twenty-one, twenty-eight, twenty-nine, thirty, thirty-one, and thirty-two; and primary teeth K, L, S, and T.

(2) **"Maxillary posterior teeth"** - molars and premolars: Permanent teeth one, two, three, four, five, twelve, thirteen, fourteen, fifteen, and sixteen; and primary teeth A, B, I, and J.

"Proximal" means the surface of the tooth near or next to the adjacent tooth.

"Reline" means to resurface the tissue side of a denture with new base material or soft tissue conditioner in order to achieve a more accurate fit.

"Root canal" is a portion of the pulp cavity inside the root of a tooth and the chamber within the root of the tooth that contains the pulp.

"Root canal therapy" is the treatment of disease and injuries of the pulp and associated periradicular conditions.

"Root planing" is a procedure to remove microbial flora, bacterial toxins, calculus, and diseased cementum or **dentin** on the root surfaces and pockets, including tooth implants.

"Scaling" is a procedure to remove plaque, calculus, and stain deposits from tooth surfaces, including tooth implants.

"Sealant" is a material applied to teeth to prevent dental caries.

"Simple extraction" means routine removal of tooth structure.

"Standard of care" means what reasonable and prudent practitioners would do in the same or similar circumstances.

"Surgical extraction" means removal of tooth structure with cutting of gingiva and bone, including soft tissue extractions, partial boney extractions, and complete boney extractions.

"Symptomatic" means having symptoms (e.g., pain, swelling, and infection).

"Temporomandibular joint dysfunction (TMJ/TMD)" means an abnormal functioning of the temporomandibular joint or other areas secondary to the dysfunction.

"Therapeutic pulpotomy" means the surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp.

"Usual and customary" means the fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill MAA.

"Wisdom teeth" means teeth one, sixteen, seventeen, and thirty-two.

"Xerostomia" means a dryness of the mouth.

[Statutory Authority: RCW 74.04.050, 74.04.057, and 74.09.530. 04-14-100, § 388-535-1050, filed 7/6/04, effective 8/6/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-077, § 388-535-1050, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-

1050, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-535-1050, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1050, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1050, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1060 Clients who are eligible for dental-related services. The following clients who receive services under the medical assistance programs listed in this section are eligible for covered dental-related services, subject to the restrictions and specific limitations described in this chapter and other applicable WAC:

- (1) Children eligible for the:
 - (a) Categorically needy program (CN or CNP);
 - (b) Children's health insurance program (CNP-CHIP); and
 - (c) Limited casualty program - medically needy program (LCP-MNP).
- (2) Adults eligible for the:
 - (a) Categorically needy program (CN or CNP); and
 - (b) Limited casualty program - medically needy program (LCP-MNP).
- (3) Clients eligible for medical care services under the following state-funded only programs are eligible only for the limited dental-related services described in WAC 388-535-1065:
 - (a) General assistance - Unemployable (GA-U); and
 - (b) General assistance - Alcohol and Drug Abuse Treatment and Support Act (ADATSA) (GA-W).
- (4) Clients who are enrolled in a managed care plan are eligible for medical assistance administration (MAA)-covered dental services that are not covered by their plan, under fee-for-service, subject to the provisions of chapter 388-535 WAC and other applicable WAC.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-077, § 388-535-1060, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1060, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1060, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1065 Coverage limits for dental-related services provided under state-only funded programs. (1) Clients who receive medical care services under the following state-funded only programs receive only the limited coverage described in subsection (2) of this section:

- (a) General assistance unemployable (GA-U); and
 - (b) Alcohol and drug abuse treatment and support act (ADATSA) (GA-W).
- (2) The medical assistance administration (MAA) covers the dental-related services described and limited in this chapter for clients eligible for GA-U or GA-W only when those services are provided as part of a medical treatment for:
- (a) Apical abscess verified by clinical examination and radiograph(s), and treated by:
 - (i) Palliative treatment (e.g., open and drain, open and broach);
 - (ii) Tooth extraction; or

(iii) Root canal therapy for permanent anterior teeth only.

(b) Tooth fractures (limited to extraction).

(c) Total dental extraction prior to and because of radiation therapy for cancer of the mouth.

[Statutory Authority: RCW 74.04.050, 74.04.057, and 74.09.530. 04-14-100, § 388-535-1065, filed 7/6/04, effective 8/6/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-077, § 388-535-1065, filed 9/12/03, effective 10/13/03.]

WAC 388-535-1070 Dental-related services provider information. (1) The following providers are eligible to enroll with the medical assistance administration (MAA) to furnish and bill for dental-related services provided to eligible clients:

- (a) Persons currently licensed by the state of Washington to:
 - (i) Practice dentistry or specialties of dentistry.
 - (ii) Practice as dental hygienists.
 - (iii) Practice as denturists.
 - (iv) Practice anesthesia by:
 - (A) Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as an anesthesiologist or dental anesthesiologist;
 - (B) Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as a certified registered nurse anesthetist (CRNA) under WAC 246-817-180; or
 - (C) Providing conscious sedation with parenteral or multiple oral agents as a dentist, when the dentist has a conscious sedation permit issued by the department of health (DOH) that is current at the time the billed service(s) is provided; or
 - (D) Providing deep sedation or general anesthesia as a dentist when the dentist has a general anesthesia permit issued by DOH that is current at the time the billed service(s) is provided.

(v) Practice medicine and osteopathy for:

(A) Oral surgery procedures; or

(B) Providing fluoride varnish under EPSDT.

(b) Facilities that are:

(i) Hospitals currently licensed by the DOH;

(ii) Federally-qualified health centers (FQHCs);

(iii) Medicare-certified ambulatory surgical centers (ASCs);

(iv) Medicare-certified rural health clinics (RHCs); or

(v) Community health centers.

(c) Participating local health jurisdictions.

(d) Bordering city or out-of-state providers of dental-related services who are qualified in their states to provide these services.

(2) Subject to the restrictions and limitations in this section and other applicable WAC, MAA pays licensed providers participating in the MAA dental program for only those services that are within their scope of practice.

(3) For the dental specialty of oral and maxillofacial surgery:

(a) MAA requires a dentist to:

(i) Be currently entitled to such specialty designation (to perform oral and maxillofacial surgery) under WAC 246-817-420; and

(ii) Meet the following requirements in order to be reimbursed for oral and maxillofacial surgery:

(A) The dentist must have participated at least three years in a maxillofacial residency program; and

(B) The dentist must be board certified or designated as "board eligible" by the American Board of Oral and Maxillofacial Surgery.

(b) A dental provider who meets the requirements in (3)(a) of this section must bill claims using appropriate current dental terminology (CDT) codes or current procedural terminology (CPT) codes for services that are identified as covered in WAC and MAA's published billing instructions or numbered memoranda.

(4) See WAC 388-502-0020 for provider documentation and record retention requirements. MAA requires additional dental documentation under specific sections in this chapter and as required by chapter 246-817 WAC.

(5) See WAC 388-502-0100 and 388-502-0150 for provider billing and payment requirements. Enrolled dental providers who do not meet the conditions in (3)(a) of this section must bill all claims using only the CDT codes for services that are identified in WAC and MAA's published billing instructions or numbered memoranda. MAA does not reimburse for billed CPT codes when the dental provider does not meet the requirements in subsection (3)(a) of this section.

(6) See WAC 388-502-0160 for regulations concerning charges billed to clients.

(7) See WAC 388-502-0230 for provider review and appeal.

(8) See WAC 388-502-0240 for provider audits and the audit appeal process.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.520, 05-06-092, § 388-535-1070, filed 3/1/05, effective 4/1/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-077, § 388-535-1070, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1070, filed 6/14/02, effective 7/15/02.]

WAC 388-535-1080 Covered dental-related services—Children. (1) The medical assistance administration (MAA) pays for covered dental and dental-related services for children listed in this section only when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary; and

(c) Within accepted dental or medical practice standards and are:

(i) Consistent with a diagnosis of dental disease or condition; and

(ii) Reasonable in amount and duration of care, treatment, or service.

(2) MAA covers the following dental-related services for eligible children:

(a) Medically necessary services for the identification of dental problems or the prevention of dental disease, subject to the limitations of this chapter;

(b) Oral health evaluations and assessments, which must be documented in the client's file according to WAC 388-502-0020, as follows:

(i) MAA allows a comprehensive oral evaluation once per provider as an initial examination, and it must include:

(A) An oral health and developmental history;

(B) An assessment of physical and oral health status; and

(C) Health education, including anticipatory guidance.

(ii) MAA allows a periodic oral evaluation once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

(iii) MAA allows a limited oral evaluation only when the provider performing the limited oral evaluation is not providing prescheduled dental services for the client. The limited oral evaluation must be:

(A) To provide limited or emergent services for a specific dental problem; or

(B) To provide an evaluation for a referral.

(c) Radiographs as follows:

(i) Intraoral (complete series, including bitewings), allowed once in a three-year period;

(ii) Bitewings, total of four allowed every twelve months; and

(iii) Panoramic, for oral surgical purposes only, as follows:

(A) Not allowed with an intraoral complete series; and

(B) Allowed once in a three-year period, except for preoperative or postoperative surgery cases. Preoperative radiographs must be provided within fourteen days prior to surgery, and postoperative radiographs must be provided within thirty days after surgery.

(d) Fluoride treatment (either gel or varnish, but not both) as follows for clients through age eighteen (additional applications require prior authorization):

(i) Topical application of fluoride gel, once every six months; or

(ii) Topical application of fluoride varnish, up to three times in a twelve-month period;

(iii) See subsection (3) of this section for clients of the division of developmental disabilities.

(e) Sealants for children only, once per tooth in a three-year period for:

(i) The occlusal surfaces of:

(A) Permanent teeth two, three, fourteen, fifteen, eighteen, nineteen, thirty, and thirty-one only; and

(B) Primary teeth A, B, I, J, K, L, S, and T only.

(ii) The lingual pits of teeth seven and ten; and

(iii) Teeth with no decay.

(f) Prophylaxis treatment, which is allowed:

(i) Once every six months for children age eight through eighteen;

(ii) Only as a component of oral hygiene instruction for children through age seven; and

(iii) For clients of the division of developmental disabilities, see subsection (3) of this section.

(g) Space maintainers, for children through age eighteen only, as follows:

(i) Fixed (unilateral type), one per quadrant;

(ii) Fixed (bilateral type), one per arch; and

(iii) Recementation of space maintainer, once per quadrant or arch.

(h) Amalgam or composite restorations, as follows:

(i) Once in a two-year period; and

(ii) For the same surface of the same tooth.

(i) Crowns as described in WAC 388-535-1230, Crowns;

(j) Restoration of teeth and maintenance of dental health, subject to limitations of WAC 388-535-1100 and as follows:

(i) Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a multisurface restoration, and are reimbursed as such; and

(ii) Proximal restorations that do not involve the incisal angle in the anterior tooth are considered to be a two-surface restoration, and are reimbursed as such;

(k) Endodontic (root canal) therapies for permanent teeth except for wisdom teeth;

(l) Therapeutic pulpotomies, once per tooth, on primary teeth only;

(m) Pulp vitality test, as follows:

(i) Once per day (not per tooth);

(ii) For diagnosis of emergency conditions only; and

(iii) Not allowed when performed on the same date as any other procedure, with the exception of an emergency examination or palliative treatment.

(n) Periodontal scaling and root planing as follows:

(i) See subsection (3) of this section for clients of the division of developmental disabilities;

(ii) Only when the client has radiographic (X-ray) evidence of periodontal disease. There must be supporting documentation, including complete periodontal charting and a definitive periodontal diagnosis;

(iii) Once per quadrant in a twenty-four month period; and

(iv) Not allowed when performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.

(o) Periodontal maintenance as follows:

(i) See subsection (3) of this section for clients of the division of developmental disabilities;

(ii) Only when the client has radiographic (X-ray) evidence of periodontal disease. There must be supporting documentation, including complete periodontal charting and a definitive periodontal diagnosis;

(iii) Once per full mouth in a twelve-month period; and

(iv) Not allowed when performed on the same date of service as prophylaxis, periodontal scaling, gingivectomy, or gingivoplasty.

(p) Complex orthodontic treatment for severe handicapping dental needs as specified in chapter 388-535A WAC, Orthodontic services;

(q) Occlusal orthotic appliance for temporomandibular joint disorder (TMJ/TMD) or bruxism, one in a two-year period;

(r) Medically necessary oral surgery when coordinated with the client's managed care plan (if any);

(s) Dental services or treatment necessary for the relief of pain and infections, including removal of symptomatic wisdom teeth. MAA does not cover routine removal of asymptomatic wisdom teeth without justifiable medical indications;

(t) Behavior management for clients through age eighteen only, whose documented behavior requires the assistance of more than one additional dental professional staff to protect the client from self-injury during treatment. See subsection (3) of this section for clients of the division of developmental disabilities.

(u) Nitrous oxide for children through age eighteen only, when medically necessary. See subsection (3) of this section for clients of the division of developmental disabilities.

(v) Professional visits, as follows:

(i) Bedside call at a nursing facility or residence when requested by the client or the client's surrogate decision maker as defined in WAC 388-97-055, or when a referral for services is made by the attending physician, the director of nursing, or the nursing facility supervisor, as appropriate, allowed once per day (not per client and not per facility), per provider.

(ii) Hospital call, including emergency care, allowed one per day.

(w) Emergency palliative treatment, as follows:

(i) Allowed only when no other definitive treatment is performed on the same day; and

(ii) Documentation must include tooth designation and a brief description of the service.

(3) For clients of the division of developmental disabilities, MAA allows services as follows:

(a) Fluoride application, either varnish or gel, allowed three times per calendar year;

(b) Prophylaxis, allowed three times per calendar year;

(c) Periodontal scaling and root planing, allowed once every six months;

(d) Periodontal maintenance, allowed three times every twelve months;

(e) Nitrous oxide;

(f) Behavior management that requires the assistance of one additional dental professional staff; and

(g) Panoramic radiographs, with documentation that behavior management is required.

(4) MAA covers medically necessary services provided in a hospital under the direction of a physician or dentist for:

(a) The care or treatment of teeth, jaws, or structures directly supporting the teeth if the procedure requires hospitalization; and

(b) Short stays when the procedure cannot be done in an office setting. See WAC 388-550-1100(6), Hospital coverage.

(5) MAA covers anesthesia for medically necessary services as follows:

(a) The anesthesia must be administered by:

(i) An oral surgeon;

(ii) An anesthesiologist;

(iii) A dental anesthesiologist;

(iv) A certified registered nurse anesthetist (CRNA); or

(v) A general dentist who has a current conscious sedation permit from the department of health (DOH).

(b) MAA pays for anesthesia services according to WAC 388-535-1350.

(6) For clients residing in nursing facilities or group homes:

(a) Dental services must be requested by the client or a referral for services made by the attending physician, the director of nursing or the nursing facility supervisor, or the client's legal guardian;

(b) Mass screening for dental services of clients residing in a facility is not permitted; and

(c) Nursing facilities must provide dental-related necessary services according to WAC 388-97-012, Nursing facility care.

(7) A request to exceed stated limitations or other restrictions on covered services is called a limitation extension (LE), which is a form of prior authorization. MAA evaluates and approves requests for LE for dental-related services when medically necessary, under the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-078, § 388-535-1080, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1080, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1080, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1100 Dental-related services not covered—Children. (1) The medical assistance administration (MAA) does not cover children's dental-related services described in subsection (2) of this section unless the services are:

(a) Required by a physician as a result of an EPSDT screen as provided under chapter 388-534 WAC; or

(b) Included in an MAA waived program.

(2) MAA does not cover the following services for children:

(a) Any service specifically excluded by statute;

(b) More costly services when less costly, equally effective services as determined by the department are available;

(c) Services, procedures, treatment, devices, drugs, or application of associated services which the department or the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA)) consider investigative or experimental on the date the services were provided;

(d) Routine fluoride treatments (gel or varnish) for clients age nineteen through twenty, unless the clients are:

(i) Clients of the division of developmental disabilities;

or

(ii) Diagnosed with xerostomia, in which case the provider must request prior authorization.

(e) Crowns, as follows:

(i) For wisdom and peg teeth;

(ii) Laboratory processed crowns for posterior teeth;

(iii) Temporary crowns, including stainless steel crowns placed as temporary crowns; and

(iv) Post and core for crowns.

(f) Root canal services for primary or wisdom teeth;

(g) Root planing, unless they are clients of the division of developmental disabilities;

(h) Bridges;

(i) Transitional or treatment dentures;

(j) Teeth implants, including follow up and maintenance;

(k) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to an accident, birth defect, or illness;

(l) Porcelain margin extensions (also known as crown lengthening), due to receding gums;

(m) Extraction of asymptomatic teeth;

(n) Minor bone grafts;

(o) Nonemergent oral surgery performed in an inpatient hospital setting, except for the following:

(i) For clients of the division of developmental disabilities, or for children eighteen years of age or younger whose surgeries cannot be performed in an office setting. This requires written prior authorization for the inpatient hospitalization; or

(ii) As provided in WAC 388-535-1080(4).

(p) Dental supplies such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners;

(q) Dentist's time writing prescriptions or calling in prescriptions or prescription refills to a pharmacy;

(r) Educational supplies;

(s) Missed or canceled appointments;

(t) Nonmedical equipment, supplies, personal or comfort items or services;

(u) Provider mileage or travel costs;

(v) Service charges or delinquent payment fees;

(w) Supplies used in conjunction with an office visit;

(x) Take-home drugs;

(y) Teeth whitening; or

(z) Restorations for anterior or posterior wear with no evidence of decay.

(3) MAA evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-078, § 388-535-1100, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1100, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1100, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1100, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1200 Dental-related services requiring prior authorization—Children. The following services for children require prior authorization:

(1) Nonemergent inpatient hospital dental admissions as described under WAC 388-535-1100 (2)(o) and 388-550-1100(1);

(2) Crowns as described in WAC 388-535-1230;

(3) Dentures as described in WAC 388-535-1240; and

(4) Selected procedures identified by the medical assistance administration (MAA) and published in its current dental billing instructions.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-078, § 388-535-1200, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1200, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1200, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1200, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1220 Obtaining prior authorization for dental-related services—Children. When the medical assistance administration (MAA) authorizes a dental-related service for children, that authorization indicates only that the specific service is medically necessary; it is not a guarantee

of payment. The client must be eligible for covered services at the time those services are provided.

(1) MAA requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on an American Dental Association (ADA) claim form, which may be obtained by writing to the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611. The request must include at least all of the following:

(a) Physiological description of the disease, injury, impairment, or other ailment;

(b) Radiographs;

(c) Treatment plan;

(d) Study model, if requested; and

(e) Photographs, if requested.

(2) MAA authorizes requested services that meet the criteria in WAC 388-535-1080.

(3) MAA denies a request for dental services when the requested service is:

(a) Not medically necessary; or

(b) A service, procedure, treatment, device, drug, or application of associated service which the department or the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (HCFA)) consider investigative or experimental on the date the service is provided.

(4) MAA may require second opinions and/or consultations before authorizing any procedure.

(5) Authorization is valid only if the client is eligible for covered services on the date of service.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-078, § 388-535-1220, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1220, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1220, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1230 Crowns for children. (1) Subject to the limitations in WAC 388-535-1100, the medical assistance administration (MAA) covers the following crowns for children without prior authorization:

(a) Stainless steel. MAA considers these as permanent crowns, and does not cover them as temporary crowns; and

(b) Nonlaboratory resin for primary anterior teeth.

(2) MAA does not cover laboratory-processed crowns for posterior teeth.

(3) MAA requires prior authorization for the following crowns, which are limited to single restorations for permanent anterior maxillary and mandibular teeth seven, eight, nine, ten, eleven, twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven:

(a) Resin (laboratory);

(b) Porcelain with ceramic substrate;

(c) Porcelain fused to high noble metal;

(d) Porcelain fused to predominantly base metal; and

(e) Porcelain fused to noble metal.

(4) Criteria for covered crowns as described in subsections (1) and (3) of this section:

(a) Crowns may be authorized when the crown is medically necessary.

(b) Coverage is based upon a supportable five-year prognosis that the client will retain the tooth if the tooth is crowned. The provider must submit the following client information:

(i) The overall condition of the mouth;

(ii) Oral health status;

(iii) Client maintenance of good oral health status;

(iv) Arch integrity; and

(v) Prognosis of remaining teeth (that is, no more involved than periodontal case type II).

(c) Anterior teeth must show traumatic or pathological destruction to loss of at least one incisal angle.

(5) The laboratory processed crowns described in subsection (3) are covered:

(a) Only when a lesser service will not suffice because of extensive coronal destruction, and treatment is beyond intra-coronal restoration;

(b) Only once per permanent tooth in a five-year period;

(c) For endodontically treated anterior teeth only after satisfactory completion of the root canal therapy. Postendodontic treatment radiographs must be submitted for prior authorization of these crowns.

(6) MAA reimburses only for covered crowns as described in subsections (1) and (3) of this section. The reimbursement is full payment; all of the following are included in the reimbursement and must not be billed separately:

(a) Tooth and soft tissue preparation;

(b) Amalgam or acrylic build-ups;

(c) Temporary restoration;

(d) Cement bases;

(e) Insulating bases;

(f) Impressions;

(g) Seating; and

(h) Local anesthesia.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-078, § 388-535-1230, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1230, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520. 01-07-077, § 388-535-1230, filed 3/20/01, effective 4/20/01. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1230, filed 3/10/99, effective 4/10/99.]

WAC 388-535-1240 Dentures, partial dentures, and overdentures for children. (1) Subject to the limitations in WAC 388-535-1100, the medical assistance administration (MAA) covers for children only one maxillary denture and one mandibular denture per client in a ten-year period, and considers that set to be the first set. The exception to this is replacement dentures, which may be allowed as specified in subsection (4) of this section. Except as described in subsection (5) of this section, MAA does not require prior authorization for the first set of dentures. The first set of dentures may be any of the following:

(a) An immediate set (constructed prior to removal of the teeth);

(b) An initial set (constructed after the client has been without teeth for a period of time); or

(c) A final set (constructed after the client has received immediate or initial dentures).

(2) The first maxillary denture and the first mandibular denture must be of the structure and quality to be considered the primary set. MAA does not cover transitional or treatment dentures.

(3) MAA covers partials (resin and cast base) once every five years, except as noted in subsection (4) of this section, and subject to the following limits:

(a) Cast base partials only when replacing three or more teeth per arch excluding wisdom teeth; and

(b) No partials are covered when they replace wisdom teeth only.

(4) Except as stated below, MAA does not require prior authorization for replacement dentures or partials when:

(a) The client's existing dentures or partials meet any of the following conditions. MAA requires prior authorization for replacement dentures or partials requested within one year of the seat date. The dentures or partials must be:

(i) No longer serviceable and cannot be relined or rebased; or

(ii) Damaged beyond repair.

(b) The client's health would be adversely affected by absence of dentures;

(c) The client has been able to wear dentures successfully;

(d) The dentures or partials meet the criteria of medically necessary; and

(e) The dentures are replacing a lost maxillary denture and/or a mandibular denture, and the replacement set does not exceed MAA's limit of one set in a ten-year period as stated in subsection (1) of this section.

(5) MAA does not reimburse separately for laboratory and professional fees for dentures and partials. However, MAA may partially reimburse for these fees when the provider obtains prior authorization and the client:

(a) Dies;

(b) Moves from the state;

(c) Cannot be located; or

(d) Does not participate in completing the dentures.

(6) The provider must document in the client's medical or dental record:

(a) Justification for replacement of dentures;

(b) Charts of missing teeth, for replacement of partials; and

(c) Receipts for laboratory costs or laboratory records and notes.

(7) For billing purposes, the provider may use the impression date as the service date for dentures, including partials, only when:

(a) Related dental services including laboratory services were provided during a client's eligible period; and

(b) The client is not eligible at the time of delivery.

(8) For billing purposes, the provider may use the delivery date as the service date when the client is using the first set of dentures in lieu of noncovered transitional or treatment dentures after oral surgery.

(9) MAA includes the cost of relines and adjustments that are done within six months of the seat date in the reimbursement for the dentures.

(10) MAA covers one rebase in a five-year period; the dentures must be at least three years old.

(11) The requirements in this section also apply to overdentures.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-079, § 388-535-1240, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225. 02-13-074, § 388-535-1240, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225. 99-07-023, § 388-535-1240, filed 3/10/99, effective 4/10/99.]

ABCD DENTAL PROGRAM

WAC 388-535-1245 Access to baby and child dentistry (ABCD) program. The access to baby and child dentistry (ABCD) program is a program established to increase access to dental services in targeted areas for Medicaid-eligible infants, toddlers, and preschoolers. Public and private sectors cooperate to administer the program.

(1) Client eligibility for the ABCD program is as follows:

(a) Clients must be five years of age or younger and reside in targeted areas selected by the medical assistance administration (MAA). Once enrolled in the ABCD program, an eligible client is covered until reaching age six.

(b) Eligible clients enrolled in a managed care plan are eligible for the ABCD program under fee-for-service.

(c) Eligible clients enrolled in the following medical assistance programs are eligible for the ABCD program:

(i) Categorically needy (CN or CNP);

(ii) Limited casualty program/medically needy program (LCP/MNP); and

(iii) Children's health.

(2) Health care providers and community service programs in the targeted areas identify and refer eligible clients to the ABCD program. If enrolled, the client and family may receive:

(a) An ABCD program identification card;

(b) Oral health information;

(c) Expectations of the client and family, including the importance of keeping appointments;

(d) Assistance with obstacles to care, such as lack of transportation; and

(e) Case management services, for families who do not cooperate with the training(s) in this subsection.

(3) Families who do not cooperate with the training(s) in subsection (2) of this section may be disqualified from the ABCD program. The client remains eligible for MAA dental coverage as described in this chapter.

(4) The University of Washington School of Pediatric Dentistry's continuing education program certifies dental providers to furnish ABCD program services.

(5) MAA pays enhanced fees to ABCD-certified participating providers for furnishing ABCD program services. In addition to services provided under MAA's dental care program, the ABCD program provides family oral health education, which is allowed twice per year, per family, and must include:

(a) Risk assessment;

(b) Oral health instruction/training;

- (c) Dietary counseling;
- (d) Fluoride supplements, if appropriate; and
- (e) Documentation in the client's file.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and .225. 02-11-136, § 388-535-1245, filed 5/21/02, effective 6/21/02.]

ADULTS' DENTAL-RELATED SERVICES

WAC 388-535-1255 Covered dental-related services—Adults. (1) The medical assistance administration (MAA) pays for covered dental and dental-related services for adults listed in this section only when they are:

- (a) Within the scope of an eligible client's medical care program;
- (b) Medically necessary; and
- (c) Within accepted dental or medical practice standards and are:
 - (i) Consistent with a diagnosis of dental disease or condition; and
 - (ii) Reasonable in amount and duration of care, treatment, or service.

(2) MAA covers the following dental-related services for eligible adults, subject to the restrictions and limitations in this section and other applicable WAC:

(a) Medically necessary services for the identification of dental problems or the prevention of dental disease, subject to the limitations of this chapter.

(b) A comprehensive oral evaluation once per provider as an initial examination, that must include:

- (i) A complete dental and medical history and a general health assessment;
- (ii) A complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; and
- (iii) The evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

(c) Periodic oral evaluations once every six months to include a periodontal screening/charting at least once per year. There must be six months between the comprehensive oral evaluation and the first periodic oral evaluation.

(d) Limited oral evaluations only when the provider is not providing prescheduled dental services for the client. The limited oral evaluation must be:

- (i) To provide limited or emergent services for a specific dental problem; and/or
- (ii) To provide an evaluation for a referral.

(e) Radiographs, as follows:

- (i) Intraoral, complete series (including bitewings), allowed only once in a three-year period;
- (ii) Panoramic film, allowed only once in a three-year period and only for oral surgical purposes (see subsection (3) of this section for clients of the division of developmental disabilities);
- (iii) Periapical radiographs as needed (periapical radiographs and bitewings taken on the same date of service cannot exceed MAA's fee for a complete intraoral series); and
- (iv) Bitewings, up to four allowed every twelve months.

(f) Fluoride treatment as follows (see subsection (3) of this section for clients of the division of developmental disabilities):

(i) Topical application of fluoride gel or fluoride varnish for adults age nineteen through sixty-four with xerostomia (requires prior authorization); and

(ii) Topical application of fluoride gel or fluoride varnish for adults age sixty-five and older for:

- (A) Rampant root surface decay; or
- (B) Xerostomia.

(g) Oral prophylaxis treatment, which is:

(i) Allowed once every twelve months for adults age nineteen and older, including nursing facility clients, and for clients of the division of developmental disabilities as provided in subsection (3) of this section;

(ii) Not reimbursed when oral prophylaxis treatment is performed on the same date of service as periodontal scaling and root planing, gingivectomy, or gingivoplasty; and

(iii) Reimbursed only if periodontal maintenance is not billed for the same client within the same twelve-month period.

(h) Restoration of teeth and maintenance of dental health, subject to the limitations in WAC 388-535-1265 and the following:

(i) Amalgam and composite restorations are allowed once for the same surface of the same tooth per client, per provider;

(ii) Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a single multisurface restoration. Payment is limited to that of a single multisurface restoration.

(iii) Proximal restorations that do not involve the incisal angle in the anterior teeth are considered to be a two-surface restoration. Payment is limited to a two-surface restoration.

(iv) Proximal restorations that involve the incisal angle are considered to be either a three- or four-surface restoration. All surfaces must be listed on the claim for payment.

(v) MAA pays for a maximum of six surfaces for a posterior tooth, which is allowed once per client, per provider, in a two-year period.

(vi) MAA pays for a maximum of six surfaces for an anterior tooth, which is allowed once per client, per provider, in a two-year period.

(vii) MAA pays for a core buildup on an anterior or a posterior tooth, including any pins, which is allowed once per client, per provider, in a two-year period, subject to the following:

(A) MAA does not pay for a core buildup when a permanent or temporary crown is being placed on the same tooth.

(B) MAA does not pay for a core buildup when placed in combination with any other restoration on the same tooth.

(viii) MAA pays for flowable composites as a restoration only, when used with a cavity preparation for a carious lesion that penetrates through the enamel:

- (A) As a small Class I (occlusal) restoration; or
- (B) As a Class V (buccal or lingual) restoration.

(i) Endodontic (root canal) therapy for permanent anterior teeth only.

(j) Periodontal scaling and root planing, which is:

(i) Allowed for clients of the division of developmental disabilities as provided in subsection (3) of this section;

- (ii) Allowed for clients age nineteen and older;
- (iii) Allowed only when the client has radiographic evidence of periodontal disease. There must be supporting documentation in the client's record, including complete periodontal charting and a definitive periodontal diagnosis;
- (iv) Allowed once per quadrant in a twenty-four month period;
- (v) Allowed only when the client's clinical condition meets existing periodontal guidelines; and
- (vi) Not allowed when performed on the same date of service as oral prophylaxis, periodontal maintenance, gingivectomy or gingivoplasty. Refer to subsection (2)(g) of this section for limitations on oral prophylaxis. Refer to subsection (2)(k) of this section for limitations on periodontal maintenance.
- (k) Periodontal maintenance, which is:
 - (i) Allowed for clients of the division of developmental disabilities as provided in subsection (3) of this section;
 - (ii) Allowed for clients age nineteen and older;
 - (iii) Allowed only when the client has been previously treated for periodontal disease, including surgical or nonsurgical periodontal therapy;
 - (iv) Allowed when supporting documentation in the client's record includes a definitive periodontal diagnosis and complete periodontal charting;
 - (v) Allowed when the client's clinical condition meets existing periodontal guidelines;
 - (vi) Allowed when periodontal maintenance starts at least twelve months after completion of periodontal scaling and root planing or surgical treatment and paid only at twelve month intervals;
 - (vii) Not reimbursed when the periodontal maintenance is performed on the same date of service as periodontal scaling and root planing, gingivectomy, or gingivoplasty; and
 - (viii) Reimbursed only if oral prophylaxis is not billed for the same client within the same twelve-month period.
- (l) Dentures and partial dentures according to WAC 388-535-1290.
- (m) Simple extractions (includes local anesthesia, suturing, and routine postoperative care).
- (n) Surgical extractions, subject to the following:
 - (i) Includes local anesthesia, suturing, and routine postoperative care; and
 - (ii) Requires documentation in the client's file to support soft tissue, partially bony, or completely bony extractions.
- (o) Medically necessary oral surgery when coordinated with the client's managed care plan (if any).
- (p) Palliative (emergency) treatment of dental pain and infections, minor procedures, which is:
 - (i) Allowed once per client, per day.
 - (ii) Reimbursed only when performed on a different date from:
 - (A) Any other definitive treatment necessary to diagnose the emergency condition; and
 - (B) Root canal therapy.
 - (iii) Reimbursed only when a description of the service is included in the client's record.
- (q) Behavior management that requires the assistance of one additional dental professional staff for clients of the division of developmental disabilities. See subsection (3) of this section.

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(3) For clients of the division of developmental disabilities, MAA allows services as follows:

- (a) Fluoride application, either varnish or gel, three times per calendar year;
- (b) One of the following combinations of preventive or periodontal procedures, subject to the limitations listed:
 - (i) Prophylaxis or periodontal maintenance, three times per calendar year;
 - (ii) Periodontal scaling and root planing, two times per calendar year; or
 - (iii) Prophylaxis or periodontal maintenance, two times per calendar year, and periodontal scaling and root planing, once per calendar year.
- (c) Gingivectomy or gingivectomy, allowed for four or more contiguous teeth or bounded teeth spaces per quadrant, once every three years.
- (d) Nitrous oxide;
- (e) Behavior management that requires the assistance of one additional dental professional staff. A description of behavior management must be documented in the client's record;
- (f) Panoramic radiographs;
- (g) General anesthesia or conscious sedation with parenteral or multiple oral agents when medically necessary for providing treatment; and
- (h) Limited visual oral assessment (does not replace an oral evaluation) when the assessment includes appropriate referrals, charting of patient data and oral health status and informing the client's parent or guardian of the results, and when at least one of the following occurs:
 - (i) The provision of triage services;
 - (ii) An intraoral screening of soft tissues by a public health dental hygienist to assess the need for prophylaxis, fluoride varnish, or referral for other dental treatments by a dentist; or
 - (iii) In circumstances where the client will be referred to a dentist for treatment, the referring provider will not provide treatment or provide a full evaluation at the time of the assessment.
- (4) MAA covers dental services that are medically necessary and provided in a hospital under the direction of a physician or dentist for:
 - (a) The care or treatment of teeth, jaws, or structures directly supporting the teeth if the procedure requires hospitalization;
 - (b) Short stays when the procedure cannot be done in an office setting. See WAC 388-550-1100(6); and
 - (c) A hospital call, including emergency care, allowed one per day, per client, per provider.
- (5) MAA covers general anesthesia and conscious sedation with parenteral or multiple oral agents for medically necessary dental services as follows:
 - (a) For treatment of clients who are eligible under the division of developmental disabilities.
 - (b) For oral surgery procedures.
 - (c) When justification for administering the general anesthesia instead of a lesser type of sedation is clearly documented in the client's record.
 - (d) When the anesthesia is administered by:
 - (i) An oral surgeon who has a current conscious sedation permit or a current general anesthesia permit from DOH;

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- (ii) An anesthesiologist;
 - (iii) A dental anesthesiologist who has a current conscious sedation permit or a current general anesthesia permit from DOH;
 - (iv) A certified registered nurse anesthetist (CRNA), if the performing dentist has a current conscious sedation permit or a current general anesthesia permit from the department of health (DOH); or
 - (v) A dentist who has a current conscious sedation permit or a current general anesthesia permit from DOH.
- (e) When the provider meets the prevailing standard of care and at least the requirements in WAC 246-817-760, Conscious sedations with parenteral or multiple oral agents and WAC 246-817-770, General anesthesia.
- (6) MAA pays for anesthesia services according to WAC 388-535-1350.
- (7) MAA covers dental-related services for clients residing in nursing facilities or group homes as follows:
- (a) Dental services must be requested by the client or the client's surrogate decision maker as defined in WAC 388-97-055, or a referral for services must be made by the attending physician, the director of nursing, or the nursing facility supervisor, as appropriate, allowed once per day (not per client and not per facility), per provider; and
 - (b) Nursing facilities must provide dental-related necessary services according to WAC 388-97-012, Nursing facility care.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-079, § 388-535-1255, filed 9/12/03, effective 10/13/03.]

WAC 388-535-1265 Dental-related services not covered—Adults. (1) The department does not cover dental-related services, described in subsection (2) of this section, for adults unless the services are included in a department waiver program.

(2) The department does not cover the following dental-related services for adults:

- (a) Any service specifically excluded by statute.
- (b) More costly services when less costly, equally effective services as determined by the department are available.
- (c) Services, procedures, treatment, devices, drugs, or application of associated services which the department or the Centers for Medicare and Medicaid Services (CMS) consider investigative or experimental on the date the services were provided.
- (d) Coronal polishing.
- (e) Fluoride treatments (gel or varnish) for adults, unless the clients are:
 - (i) Clients of the division of developmental disabilities;
 - (ii) Diagnosed with xerostomia, in which case the provider must request prior authorization; or
 - (iii) High-risk adults sixty-five and older. High-risk means the client has at least one of the following:
 - (A) Rampant root surface decay; or
 - (B) Xerostomia.
- (f) Restorations for wear on any surface of any tooth without evidence of decay through the enamel or on the root surface.
- (g) Flowable composites for interproximal or incisal restorations.

- (h) Any permanent crowns, temporary crowns, or crown post and cores.
- (i) Bridges, including abutment teeth and pontics.
- (j) Root canal services for primary teeth.
- (k) Root canal services for permanent teeth other than teeth six, seven, eight, nine, ten, eleven, twenty-two, twenty-three, twenty-four, twenty-five, twenty-six, and twenty-seven.
- (l) Pulpotomy services for permanent teeth.
- (m) Transitional or treatment dentures.
- (n) Overdentures.
- (o) Replacements for:
 - (i) Immediate maxillary or mandibular dentures;
 - (ii) Maxillary or mandibular partial dentures (resin); or
 - (iii) Complete maxillary or mandibular dentures in excess of one replacement in a ten-year period; or
 - (iv) Cast metal framework maxillary or mandibular partial dentures in excess of one replacement in a ten-year period.
- (p) Rebasement of complete and immediate dentures and partial dentures.
- (q) Adjustments of complete and immediate dentures and partial dentures.
- (r) Tooth implants, including insertion, postinsertion, maintenance, and implant removal.
- (s) Periodontal bone grafts or oral soft tissue grafts.
- (t) Gingivectomy, gingivoplasty, or frenectomy, frenoplasty and other periodontal surgical procedures.
- (u) Crown lengthening procedures.
- (v) Orthotic appliances, including but not limited to, night guards, temporomandibular joint dysfunction (TMJ/TMD) appliances, and all other mouth guards.
- (w) Any treatment of TMJ/TMD.
- (x) Extraction of:
 - (i) Asymptomatic teeth;
 - (ii) Asymptomatic wisdom teeth; and
 - (iii) Surgical extraction of anterior teeth seven, eight, nine, ten, twenty-three, twenty-four, twenty-five, or twenty-six, which are considered simple extractions and paid as such.
- (y) Alveoloplasty, alveolotomy or tori, exostosis removal.
- (z) Debridement of granuloma or cyst associated with tooth extraction.
- (aa) Cosmetic treatment or surgery, except as prior authorized by the department for medically necessary reconstructive surgery to correct defects attributable to an accident, birth defect, or illness.
- (bb) Nonemergent oral surgery for adults performed in an inpatient hospital setting, except:
 - (i) Nonemergent oral surgery is covered in an inpatient hospital setting for clients of the division of developmental disabilities when written prior authorization is obtained for the inpatient hospitalization; or
 - (ii) As provided in WAC 388-535-1080(4).
- (cc) Dental supplies such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners.
- (dd) Dentist's time writing and calling in prescriptions or prescription refills.
- (ee) Educational supplies.
- (ff) Missed or canceled appointments.

(gg) Nonmedical equipment, supplies, personal or comfort items or services.

(hh) Provider mileage or travel costs.

(ii) Service charges or delinquent payment fees.

(jj) Supplies used in conjunction with an office visit.

(kk) Take-home drugs.

(ll) Teeth whitening.

(3) The department evaluates a request for any dental-related service that is listed as noncovered under the provisions of WAC 388-501-0160.

(4) The department evaluates a request for a covered service in excess of the dental program's service limitations or restrictions according to the provisions of WAC 388-501-0169.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-535-1265, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-079, § 388-535-1265, filed 9/12/03, effective 10/13/03.]

WAC 388-535-1270 Dental-related services requiring prior authorization—Adults. The following dental-related services for adults require prior authorization:

(1) Nonemergent inpatient hospital dental admissions as described under WAC 388-535-1100 (2)(o) and 388-550-1100(1);

(2) Dentures and partial dentures as described in WAC 388-550-1290;

(3) Fluoride treatment (gel or varnish) for clients age nineteen through sixty-four who are diagnosed with xerostomia; and

(4) Selected procedures identified by the medical assistance administration (MAA) and published in its current dental billing instructions.

(5) See WAC 388-535-1280 for obtaining prior authorization for dental-related services for adults.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-080, § 388-535-1270, filed 9/12/03, effective 10/13/03.]

WAC 388-535-1280 Obtaining prior authorization for dental-related services—Adults. When the medical assistance administration (MAA) authorizes dental-related services for adults, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for covered services at the time those services are provided.

(1) MAA requires a dental provider who is requesting prior authorization to submit sufficient objective clinical information to establish medical necessity. The request must be submitted in writing on an American Dental Association (ADA) claim form, which may be obtained by writing to the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611. The request must include at least all of the following:

(a) The client's patient identification code (PIC);

(b) The client's name and address;

(c) The provider's name and address;

(d) The provider's telephone and fax number (including area code);

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(e) The provider's MAA-assigned seven-digit provider number;

(f) The physiological description of the disease, injury, impairment, or other ailment;

(g) The most recent and relevant radiographs that are identified with client name, provider name, and date the radiograph was taken;

(h) The treatment plan;

(i) Periodontal when radiographs do not sufficiently support the medical necessity for extractions;

(j) Study model, if requested; and

(k) Photographs, if requested.

(2) MAA considers requests for services according to WAC 388-535-1270.

(3) MAA denies a request for dental services when the requested service is:

(a) Not listed in chapter 388-535 WAC as a covered service;

(b) Not medically necessary;

(c) A service, procedure, treatment, device, drug, or application of associated service that the department or the Centers for Medicare and Medicaid Services (CMS) consider investigative or experimental on the date the service is provided; or

(d) Covered under another department program or by an agency outside the department.

(4) MAA may require second opinions and/or consultations before authorizing any procedure.

(5) Authorization is valid only if the client is eligible for covered services on the date of service.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-080, § 388-535-1280, filed 9/12/03, effective 10/13/03.]

WAC 388-535-1290 Dentures and partial dentures for adults. (1) The medical assistance administration (MAA) requires prior authorization for the dentures (complete or immediate), replacement dentures, partial dentures, and replacement partial dentures that are described in this section.

(2) Subject to the criteria in this section and other applicable WAC, MAA covers the following for eligible adults:

(a) Dentures, subject to the following limitations:

(i) Only one complete maxillary denture and one complete mandibular denture allowed per client in a ten-year period, when constructed after the client has been without teeth for a period of time; or

(ii) Only one immediate maxillary denture and one immediate mandibular denture allowed per client, per lifetime, and only when constructed prior to the removal of the client's teeth.

(b) Replacement dentures, subject to the following limitations:

(i) Only one replacement of a complete maxillary denture and one replacement of a complete mandibular denture allowed per client in a ten-year period; and

(ii) Allowed only when the applicable criteria in subsection (6) of this section are met.

(c) Partial dentures, subject to the following limitations:

(i) Only one maxillary partial denture (resin) and one mandibular partial denture (resin) to replace one, two, or

three missing anterior teeth per arch, allowed per client in a ten-year period; or

(ii) Only one maxillary partial denture (cast metal framework) and one mandibular partial denture (cast metal framework) allowed per client in a ten-year period to replace:

(A) Any combination of at least six anterior and posterior missing teeth per arch, excluding wisdom teeth; or

(B) At least four anterior missing teeth per arch.

(d) Replacement partial dentures, subject to the following limitations:

(i) Only one replacement of a maxillary partial denture (cast metal framework) and a mandibular partial denture (cast metal framework) allowed per client in a ten-year period; and

(ii) Allowed only when the applicable criteria in subsection (6) of this section are met.

(3) Dentures must be of an acceptable structure and quality to meet the standard of care.

(4) MAA covers complete denture and partial denture relines only once in a five-year period.

(5) MAA covers complete dentures and partial denture repairs when medically necessary.

(6) In addition to the prior authorization requirement and other limitations in this section, all replacement complete dentures and cast metal framework partial dentures are allowed once in a ten-year period and must:

(a) Replace a complete maxillary denture, a complete mandibular denture, a maxillary partial denture (cast metal framework) or a mandibular partial denture (cast metal framework) (see subsection (2) of this section);

(b) Replace dentures or partial dentures that are no longer serviceable and are unable to be relined;

(c) Replace dentures or partial dentures that are damaged beyond repair;

(d) Replace dentures or partial dentures that a client has been able to wear successfully; and

(e) Be medically necessary, as defined in WAC 388-500-0005.

(7) For billing purposes, a provider must:

(a) Use the delivery date as the service date for the dentures and partial dentures; and

(b) Use the impression date as the service date for dentures and partial dentures only when:

(i) Related dental services, including laboratory services, were provided during a client's eligible period; and

(ii) The client is not eligible at the time of delivery; or

(iii) The client does not return to obtain the dentures or partial dentures.

(8) A provider must retain in a client's record:

(a) Written laboratory prescriptions;

(b) Receipts for laboratory fees;

(c) Charts of missing teeth for partial dentures; and

(d) Documentation that justifies the placement or replacement of dentures or partial dentures.

(9) MAA does not pay separately for laboratory and professional fees for dentures and partial dentures. However, MAA may partially reimburse for these fees when the provider obtains prior authorization and the client:

(a) Dies;

(b) Moves from the state;

(c) Cannot be located; or

(d) Does not participate in completing the dentures.

(10) MAA does not pay separately for relines that are done within six months of the seat date. These procedures are included in the reimbursement for the dentures and partial dentures.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191. 03-19-080, § 388-535-1290, filed 9/12/03, effective 10/13/03.]

PAYMENT

WAC 388-535-1350 Payment methodology for dental-related services. The medical assistance administration (MAA) uses the description of dental services described in the American Dental Association's Current Dental Terminology, and the American Medical Association's Physician's Current Procedural Terminology (CPT).

(1) For covered dental-related services provided to eligible clients, MAA pays dentists and other eligible providers on a fee-for-service or contractual basis, subject to the exceptions and restrictions listed under WAC 388-535-1100 and 388-535-1400.

(2) MAA sets maximum allowable fees for dental services provided to children as follows:

(a) MAA's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) MAA consults with representatives of the provider community to identify program areas and concerns that need to be addressed.

(c) MAA consults with dental experts and public health professionals to identify and prioritize dental services and procedures for their effectiveness in improving or promoting children's dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for children's dental services are allocated to specific procedures based on the priorities identified in (c) of this subsection and considerations of access to services.

(e) Larger percentage increases may be given to those procedures which have been identified as most effective in improving or promoting children's dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the department's evaluation of utilization trends, effectiveness of interventions, and access issues.

(3) MAA reimburses dental general anesthesia services for eligible clients on the basis of base anesthesia units plus time. Payment for dental general anesthesia is calculated as follows:

(a) Dental procedures are assigned an anesthesia base unit of five;

(b) Fifteen minutes constitute one unit of time. When a dental procedure requiring dental general anesthesia results in multiple time units and a remainder (less than fifteen minutes), the remainder or fraction is considered as one time unit;

(c) Time units are added to the anesthesia base unit of five and multiplied by the anesthesia conversion factor;

(d) The formula for determining payment for dental general anesthesia is: (5.0 base anesthesia units + time units) x conversion factor = payment.

(4) When billing for anesthesia, the provider must show the actual beginning and ending times on the claim. Anesthesia time begins when the provider starts to physically prepare

the client for the induction of anesthesia in the operating room area (or its equivalent), and ends when the provider is no longer in constant attendance (i.e., when the client can be safely placed under postoperative supervision).

(5) MAA pays eligible providers listed in WAC 388-535-1070 for conscious sedation with parenteral and multiple oral agents, or for general anesthesia when the provider meets the criteria in this chapter and other applicable WAC.

(6) Dental hygienists who have a contract with MAA are paid at the same rate as dentists who have a contract with MAA, for services allowed under The Dental Hygienist Practice Act.

(7) Licensed denturists who have a contract with MAA are paid at the same rate as dentists who have a contract with MAA, for providing dentures and partials.

(8) MAA makes fee schedule changes whenever the legislature authorizes vendor rate increases or decreases.

(9) MAA may adjust maximum allowable fees to reflect changes in services or procedure code descriptions.

(10) MAA does not pay separately for chart or record setup, or for completion of reports, forms, or charting. The fees for these services are included in MAA's reimbursement for comprehensive oral evaluations or limited oral evaluations.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-080, § 388-535-1350, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.-500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1350, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225, 99-07-023, § 388-535-1350, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1350, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1400 Payment for dental-related services. (1) The medical assistance administration (MAA) considers that a provider who furnishes covered dental services to an eligible client has accepted MAA's rules and fees.

(2) Participating providers must bill MAA their usual and customary fees.

(3) Payment for dental services is based on MAA's schedule of maximum allowances. Fees listed in the MAA fee schedule are the maximum allowable fees.

(4) MAA pays the provider the lesser of the billed charge (usual and customary fee) or MAA's maximum allowable fee.

(5) MAA pays "by report" on a case-by-case basis, for a covered service that does not have a set fee.

(6) Participating providers must bill a client according to WAC 388-502-0160, unless otherwise specified in this chapter.

(7) If the client's eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility. The exception to this is dentures and partial dentures as described in WAC 388-535-1240 and 388-535-1290.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-080, § 388-535-1400, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.-500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1400, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a),

(2007 Ed.)

CFR 440.100 and 440.225, 99-07-023, § 388-535-1400, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1400, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1450 Payment for denture laboratory services. The medical assistance administration (MAA) does not directly reimburse denture laboratories. MAA's reimbursement for complete dentures, immediate dentures, partial dentures, and overdentures includes laboratory fees. The provider is responsible to pay a denture laboratory for services furnished at the request of the provider.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 2003 1st sp.s. c 25, P.L. 104-191, 03-19-080, § 388-535-1450, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.-500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1450, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225, 99-07-023, § 388-535-1450, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1450, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1500 Payment for dental-related hospital services. The medical assistance administration (MAA) pays for medically necessary dental-related hospital inpatient and outpatient services in accord with WAC 388-550-1100.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1500, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225, 99-07-023, § 388-535-1500, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1500, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1550 Payment for dental care provided out-of-state. (1) Clients, except those receiving services under state-funded only programs, who are temporarily outside the state receive the same dental care services as clients in the state, subject to the same exceptions and limitations.

(2) The medical assistance administration (MAA) does not cover out-of-state dental care for clients receiving services under state-funded only programs.

(3) Eligible clients in MAA-designated border areas may receive the same dental services as if provided in state.

(4) Dental providers who are out-of-state must meet the same criteria for payment as in-state providers, including the requirements to contract with MAA. See WAC 388-535-1070, Dental-related services provider information.

[Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.500, 74.09.520, 42 U.S.C. 1396d(a), 42 C.F.R. 440.100 and 440.225, 02-13-074, § 388-535-1550, filed 6/14/02, effective 7/15/02. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520 and 74.09.700, 42 USC 1396d(a), CFR 440.100 and 440.225, 99-07-023, § 388-535-1550, filed 3/10/99, effective 4/10/99. Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090, 96-01-006 (Order 3931), § 388-535-1550, filed 12/6/95, effective 1/6/96.]

Chapter 388-535A WAC ORTHODONTIC SERVICES

WAC

388-535A-0010	Definitions for orthodontic services.
388-535A-0020	Eligibility for orthodontic services.
388-535A-0030	Providers of orthodontic services.

388-535A-0040	Covered and noncovered orthodontic services and limitations to coverage.
388-535A-0050	Authorization and prior authorization for orthodontic services.
388-535A-0060	Reimbursement for orthodontic services.

WAC 388-535A-0010 Definitions for orthodontic services. The following definitions and those found in WAC 388-500-0005 apply to this chapter.

"Appliance placement" means the application of orthodontic attachments to the teeth for the purpose of correcting dentofacial abnormalities.

"Cleft" means an opening or fissure involving the dentition and supporting structures, especially one occurring in utero. These can be:

- (1) Cleft lip;
- (2) Cleft palate (involving the roof of the mouth); or
- (3) Facial clefts (e.g., macrostomia).

"Comprehensive full orthodontic treatment" means utilizing fixed orthodontic appliances for treatment of the permanent dentition leading to the improvement of a client's severe handicapping craniofacial dysfunction and/or dentofacial deformity, including anatomical and functional relationships.

"Craniofacial anomalies" means abnormalities of the head and face, either congenital or acquired, involving disruption of the dentition and supporting structures.

"Craniofacial team" means a department of health- and medical assistance administration-recognized cleft palate/maxillofacial team or an American Cleft Palate Association-certified craniofacial team. These teams are responsible for the management (review, evaluation, and approval) of patients with cleft palate craniofacial anomalies to provide integrated case management, promote parent-professional partnership, and make appropriate referrals to implement and coordinate treatment plans.

"Dental dysplasia" means an abnormality in the development of the teeth.

"EPSDT" means the department's early and periodic screening, diagnosis, and treatment program for clients twenty years of age and younger as described in chapter 388-534 WAC.

"Hemifacial microsomia" means a developmental condition involving the first and second brachial arch. This creates an abnormality of the upper and lower jaw, ear, and associated structures (half or part of the face appears smaller sized).

"Interceptive orthodontic treatment" means procedures to lessen the severity or future effects of a malformation and to affect or eliminate the cause. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental cross-bite, or recovery of recent minor space loss where overall space is adequate.

"Limited transitional orthodontic treatment" means orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed only at the existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

"Malocclusion" means improper alignment of biting or chewing surfaces of upper and lower teeth.

"Maxillofacial" means relating to the jaws and face.

"Occlusion" means the relation of the upper and lower teeth when in functional contact during jaw movement.

"Orthodontics" means treatment involving the use of any appliance, in or out of the mouth, removable or fixed, or any surgical procedure designed to redirect teeth and surrounding tissues.

"Orthodontist" means a dentist who specializes in orthodontics, who is a graduate of a postgraduate program in orthodontics that is accredited by the American Dental Association, and who meets the licensure requirements of the department of health.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0010, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0010, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0020 Eligibility for orthodontic services. (1) Subject to the limitations of this chapter, the medical assistance administration (MAA) covers medically necessary orthodontic treatment for severe handicapping malocclusions, craniofacial anomalies, or cleft lip or palate for children only, as follows:

(a) Clients in the categorically needy program (CN) or (CNP) receive orthodontic services through age twenty.

(b) Clients in the medically needy program (MNP) receive orthodontic services through age twenty.

(c) Clients in the children's health insurance program (CHIP) receive orthodontic services through age eighteen. See WAC 388-416-0015 for when certification periods may be extended.

(d) Clients who are eligible for services under the EPSDT program may receive orthodontic services under the provisions of WAC 388-534-0100.

(2) MAA does not cover orthodontic services for adults.

(3) Eligible clients may receive the same orthodontic services in designated border cities as if provided in-state. See WAC 388-501-0175.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0020, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0020, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0030 Providers of orthodontic services. The following provider types may furnish and be reimbursed for providing covered orthodontic services to medical assistance administration (MAA) clients:

(1) Orthodontists;

(2) Pediatric dentists;

(3) General dentists; and

(4) Department recognized craniofacial teams or other orthodontic specialists approved by MAA's orthodontic consultant.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0030, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0030, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0040 Covered and noncovered orthodontic services and limitations to coverage. (1) Subject to the limitations in this section and other applicable WAC, the department covers orthodontic treatment for a client who has one of the following medical conditions:

(a) Cleft lip, cleft palate, or other craniofacial anomalies when the client is treated by and receives follow-up care from a department-recognized craniofacial team for:

(i) Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement;

(ii) Craniofacial anomalies, including but not limited to:

(A) Hemifacial microsomia;

(B) Craniosynostosis syndromes;

(C) Cleidocranial dental dysplasia;

(D) Arthrogryposis; or

(E) Marfan syndrome.

(iii) Other medical conditions with significant facial growth impact (e.g., juvenile rheumatoid arthritis (JRA)); or

(iv) Post-traumatic, post-radiation, or post-burn jaw deformity.

(b) Other severe handicapping malocclusions, including one or more of the following:

(i) Deep impinging overbite when lower incisors are destroying the soft tissues of the palate;

(ii) Crossbite of individual anterior teeth when destruction of the soft tissue is present;

(iii) Severe traumatic malocclusion (e.g., loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology);

(iv) Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties; or

(v) Medical conditions as indicated on the Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score that result in a score of twenty-five or higher. On a case-by-case basis, the department reviews all requests for treatment for conditions that result in a score of less than twenty-five, based on medical necessity.

(2) The department may cover requests for orthodontic treatment for dental malocclusions other than those listed in subsection (1) of this section when the department determines that the treatment is medically necessary.

(3) The department does not cover:

(a) Lost or broken orthodontic appliances;

(b) Orthodontic treatment for cosmetic purposes;

(c) Orthodontic treatment that is not medically necessary (see WAC 388-500-0005);

(d) Out-of-state orthodontic treatment; or

(e) Orthodontic treatment and orthodontic-related services that do not meet the requirements of this section or other applicable WAC.

(4) The department covers the following orthodontic treatment and orthodontic-related services, subject to the limitations listed (providers must bill for these services according to WAC 388-535A-0060):

(a) Panoramic radiographs (X rays), once per client in a three-year period.

(b) Interceptive orthodontic treatment, once per the client's lifetime.

(c) Limited transitional orthodontic treatment, up to one year from date of original appliance placement (see subsection (2007 Ed.)

tion (5) of this section for information on limitation extensions).

(d) Comprehensive full orthodontic treatment, up to two years from the date of original appliance placement (see subsection (5) of this section for information on limitation extensions).

(e) Orthodontic appliance removal only when:

(i) The client's appliance was placed by a different provider; and

(ii) The provider has not furnished any other orthodontic treatment to the client.

(f) Other medically necessary orthodontic treatment and orthodontic-related services as determined by the department.

(5) A request to exceed stated limitations or other restrictions on covered services is called a limitation extension (LE), which is a form of prior authorization. The department evaluates and approves requests for LE for orthodontic services when medically necessary, under the provisions of WAC 388-501-0165.

(6) The department evaluates a request for any orthodontic service not listed as covered in this section under the provisions of WAC 388-501-0160.

(7) The department reviews requests for orthodontic treatment for clients who are eligible for services under the EPSDT program according to the provisions of WAC 388-534-0100.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-535A-0040, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0040, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C. 1396d(a), C.F.R. 440.100 and 225.02-01-050, § 388-535A-0040, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0050 Authorization and prior authorization for orthodontic services.

(1) When the medical assistance administration (MAA) authorizes an interceptive orthodontic treatment, limited orthodontic treatment, or full orthodontic treatment for a client, including a client eligible for services under the EPSDT program, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. The client must be eligible for the covered service at the time the service is provided.

(2) For orthodontic treatment of a client with cleft lip, cleft palate, or other craniofacial anomaly, prior authorization:

(a) Is not required if the client is being treated by a department-recognized craniofacial team, or an orthodontic specialist who has been approved by an MAA dental consultant to treat cleft lip, cleft palate, or other craniofacial anomalies; and

(b) Is required if the client is not being treated by a provider listed in (a) of this subsection.

(3) Subject to the conditions and limitations of this section and other applicable WAC, MAA requires prior authorization for orthodontic treatment for other dental malocclusions that are not listed in WAC 388-535A-0040(1).

[Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0050, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C.

1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0050, filed 12/11/01, effective 1/11/02.]

WAC 388-535A-0060 Reimbursement for orthodontic services. (1) The medical assistance administration (MAA) reimburses providers for furnishing covered orthodontic services described in WAC 388-535A-0040 according to this section and other applicable WAC.

(2) MAA considers that a provider who furnishes covered orthodontic services to an eligible client has accepted MAA's rates and fees.

(3) To be reimbursed for providing limited transitional orthodontic treatment, providers must bill MAA in intervals during the treatment and complete treatment within twelve months of the date of appliance placement:

(a) The first three months of treatment starts the date the initial appliance is placed and includes active treatment for the first three months. The provider should bill MAA with the date of service that the initial appliance is placed.

(b) Continuing follow-up treatment must be billed after each three-month treatment interval during the treatment. Treatment provided after one year from the date the appliance is placed requires a limitation extension. See WAC 388-535A-0040(5).

(4) To be reimbursed for providing comprehensive full orthodontic treatment, providers must bill MAA in intervals during the treatment and complete treatment within twenty-four months of the date of the appliance placement:

(a) The first six months of treatment starts the date the initial appliance is placed and includes active treatment within the six months. The provider should bill MAA with the date of service that the initial appliance is placed.

(b) Continuing follow-up treatment must be billed after each three-month treatment interval, with the first three-month interval beginning six months after the initial appliance placement. Treatment provided after two years from the date the appliance is placed requires a limitation extension. See WAC 388-535A-0040(5).

(5) Payment for orthodontic services is based on MAA's schedule of maximum allowances; fees listed in the fee schedule are the maximum allowable fees.

(6) Orthodontic providers who are in department-designated bordering cities must:

(a) Meet the licensure requirements of their state; and

(b) Meet the same criteria for payment as in-state providers, including the requirements to contract with MAA.

(7) If the client's eligibility for orthodontic treatment under WAC 388-535A-0020 ends before the conclusion of the orthodontic treatment, payment for any remaining treatment is the individual's responsibility; MAA does not reimburse for these services.

(8) The client is responsible for payment of any orthodontic service or treatment received during any period of ineligibility, even if the treatment was started when the client was eligible; MAA does not reimburse for these services.

(9) See WAC 388-502-0160 and 388-501-0200 for when a provider or a client is responsible to pay for a covered service.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 74.09.035, 74.09.500. 05-01-064, § 388-535A-0060, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.520, 74.09.500, 42 U.S.C.

1396d(a), C.F.R. 440.100 and 225. 02-01-050, § 388-535A-0060, filed 12/11/01, effective 1/11/02.]

Chapter 388-537 WAC SCHOOL SERVICES

WAC

388-537-0100 School medical services for students in special education programs.

WAC 388-537-0100 School medical services for students in special education programs. (1) The medical assistance administration (MAA) pays school districts or educational service districts (ESD) for qualifying medical services provided to an eligible student. To be covered under this section, the student must be eligible for Title XIX (i.e., either the categorically needy or medically needy programs).

(2) To qualify for payment under this section, the medical services must be provided:

(a) By the school district or the ESD; and

(b) To the eligible special education student as part of the student's individualized education program (IEP) or individualized family service plan (IFSP).

(3) To qualify for payment under this section, the medical services must be provided by one of the following service providers:

(a) A qualified Medicaid provider as described under WAC 388-502-0010;

(b) A psychologist, licensed by the state of Washington or granted an educational staff associate (ESA) certificate by the state board of education;

(c) A school guidance counselor, or a school social worker, who has been granted an ESA certificate by the state board of education; or

(d) A person trained and supervised by any of the following:

(i) A licensed registered nurse;

(ii) A licensed physical therapist or physiatrist;

(iii) A licensed occupational therapist; or

(iv) A speech pathologist or audiologist who:

(A) Has been granted a certificate of clinical competence by the American speech, hearing, and language association;

(B) Is a person who completed the equivalent educational and work experience necessary for such a certificate; or

(C) Is a person who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(4) Student service recommendations and referrals must be updated at least annually.

(5) The student does not need a provider prescription to receive services described under this section.

(6) MAA pays for school-based medical services according to the department-established rate or the billed amount, whichever is lower.

(7) MAA does not pay individual school practitioners who provide school-based medical services.

(8) For medical services billed to Medicaid, school districts or ESD, must pursue third-party resources.

[Statutory Authority: RCW 74.08.090, 01-02-076, § 388-537-0100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.04.050 and 74.08.090, 00-01-088, § 388-537-0100, filed 12/14/99, effective 1/14/00.]

Chapter 388-538 WAC

MANAGED CARE

WAC

388-538-050	Definitions.
388-538-060	Managed care and choice.
388-538-061	Voluntary enrollment into managed care—Washington Medicaid integration partnership (WMIP) or Medicare/Medicaid integration program (MMIP).
388-538-063	Mandatory enrollment in managed care for GAU clients.
388-538-065	Medicaid-eligible basic health (BH) enrollees.
388-538-067	Managed care provided through managed care organizations (MCOs).
388-538-068	Managed care provided through primary care case management (PCCM).
388-538-070	Managed care payment.
388-538-095	Scope of care for managed care enrollees.
388-538-100	Managed care emergency services.
388-538-110	The grievance system for managed care organizations (MCO).
388-538-111	Primary care case management (PCCM) grievances and appeals.
388-538-112	The department of social and health services' (DSHS) hearing process for enrollee appeals of managed care organization (MCO) actions.
388-538-120	Enrollee request for a second medical opinion.
388-538-130	Exemptions and ending enrollment in managed care.
388-538-140	Quality of care.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-538-001	Purpose. [Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-001, filed 8/11/93, effective 9/11/93. Formerly WAC 388-83-010 (part).] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.
388-538-066	Children's health insurance program (CHIP) enrollees. [Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-066, filed 2/1/00, effective 3/3/00.] Repealed by 02-01-075, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396.
388-538-080	Managed care exemptions. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-080, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-080, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 96-24-074, § 388-538-080, filed 12/2/96, effective 1/1/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-080, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-080, filed 8/11/93, effective 9/11/93.] Repealed by 03-18-109, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.08.090, 74.09.522.
388-538-090	Client's choice of primary care provider. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-090, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-090, filed 8/11/93, effective 9/11/93.] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.
388-538-150	Managed care medical audit. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-150, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-150, filed 8/11/93, effective 9/11/93.] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.

tive 9/11/93.] Repealed by 00-04-080, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2.

WAC 388-538-050 Definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions, apply to this chapter. References to managed care in this chapter do not apply to mental health managed care administered under chapter 388-865 WAC.

"Action":

- (1) The denial or limited authorization of a requested service, including the type or level of service;
- (2) The reduction, suspension, or termination of a previously authorized service;
- (3) The denial, in whole or in part, of payment for a service;
- (4) The failure to provide services in a timely manner, as defined by the state; or
- (5) The failure of a managed care organization (MCO) to act within the time frames provided in 42 C.F.R. 438.408(b).

"Ancillary health services"—Health services ordered by a provider, including but not limited to, laboratory services, radiology services, and physical therapy.

"Appeal"—A request by an enrollee or provider with written permission of an enrollee for reconsideration of an action.

"Assign" or "assignment"—The department selects an MCO or primary care case management (PCCM) provider to serve a client who has not selected an MCO or PCCM provider.

"Auto enrollment"—When the department automatically enrolls a client into an MCO in his or her area.

"Basic health" or "BH"—The health care program authorized by chapter 70.47 RCW and administered by the health care authority (HCA).

"Basic health plus"—Refer to WAC 388-538-065.

"Children with special health care needs"—Children under nineteen years of age identified by the department as having special health care needs. This includes:

- (1) Children designated as having special health care needs by the department of health (DOH) and receiving services under the Title V program;
- (2) Children eligible for Supplemental Security Income under Title 16 of the Social Security Act (SSA); and
- (3) Children who are in foster care or who are served under subsidized adoption.

"Client"—For the purpose of this chapter, an individual eligible for any medical program, including managed care programs, but who is not enrolled with an MCO or PCCM provider. In this chapter, "client" refers to a person before he or she is enrolled in managed care, while "enrollee" refers to an individual eligible for any medical program who is enrolled in managed care.

"Department"—The department of social and health services (DSHS).

"Emergency medical condition"—A condition meeting the definition in 42 C.F.R. 438.114(a).

"Emergency services"—Services defined in 42 C.F.R. 438.114(a).

"End enrollment"—An enrollee is currently enrolled in managed care, either with an MCO or with a PCCM provider, and his or her enrollment is discontinued and he or she returns to the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-130. This is also referred to as "disenrollment."

"Enrollee"—An individual eligible for any medical program who is enrolled in managed care through an MCO or PCCM provider that has a contract with the state.

"Enrollees representative"—An individual with a legal right or written authorization from the enrollee to act on behalf of the enrollee in making decisions.

"Enrollees with special health care needs"—Persons having chronic and disabling conditions, including persons with special health care needs that meet all of the following conditions:

- (1) Have a biologic, psychologic, or cognitive basis;
- (2) Have lasted or are virtually certain to last for at least one year; and
- (3) Produce one or more of the following conditions stemming from a disease:
 - (a) Significant limitation in areas of physical, cognitive, or emotional function;
 - (b) Dependency on medical or assistive devices to minimize limitation of function or activities; or
 - (c) In addition, for children, any of the following:
 - (i) Significant limitation in social growth or developmental function;
 - (ii) Need for psychological, educational, medical, or related services over and above the usual for the child's age; or
 - (iii) Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

"Exemption"—Department approval of a client's preenrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-130.

"Grievance"—An expression of dissatisfaction about any matter other than an action, as "action" is defined in this section.

"Grievance system"—The overall system that includes grievances and appeals handled at the MCO level and access to the department's hearing process.

"Health care service" or "service"—A service or item provided for the prevention, cure, or treatment of an illness, injury, disease, or condition.

"Healthy Options program" or "HO program"—The department's prepaid managed care health program for Medicaid-eligible clients and clients enrolled in the state children's health insurance program (SCHIP).

"Managed care"—A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either an MCO or PCCM provider.

"Managed care contract"—The agreement between the department and an MCO to provide prepaid contracted services to enrollees.

"Managed care organization" or "MCO"—An organization having a certificate of authority or certificate of registration from the office of insurance commissioner that con-

tracts with the department under a comprehensive risk contract to provide prepaid health care services to eligible clients under the department's managed care programs.

"Mandatory enrollment"—The department's requirement that a client enroll in managed care.

"Mandatory service area"—A service area in which eligible clients are required to enroll in an MCO.

"Medicare/Medicaid integration program" or "MMIP"—The department's prepaid managed care program that integrates medical and long-term care services for clients who are sixty-five years of age or older and eligible for Medicare only or eligible for Medicare and Medicaid. Clients eligible for Medicaid only are not eligible for this program.

"Nonparticipating provider"—A healthcare provider that does not have a written agreement with an MCO but that provides MCO-contracted health care services to managed care enrollees with the MCO's authorization.

"Participating provider"—A healthcare provider with a written agreement with an MCO to provide health care services to the MCO's managed care enrollees. A participating provider must look solely to the MCO for payment for such services.

"Primary care case management" or "PCCM"—The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services.

"Primary care provider" or "PCP"—A person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.

"Prior authorization" or "PA"—A process by which enrollees or providers must request and receive department approval for services provided through the department's fee-for-service system, or MCO approval for services provided through the MCO, for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization. See WAC 388-501-0165.

"Timely"—In relation to the provision of services, means an enrollee has the right to receive medically necessary health care as expeditiously as the enrollee's health condition requires. In relation to authorization of services and grievances and appeals, means according to the department's managed care program contracts and the time frames stated in this chapter.

"Washington Medicaid integration partnership" or "WMIP"—The managed care program that is designed to integrate medical, mental health, chemical dependency treatment, and long-term care services into a single coordinated health plan for eligible aged, blind, or disabled clients.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-050, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-050, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-109, § 388-538-050, filed 9/2/03, effective 10/1/03.]

tive 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-050, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-050, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-050, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-050, filed 8/11/93, effective 9/11/93.]

WAC 388-538-060 Managed care and choice. (1)

Except as provided in subsection (2) of this section, the department requires a client to enroll in managed care when that client:

- (a) Is eligible for one of the medical programs for which enrollment is mandatory;
- (b) Resides in an area where enrollment is mandatory; and
- (c) Is not exempt from managed care enrollment or the department has not ended the client's managed care enrollment, consistent with WAC 388-538-130, and any related hearing has been held and decided.

(2) American Indian/Alaska Native (AI/AN) clients who meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally recognized tribal members and their descendants may choose one of the following:

(a) Enrollment with a managed care organization (MCO) available in their area;

(b) Enrollment with an Indian or tribal primary care case management (PCCM) provider available in their area; or

(c) The department's fee-for-service system.

(3) A client may enroll with an MCO or PCCM provider by calling the department's toll-free enrollment line or by sending a completed enrollment form to the department's unit responsible for managed care enrollment as listed on the department's enrollment form.

(a) A client must enroll with an MCO or PCCM provider available in the area where the client lives.

(b) All family members must either enroll with the same MCO or enroll with PCCM providers.

(c) Enrollees may request an MCO or PCCM provider change at any time.

(d) When a client requests enrollment with an MCO or PCCM provider, the department enrolls a client effective the earliest possible date given the requirements of the department's enrollment system. The department does not enroll clients retrospectively.

(4) The department assigns a client who does not choose an MCO or PCCM provider as follows:

(a) If the client has family members enrolled with an MCO, the client is enrolled with that MCO;

(b) If the client does not have family members enrolled with an MCO that is currently under contract with the department, and the client was previously enrolled with the MCO or PCCM provider, and the department can identify the previous enrollment, the client is reenrolled with the same MCO or PCCM provider;

(c) If a client does not choose an MCO or a PCCM provider, but indicates a preference for a provider to serve as the client's primary care provider (PCP), the department attempts to contact the client to complete the required choice. If the department is not able to contact the client in a timely man-

ner, the department documents the attempted contacts and, using the best information available, assigns the client as follows. If the client's preferred PCP is:

(i) Available with one MCO, the department assigns the client in the MCO where the client's PCP provider is available. The MCO is responsible for PCP choice and assignment;

(ii) Available only as a tribal PCCM provider and the client meets the criteria of subsection (2) of this section, the department assigns the client to the preferred provider as the client's PCCM provider;

(iii) Available with multiple MCOs or through an MCO and as a PCCM provider, the department assigns the client to an MCO as described in (d) of this subsection;

(iv) Not available through any MCO or as a PCCM provider, the department assigns the client to an MCO or PCCM provider as described in (d) of this subsection.

(d) If the client cannot be assigned according to (a), (b), or (c) of this subsection, the department assigns the client as follows:

(i) If an AI/AN client does not choose an MCO or PCCM provider, the department assigns the client to a tribal PCCM provider if that client lives in a zip code served by a tribal PCCM provider. If there is no tribal PCCM provider in the client's area, the client continues to be served by the department's fee-for-service system. A client assigned under this subsection may request to end enrollment at any time.

(ii) If a non-AI/AN client does not choose an MCO provider, the department assigns the client to an MCO available in the area where the client lives. The MCO is responsible for PCP choice and assignment.

(iii) For clients who are new recipients to medical assistance or who have had a break in eligibility of greater than two months, the department sends a written notice to each household of one or more clients who are assigned to an MCO or PCCM provider. The assigned client has ten calendar days to contact the department to change the MCO or PCCM provider assignment before enrollment is effective. The notice includes the name of the MCO or PCCM provider to which each client has been assigned, the effective date of enrollment, the date by which the client must respond in order to change the assignment, and the toll-free telephone number of either:

(A) The MCO for enrollees assigned to an MCO; or

(B) The department for enrollees assigned to a PCCM provider.

(iv) If the client has a break in eligibility of less than two months, the client will be automatically reenrolled with his or her previous MCO or PCCM provider and no notice will be sent.

(5) An MCO enrollee's selection of the enrollee's PCP or the enrollee's assignment to a PCP occurs as follows:

(a) MCO enrollees may choose:

(i) A PCP or clinic that is in the enrollee's MCO and accepting new enrollees; or

(ii) Different PCPs or clinics participating with the enrollee's MCO for different family members.

(b) The MCO assigns a PCP or clinic that meets the access standards set forth in the relevant managed care contract if the enrollee does not choose a PCP or clinic;

(c) MCO enrollees may change PCPs or clinics in an MCO for any reason, with the change becoming effective no later than the beginning of the month following the enrollee's request; or

(d) In accordance with this subsection, MCO enrollees may file a grievance with the MCO and may change plans if the MCO does not approve an enrollee's request to change PCPs or clinics.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-060, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-060, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-109, § 388-538-060, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-060, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-060, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-060, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-060, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-060, filed 8/11/93, effective 9/11/93.]

WAC 388-538-061 Voluntary enrollment into managed care—Washington Medicaid integration partnership (WMIP) or Medicare/Medicaid integration program (MMIP). (1) The purpose of this section is to describe the managed care requirements for clients eligible for either the Washington Medicaid Integration Partnership (WMIP) or the Medicare/Medicaid Integration Program (MMIP).

(2) Unless otherwise stated in this section, all of the provisions of chapter 388-538 WAC apply to clients enrolled in WMIP and MMIP.

(3) The following sections of chapter 388-538 WAC do not apply to WMIP enrollees or MMIP enrollees:

(a) WAC 388-538-060. However, WAC 388-538-060(5), describing enrollees' ability to choose their PCP, does apply to WMIP enrollees and MMIP enrollees;

(b) WAC 388-538-063;

(c) WAC 388-538-065;

(d) WAC 388-538-068; and

(e) WAC 388-538-130. However, WAC 388-538-130 (3) and (4), describing the process used when the department receives a request from an MCO to remove an enrollee from enrollment in managed care, do apply to WMIP enrollees and MMIP enrollees. Also, WAC 388-538-130(9), describing the MCO's ability to refer enrollees to the department's "Patient Review and Restriction" program, does apply to WMIP enrollees and MMIP enrollees.

(4) The process for enrollment of WMIP and MMIP clients is as follows:

(a) Enrollment in WMIP and MMIP is voluntary, subject to program limitations in subsection (b) and (c) of this section.

(b) For WMIP, the department automatically enrolls clients, with the exception of American Indian/Alaska natives and clients eligible for both Medicare and Medicaid, when they:

(i) Are aged, blind, or disabled;

(ii) Are twenty-one years of age or older; and

(iii) Receive categorically needy medical assistance.

(c) For MMIP, clients may enroll when they:

(i) Are sixty-five years of age or older; and

(ii) Receive Medicare and/or Medicaid.

(d) American Indian/Alaska native (AI/AN) clients and clients who are eligible for Medicare and Medicaid who meet the eligibility criteria in (b) or (c) of this subsection may voluntarily enroll or end enrollment in WMIP or MMIP at any time.

(e) The department will not enroll a client in WMIP or MMIP, or will end an enrollee's enrollment in WMIP or MMIP when the client has, or becomes eligible for, CHAMPUS/TRICARE or any other third-party health care coverage that would require the department to either exempt the client from enrollment in managed care or end the enrollees enrollment in managed care.

(f) A client or enrollee in WMIP or MMIP or the client's or enrollee's representative may end enrollment from the MCO at any time without cause. The client may then reenroll at any time with the MCO. The department ends enrollment for clients prospectively to the first of the month following request to end enrollment, except as provided in subsection (g) of this section.

(g) Clients may request that the department retroactively end enrollment from WMIP and MMIP. On a case-by-case basis, the department may retroactively end enrollment from WMIP and MMIP when, in the department's judgment:

(i) The client or enrollee has a documented and verifiable medical condition; and

(ii) Enrollment in managed care could cause an interruption of on-going treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(5) In addition to the scope of medical care described in WAC 388-538-095, WMIP and MMIP are designed to include the following services:

(a) For WMIP enrollees - mental health, chemical dependency treatment, and long-term care services; and

(b) For MMIP enrollees - long-term care services.

(6) The department sends each client written information about covered services when the client is eligible to enroll in WMIP or MMIP, and any time there is a change in covered services. In addition, the department requires MCOs to provide new enrollees with written information about covered services. This notice informs the client about the right to end enrollment and how to do so.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-061, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-061, filed 12/8/04, effective 1/8/05.]

WAC 388-538-063 Mandatory enrollment in managed care for GAU clients. (1) The purpose of this section is to describe the department's managed care requirement for general assistance unemployable (GAU) clients mandated by the Laws of 2003, chapter 25, section 209(15).

(2) The only sections of chapter 388-538 WAC that apply to GAU clients described in this section are incorporated by reference into this section.

(3) To receive department-paid medical care, GAU clients must enroll in a managed care plan as required by WAC

388-505-0110(7) when they reside in a county designated as a mandatory managed care plan county.

(4) GAU clients are exempt from mandatory enrollment in managed care if they:

- (a) Are American Indian or Alaska Native (AI/AN); and
- (b) Meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally recognized tribal members and their descendants.

(5) In addition to subsection (4), the department will exempt a GAU client from mandatory enrollment in managed care or end an enrollee's enrollment in managed care in accordance with WAC 388-538-130(3) and 388-538-130(4).

(6) On a case-by-case basis, the department may grant a GAU client's request for exemption from managed care or a GAU enrollee's request to end enrollment when, in the department's judgment:

(a) The client or enrollee has a documented and verifiable medical condition; and

(b) Enrollment in managed care could cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(7) The department enrolls GAU clients in managed care effective on the earliest possible date, given the requirements of the enrollment system. The department does not enroll clients in managed care on a retroactive basis.

(8) Managed care organizations (MCOs) that contract with the department to provide services for GAU clients must meet the qualifications and requirements in WAC 388-538-067 and 388-538-095 (3)(a), (b), (c), and (d).

(9) The department pays MCOs capitated premiums for GAU enrollees based on legislative allocations for the GAU program.

(10) GAU enrollees are eligible for the scope of care as described in WAC 388-501-0060 for medical care services (MCS) programs. Other scope of care provisions that apply:

(a) A client is entitled to timely access to medically necessary services as defined in WAC 388-500-0005;

(b) MCOs cover the services included in the managed care contract for GAU enrollees. MCOs may, at their discretion, cover services not required under the MCO's contract for GAU enrollees;

(c) The department pays providers on a fee-for-service basis for the medically necessary, covered medical care services not covered under the MCO's contract for GAU enrollees; and

(d) A GAU enrollee may obtain emergency services in accordance with WAC 388-538-100.

(11) The department does not pay providers on a fee-for-service basis for services covered under the MCO's contract for GAU enrollees, even if the MCO has not paid for the service, regardless of the reason. The MCO is solely responsible for payment of MCO-contracted health care services that are:

- (a) Provided by an MCO-contracted provider; or
- (b) Authorized by the MCO and provided by nonparticipating providers.

(12) The following services are not covered for GAU enrollees unless the MCO chooses to cover these services at no additional cost to the department:

- (a) Services that are not medically necessary;
- (b) Services not included in the medical care services scope of care;

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(c) Services, other than a screening exam as described in WAC 388-538-100(3), received in a hospital emergency department for nonemergency medical conditions; and

(d) Services received from a nonparticipating provider requiring prior authorization from the MCO that were not authorized by the MCO.

(13) A provider may bill a GAU enrollee for noncovered services described in subsection (12), if the requirements of WAC 388-502-0160 and 388-538-095(5) are met.

(14) The grievance and appeal process found in WAC 388-538-110 applies to GAU enrollees described in this section.

(15) The hearing process found in chapter 388-02 WAC and WAC 388-538-112 applies to GAU enrollees described in this section.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-538-063, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-063, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.522, and 2003 1st sp.s. c 25 § 209(15). 04-15-003, § 388-538-063, filed 7/7/04, effective 8/7/04.]

WAC 388-538-065 Medicaid-eligible basic health (BH) enrollees. (1) Certain children and pregnant women who have applied for, or are enrolled in, managed care through basic health (BH) (chapter 70.47 RCW) are eligible for Medicaid under pediatric and maternity expansion provisions of the Social Security Act. The department determines Medicaid eligibility for children and pregnant women who enroll through BH.

(2) Eligible children are enrolled in the basic health plus program and eligible pregnant women are enrolled in the maternity benefits program.

(3) The administrative rules and regulations that apply to managed care enrollees also apply to Medicaid-eligible clients enrolled through BH, except as follows:

(a) The process for enrolling in managed care described in WAC 388-538-060(3) does not apply since enrollment is through the health care authority, the state agency that administers BH;

(b) American Indian/Alaska native (AI/AN) clients cannot choose fee-for-service or PCCM as described in WAC 388-538-060(2). They must enroll in a BH-contracted MCO.

(c) If a Medicaid eligible client applying for BH plus does not choose an MCO prior to the department's eligibility determination, the client is transferred from BH plus to the department for assignment to managed care.

(d) The department does not consider the basic health plus and the maternity benefits programs to be third party.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-065, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-065, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-065, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-065, filed 2/1/00, effective 3/3/00.]

WAC 388-538-067 Managed care provided through managed care organizations (MCOs). (1) Managed care organizations (MCOs) may contract with the department to

provide prepaid health care services to eligible clients. The MCOs must meet the qualifications in this section to be eligible to contract with the department. The MCO must:

(a) Have a certificate of registration from the office of the insurance commissioner (OIC) that allows the MCO to provide the services in subsection (1) of this section;

(b) Accept the terms and conditions of the department's managed care contract;

(c) Be able to meet the network and quality standards established by the department; and

(d) Accept the prepaid rates published by the department.

(2) The department reserves the right not to contract with any otherwise qualified MCO.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-067, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-067, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-112, § 388-538-067, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, RCW 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-067, filed 12/14/01, effective 1/14/02.]

WAC 388-538-068 Managed care provided through primary care case management (PCCM). A provider may contract with the department as a primary care case management (PCCM) provider to coordinate health care services to eligible clients under the department's managed care program. The PCCM provider or the individual providers in a PCCM group or clinic must:

(1) Have a core provider agreement with the department;

(2) Be a recognized urban Indian health center or tribal clinic;

(3) Accept the terms and conditions of the department's PCCM contract;

(4) Be able to meet the quality standards established by the department; and

(5) Accept PCCM rates published by the department.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-068, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-068, filed 12/14/01, effective 1/14/02.]

WAC 388-538-070 Managed care payment. (1) The department pays managed care organizations (MCOs) monthly capitated premiums that:

(a) Have been determined using generally accepted actuarial methods;

(b) Are based on historical analysis of financial cost and/or rate information; and

(c) Are paid based on legislative allocations.

(2) The department pays primary care case management (PCCM) providers a monthly case management fee according to contracted terms and conditions.

(3) The department does not pay providers under the fee-for-service system for services that are the MCO's responsibility, even if the MCO has not paid for the service for any reason. The MCO is solely responsible for payment of MCO-contracted health care services.

(4) The department pays an enhancement rate to federally qualified health care centers (FQHC) and rural health

clinics (RHC) for each client enrolled with MCOs through the FQHC or RHC. The enhancement rate from the department is in addition to the negotiated payments FQHCs and RHCs receive from the MCOs for services provided to MCO enrollees.

(5) The department pays MCOs a delivery case rate, separate from the capitation payment, when an enrollee delivers a child.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-070, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-070, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-109, § 388-538-070, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-070, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-070, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. 96-24-073, § 388-538-070, filed 12/2/96, effective 1/2/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-070, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-070, filed 8/11/93, effective 9/11/93.]

WAC 388-538-095 Scope of care for managed care enrollees. (1) Managed care enrollees are eligible for the scope of medical care as described in WAC 388-501-0060 for categorically needy clients.

(a) A client is entitled to timely access to medically necessary services as defined in WAC 388-500-0005.

(b) The managed care organization (MCO) covers the services included in the MCO contract for MCO enrollees. MCOs may, at their discretion, cover additional services not required under the MCO contract. However, the department may not require the MCO to cover any additional services outside the scope of services negotiated in the MCO's contract with the department.

(c) The department covers medically necessary services described in WAC 388-501-0060 and 388-501-0065 that are excluded from coverage in the MCO contract.

(d) The department covers services through the fee-for-service system for enrollees with a primary care case management (PCCM) provider. Except for emergencies, the PCCM provider must either provide the covered services needed by the enrollee or refer the enrollee to other providers who are contracted with the department for covered services. The PCCM provider is responsible for instructing the enrollee regarding how to obtain the services that are referred by the PCCM provider. The services that require PCCM provider referral are described in the PCCM contract. The department informs enrollees about the enrollee's program coverage, limitations to covered services, and how to obtain covered services.

(e) MCO enrollees may obtain certain services from either an MCO provider or from a department-enrolled provider with a current core provider agreement without needing to obtain a referral from the PCP or MCO. These services are described in the managed care contract, and are communicated to enrollees by the department and MCOs as described in (f) of this subsection.

(f) The department sends each client written information about covered services when the client is required to enroll in managed care, and any time there is a change in covered services. This information describes covered services, which services are covered by the department, and which services are covered by MCOs. In addition, the department requires MCOs to provide new enrollees with written information about covered services.

(2) For services covered by the department through PCCM contracts for managed care:

(a) The department covers medically necessary services included in the categorically needy scope of care and rendered by providers who have a current core provider agreement with the department to provide the requested service;

(b) The department may require the PCCM provider to obtain authorization from the department for coverage of nonemergency services;

(c) The PCCM provider determines which services are medically necessary;

(d) An enrollee may request a hearing for review of PCCM provider or the department coverage decisions (see WAC 388-538-110); and

(e) Services referred by the PCCM provider require an authorization number in order to receive payment from the department.

(3) For services covered by the department through contracts with MCOs:

(a) The department requires the MCO to subcontract with a sufficient number of providers to deliver the scope of contracted services in a timely manner. Except for emergency services, MCOs provide covered services to enrollees through their participating providers;

(b) The department requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;

(c) For nonemergency services, MCOs may require the enrollee to obtain a referral from the primary care provider (PCP), or the provider to obtain authorization from the MCO, according to the requirements of the MCO contract;

(d) MCOs and their providers determine which services are medically necessary given the enrollee's condition, according to the requirements included in the MCO contract;

(e) The department requires the MCO to coordinate benefits with other insurers in a manner that does not reduce benefits to the enrollee or result in costs to the enrollee;

(f) A managed care enrollee does not need a PCP referral to receive women's health care services, as described in RCW 48.42.100 from any women's health care provider participating with the MCO. Any covered services ordered and/or prescribed by the women's health care provider must meet the MCO's service authorization requirements for the specific service.

(g) For enrollees temporarily outside their MCOs service area, the MCO is required to cover enrollees for up to ninety days for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their service area.

(4) Unless the MCO chooses to cover these services, or an appeal, independent review, or a hearing decision reverses an MCO or department denial, the following services are not covered:

(a) For all managed care enrollees:

(i) Services that are not medically necessary;

(ii) Services not included in the categorically needy scope of services; and

(iii) Services, other than a screening exam as described in WAC 388-538-100(3), received in a hospital emergency department for nonemergency medical conditions.

(b) For MCO enrollees:

(i) Services received from a participating specialist that require prior authorization from the MCO, but were not authorized by the MCO; and

(ii) Services received from a nonparticipating provider that require prior authorization from the MCO that were not authorized by the MCO. All nonemergency services covered under the MCO contract and received from nonparticipating providers require prior authorization from the MCO.

(c) For PCCM enrollees, services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider.

(5) A provider may bill an enrollee for noncovered services as described in subsection (4) of this section, if the requirements of WAC 388-502-0160 are met. The provider must give the original agreement to the enrollee and file a copy in the enrollee's record.

(a) The agreement must state all of the following:

(i) The specific service to be provided;

(ii) That the service is not covered by either the department or the MCO;

(iii) An explanation of why the service is not covered by the MCO or the department, such as:

(A) The service is not medically necessary; or

(B) The service is covered only when provided by a participating provider.

(iv) The enrollee chooses to receive and pay for the service; and

(v) Why the enrollee is choosing to pay for the service, such as:

(A) The enrollee understands that the service is available at no cost from a provider participating with the MCO, but the enrollee chooses to pay for the service from a provider not participating with the MCO;

(B) The MCO has not authorized emergency department services for nonemergency medical conditions and the enrollee chooses to pay for the emergency department's services rather than wait to receive services at no cost in a participating provider's office; or

(C) The MCO or PCCM has determined that the service is not medically necessary and the enrollee chooses to pay for the service.

(b) For enrollees with limited English proficiency, the agreement must be translated or interpreted into the enrollee's primary language to be valid and enforceable.

(c) The agreement is void and unenforceable, and the enrollee is under no obligation to pay the provider, if the service is covered by the department or the MCO as described in subsection (1) of this section, even if the provider is not paid for the covered service because the provider did not satisfy the payor's billing requirements.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-538-095, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-095,

filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924), 05-01-066, § 388-538-095, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522, 03-18-109, § 388-538-095, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396, 02-01-075, § 388-538-095, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 01-02-076, § 388-538-095, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2, 00-04-080, § 388-538-095, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-538-095, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18, 95-18-046 (Order 3886), § 388-538-095, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090, 93-17-039 (Order 3621), § 388-538-095, filed 8/11/93, effective 9/11/93.]

WAC 388-538-100 Managed care emergency services. (1) A managed care enrollee may obtain emergency services, for emergency medical conditions from any qualified Medicaid provider. ("Emergency services" and "emergency medical condition" are as defined in this chapter.)

(a) The managed care organization (MCO) covers emergency services for MCO enrollees.

(b) The department covers emergency services for primary care case management (PCCM) enrollees.

(2) Emergency services for emergency medical conditions do not require prior authorization by the MCO, primary care provider (PCP), PCCM provider, or the department.

(3) MCOs must cover all emergency services provided to an enrollee by a provider who is qualified to furnish Medicaid services, without regard to whether the provider is a participating or nonparticipating provider.

(4) An enrollee who requests emergency services is entitled to receive an exam to determine if the enrollee has an emergency medical condition. What constitutes an emergency medical condition may not be limited on the basis of diagnosis or symptoms.

(5) The MCO must cover emergency services provided to an enrollee when:

(a) The enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition; and

(b) The plan provider or other MCO representative instructs the enrollee to seek emergency services.

(6) In any disagreement between a hospital and the MCO about whether the enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails.

[Statutory Authority: RCW 74.08.090 and 74.09.522, 06-03-081, § 388-538-100, filed 1/12/06, effective 2/12/06; 03-18-110, § 388-538-100, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396, 02-01-075, § 388-538-100, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2, 00-04-080, § 388-538-100, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18, 95-18-046 (Order 3886), § 388-538-100, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090, 95-04-033 (Order 3826), § 388-538-100, filed 1/24/95, effective 2/1/95; 93-17-039 (Order 3621), § 388-538-100, filed 8/11/93, effective 9/11/93.]

WAC 388-538-110 The grievance system for managed care organizations (MCO). (1) This section contains information about the grievance system for managed care organization (MCO) enrollees, which includes grievances and appeals. See WAC 388-538-111 for information about the grievance system for PCCM enrollees, which includes grievances and appeals.

(2) An MCO enrollee may voice a grievance or appeal an action by an MCO to the MCO either orally or in writing.

(3) MCOs must maintain records of grievances and appeals and must review the information as part of the MCO's quality strategy.

(4) MCOs must provide information describing the MCO's grievance system to all providers and subcontractors.

(5) Each MCO must have a grievance system in place for enrollees. The system must comply with the requirements of this section and the regulations of the state office of the insurance commissioner (OIC). If a conflict exists between the requirements of this chapter and OIC regulations, the requirements of this chapter take precedence. The MCO grievance system must include all of the following:

(a) A grievance process for complaints about any matter other than an action, as defined in WAC 388-538-050. See subsection (6) of this section for this process;

(b) An appeal process for an action, as defined in WAC 388-538-050. See subsection (7) of this section for the standard appeal process and subsection (8) of this section for the expedited appeal process;

(c) Access to the department's hearing process for actions as defined in WAC 388-538-050. The department's hearing process described in chapter 388-02 WAC applies to this chapter. Where conflicts exist, the requirements in this chapter take precedence. See WAC 388-538-112 for the department's hearing process for MCO enrollees;

(d) Access to an independent review (IR) as described in RCW 48.43.535, for actions as defined in WAC 388-538-050 (see WAC 388-538-112 for additional information about the IR); and

(e) Access to the board of appeals (BOA) for actions as defined in WAC 388-538-050 (also see chapter 388-02 WAC and WAC 388-538-112).

(6) The MCO grievance process:

(a) Only an enrollee may file a grievance with an MCO; a provider may not file a grievance on behalf of an enrollee.

(b) To ensure the rights of MCO enrollees are protected, each MCO's grievance process must be approved by the department.

(c) MCOs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MCO's grievance process, including how to use the department's hearing process. The MCOs must have department approval for all written information the MCO sends to enrollees.

(d) The MCO must give enrollees any assistance necessary in taking procedural steps for grievances (e.g., interpreter services and toll-free numbers).

(e) The MCO must acknowledge receipt of each grievance either orally or in writing, and each appeal in writing, within five working days.

(f) The MCO must ensure that the individuals who make decisions on grievances are individuals who:

(i) Were not involved in any previous level of review or decision making; and

(ii) If deciding any of the following, are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:

(A) A grievance regarding denial of an expedited resolution of an appeal; or

(B) A grievance involving clinical issues.

(g) The MCO must complete the disposition of a grievance and notice to the affected parties within ninety days of receiving the grievance.

(7) The MCO appeal process:

(a) An MCO enrollee, or the enrollee's representative with the enrollee's written consent, may appeal an MCO action.

(b) To ensure the rights of MCO enrollees are protected, each MCO's appeal process must be approved by the department.

(c) MCOs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MCO's appeal process and the department's hearing process. The MCOs must have department approval for all written information the MCO sends to enrollees.

(d) For standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety calendar days of the date on the MCO's notice of action. This also applies to an enrollee's request for an expedited appeal.

(e) For appeals for termination, suspension, or reduction of previously authorized services, if the enrollee is requesting continuation of services, the enrollee must file an appeal within ten calendar days of the date of the MCO mailing the notice of action. Otherwise, the time frames in subsection (7)(d) of this section apply.

(f) The MCO's notice of action must:

(i) Be in writing;

(ii) Be in the enrollee's primary language and be easily understood as required in 42 C.F.R. 438.10 (c) and (d);

(iii) Explain the action the MCO or its contractor has taken or intends to take;

(iv) Explain the reasons for the action;

(v) Explain the enrollee's or the enrollee's representative's right to file an MCO appeal;

(vi) Explain the procedures for exercising the enrollee's rights;

(vii) Explain the circumstances under which expedited resolution is available and how to request it (also see subsection (8) of this section);

(viii) Explain the enrollee's right to have benefits continue pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services (also see subsection (9) of this section); and

(ix) Be mailed as expeditiously as the enrollee's health condition requires, and as follows:

(A) For denial of payment, at the time of any action affecting the claim. This applies only when the client can be held liable for the costs associated with the action.

(B) For standard service authorization decisions that deny or limit services, not to exceed fourteen calendar days following receipt of the request for service, with a possible

extension of up to fourteen additional calendar days if the enrollee or provider requests extension. If the request for extension is granted, the MCO must:

(I) Give the enrollee written notice of the reason for the decision for the extension and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision; and

(II) Issue and carry out the determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(C) For termination, suspension, or reduction of previously authorized services, ten days prior to such termination, suspension, or reduction, except if the criteria stated in 42 C.F.R. 431.213 and 431.214 are met. The notice must be mailed by a method which certifies receipt and assures delivery within three calendar days.

(D) For expedited authorization decisions, in cases where the provider indicates or the MCO determines that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, no later than three calendar days after receipt of the request for service.

(g) The MCO must give enrollees any assistance necessary in taking procedural steps for an appeal (e.g., interpreter services and toll-free numbers).

(h) The MCO must acknowledge receipt of each appeal.

(i) The MCO must ensure that the individuals who make decisions on appeals are individuals who:

(i) Were not involved in any previous level of review or decision making; and

(ii) If deciding any of the following, are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:

(A) An appeal of a denial that is based on lack of medical necessity; or

(B) An appeal that involves clinical issues.

(j) The process for appeals must:

(i) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), and must be confirmed in writing, unless the enrollee or provider requests an expedited resolution. Also see subsection (8) for information on expedited resolutions;

(ii) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO must inform the enrollee of the limited time available for this in the case of expedited resolution;

(iii) Provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process; and

(iv) Include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate.

(k) MCOs must resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following time frames:

(i) For standard resolution of appeals and notice to the affected parties, no longer than forty-five calendar days from

the day the MCO receives the appeal. This time frame may not be extended.

(ii) For expedited resolution of appeals, including notice to the affected parties, no longer than three calendar days after the MCO receives the appeal.

(iii) For appeals for termination, suspension, or reduction of previously authorized services, no longer than forty-five calendar days from the day the MCO receives the appeal.

(l) The notice of the resolution of the appeal must:

(i) Be in writing. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice (also see subsection (8) of this section).

(ii) Include the results of the resolution process and the date it was completed.

(iii) For appeals not resolved wholly in favor of the enrollee:

(A) Include information on the enrollee's right to request a department hearing and how to do so (also see WAC 388-538-112);

(B) Include information on the enrollee's right to receive services while the hearing is pending and how to make the request (also see subsection (9) of this section); and

(C) Inform the enrollee that the enrollee may be held liable for the cost of services received while the hearing is pending, if the hearing decision upholds the MCO's action (also see subsection (10) of this section).

(m) If an MCO enrollee does not agree with the MCO's resolution of the appeal, the enrollee may file a request for a department hearing within the following time frames (see WAC 388-538-112 for the department's hearing process for MCO enrollees):

(i) For hearing requests regarding a standard service, within ninety days of the date of the MCO's notice of the resolution of the appeal.

(ii) For hearing requests regarding termination, suspension, or reduction of a previously authorized service, within ten days of the date on the MCO's notice of the resolution of the appeal.

(n) The MCO enrollee must exhaust all levels of resolution and appeal within the MCO's grievance system prior to requesting a hearing with the department.

(8) The MCO expedited appeal process:

(a) Each MCO must establish and maintain an expedited appeal review process for appeals when the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request), that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) When approving an expedited appeal, the MCO will issue a decision as expeditiously as the enrollee's health condition requires, but not later than three business days after receiving the appeal.

(c) The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(d) If the MCO denies a request for expedited resolution of an appeal, it must:

(i) Transfer the appeal to the time frame for standard resolution; and

(ii) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

(9) Continuation of previously authorized services:

(a) The MCO must continue the enrollee's services if all of the following apply:

(i) The enrollee or the provider files the appeal on or before the later of the following:

(A) Unless the criteria in 42 C.F.R. 431.213 and 431.214 are met, within ten calendar days of the MCO mailing the notice of action, which for actions involving services previously authorized, must be delivered by a method which certifies receipt and assures delivery within three calendar days; or

(B) The intended effective date of the MCO's proposed action.

(ii) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(iii) The services were ordered by an authorized provider;

(iv) The original period covered by the original authorization has not expired; and

(v) The enrollee requests an extension of services.

(b) If, at the enrollee's request, the MCO continues or reinstates the enrollee's services while the appeal is pending, the services must be continued until one of the following occurs:

(i) The enrollee withdraws the appeal;

(ii) Ten calendar days pass after the MCO mails the notice of the resolution of the appeal and the enrollee has not requested a department hearing (with continuation of services until the department hearing decision is reached) within the ten days;

(iii) Ten calendar days pass after the state office of administrative hearings (OAH) issues a hearing decision adverse to the enrollee and the enrollee has not requested an independent review (IR) within the ten days (see WAC 388-538-112);

(iv) Ten calendar days pass after the IR mails a decision adverse to the enrollee and the enrollee has not requested a review with the board of appeals within the ten days (see WAC 388-538-112);

(v) The board of appeals issues a decision adverse to the enrollee (see WAC 388-538-112); or

(vi) The time period or service limits of a previously authorized service has been met.

(c) If the final resolution of the appeal upholds the MCO's action, the MCO may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

(10) Effect of reversed resolutions of appeals:

(a) If the MCO or OAH reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(b) If the MCO or OAH reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-110, filed 1/12/06, effective 2/12/06; 03-18-110, § 388-538-110, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-110, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-110, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. 97-04-004, § 388-538-110, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-110, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 94-04-038 (Order 3701), § 388-538-110, filed 1/26/94, effective 2/26/94; 93-17-039 (Order 3621), § 388-538-110, filed 8/11/93, effective 9/11/93.]

WAC 388-538-111 Primary care case management (PCCM) grievances and appeals. (1) This section contains information about the grievance system for PCCM enrollees, which includes grievances and appeals. See WAC 388-538-110 for information about the grievance system for MCO enrollees.

(2) A PCCM enrollee may voice a grievance or file an appeal, either orally or in writing. PCCM enrollees use the department's grievance and appeal processes.

(3) The grievance process for PCCM enrollees;

(a) A PCCM enrollee may file a grievance with the department. A provider may not file a grievance on behalf of a PCCM enrollee.

(b) The department provides PCCM enrollees with information equivalent to that described in WAC 388-538-110 (7)(c).

(c) When a PCCM enrollee files a grievance with the department, the enrollee is entitled to:

(i) Any reasonable assistance in taking procedural steps for grievances (e.g., interpreter services and toll-free numbers);

(ii) Acknowledgment of the department's receipt of the grievance;

(iii) A review of the grievance. The review must be conducted by a department representative who was not involved in the grievance issue; and

(iv) Disposition of a grievance and notice to the affected parties within ninety days of the department receiving the grievance.

(4) The appeal process for PCCM enrollees:

(a) A PCCM enrollee may file an appeal of a department action with the department. A provider may not file an appeal on behalf of a PCCM enrollee.

(b) The department provides PCCM enrollees with information equivalent to that described in WAC 388-538-110 (8)(c).

(c) The appeal process for PCCM enrollees follows that described in chapter 388-02 WAC. Where a conflict exists, the requirements in this chapter take precedence.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-111, filed 1/12/06, effective 2/12/06; 03-18-110, § 388-538-111, filed 9/2/03, effective 10/3/03.]

WAC 388-538-112 The department of social and health services' (DSHS) hearing process for enrollee appeals of managed care organization (MCO) actions. (1) The hearing process described in chapter 388-02 WAC applies to the hearing process described in this chapter.

(2007 Ed.)

Where a conflict exists, the requirements in this chapter take precedence.

(2) An MCO enrollee must exhaust all levels of resolution and appeal within the MCO's grievance system prior to requesting a hearing with the department. See WAC 388-538-110 for the MCO grievance system.

(3) If an MCO enrollee does not agree with the MCO's resolution of the enrollee's appeal, the enrollee may file a request for a department hearing within the following time frames:

(a) For hearing requests regarding a standard service, within ninety calendar days of the date of the MCO's notice of the resolution of the appeal.

(b) For hearing requests regarding termination, suspension, or reduction of a previously authorized service, and the enrollee is requesting continuation of services, within ten calendar days of the date on the MCO's notice of the resolution of the appeal.

(4) The entire appeal and hearing process, including the MCO appeal process, must be completed within ninety calendar days of the date the MCO enrollee filed the appeal with the MCO, not including the number of days the enrollee took to subsequently file for a department hearing.

(5) Expedited hearing process:

(a) The office of administrative hearings (OAH) must establish and maintain an expedited hearing process when the enrollee or the enrollee's representative requests an expedited hearing and OAH indicates that the time taken for a standard resolution of the claim could seriously jeopardize the enrollee's life or health and ability to attain, maintain, or regain maximum function.

(b) When approving an expedited hearing, OAH must issue a hearing decision as expeditiously as the enrollee's health condition requires, but not later than three business days after receiving the case file and information from the MCO regarding the action and MCO appeal.

(c) When denying an expedited hearing, OAH gives prompt oral notice to the enrollee followed by written notice within two calendar days of request and transfer the hearing to the time frame for a standard service.

(6) Parties to the hearing include the department, the MCO, the enrollee, and the enrollee's representative or the representative of a deceased enrollee's estate.

(7) If an enrollee disagrees with the hearing decision, then the enrollee may request an independent review (IR) in accordance with RCW 48.43.535.

(8) If there is disagreement with the IR decision, any party may request a review by the department's board of appeals (BOA) within twenty-one days of the IR decision. The department's BOA issues the final administrative decision.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-112, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-112, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522, and 74.09.450. 04-13-002, § 388-538-112, filed 6/2/04, effective 7/3/04. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-110, § 388-538-112, filed 9/2/03, effective 10/3/03.]

WAC 388-538-120 Enrollee request for a second medical opinion. (1) A managed care enrollee has the right to a timely referral for a second opinion upon request when:

(a) The enrollee needs more information about treatment recommended by the provider or managed care organization (MCO); or

(b) The enrollee believes the MCO is not authorizing medically necessary care.

(2) A managed care enrollee has a right to a second opinion from a participating provider. At the MCO's discretion, a clinically appropriate nonparticipating provider who is agreed upon by the MCO and the enrollee may provide the second opinion.

(3) Primary care case management (PCCM) enrollees have a right to a timely referral for a second opinion by another provider who has a core provider agreement with the department.

[Statutory Authority: RCW 74.08.090 and 74.09.522, 06-03-081, § 388-538-120, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924), 05-01-066, § 388-538-120, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-120, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-120, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-120, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-120, filed 8/11/93, effective 9/11/93.]

WAC 388-538-130 Exemptions and ending enrollment in managed care. (1) The department exempts a client from mandatory enrollment in managed care or ends an enrollee's enrollment in managed care (also referred to as disenrollment) as specified in this section.

(2) A client or enrollee, or the client's or enrollee's representative as defined in RCW 7.70.065, may request the department to exempt or end enrollment in managed care as described in this section.

(a) If a client requests exemption prior to the enrollment effective date, the client is not enrolled until the department approves or denies the request.

(b) If an enrollee requests to end enrollment, the enrollee remains enrolled pending the department's final decision, unless staying in managed care would adversely affect the enrollee's health status.

(c) The client or enrollee receives timely notice by telephone or in writing when the department approves or denies the client's or enrollee's request. The department follows a telephone denial by written notification. The written notice contains all of the following:

- (i) The action the department intends to take;
- (ii) The reason(s) for the intended action;
- (iii) The specific rule or regulation supporting the action;
- (iv) The client's or enrollee's right to request a hearing;

and

(v) A translation into the client's or enrollee's primary language when the client or enrollee has limited English proficiency.

(3) A managed care organization (MCO) or primary care case management (PCCM) provider may request the depart-

ment to end enrollment. The request must be in writing and be sufficient to satisfy the department that the enrollee's behavior is inconsistent with the MCO's or PCCM provider's rules and regulations (e.g., intentional misconduct). The department does not approve a request to remove an enrollee from managed care when the request is solely due to an adverse change in the enrollee's health or the cost of meeting the enrollee's health care needs. The MCO or PCCM provider's request must include documentation that:

(a) The provider furnished clinically appropriate evaluation(s) to determine whether there is a treatable problem contributing to the enrollee's behavior;

(b) Such evaluation either finds no treatable condition to be contributing, or after evaluation and treatment, the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee; and

(c) The enrollee received written notice of the provider's intent to request the enrollee's removal, unless the department has waived the requirement for provider notice because the enrollee's conduct presents the threat of imminent harm to others. The provider's notice must include:

(i) The enrollee's right to use the provider's grievance system as described in WAC 388-538-110 and 388-538-111; and

(ii) The enrollee's right to use the department's hearing process, after the enrollee has exhausted all grievance and appeals available through the provider's grievance system (see WAC 388-538-110 and 388-538-111 for provider grievance systems, and WAC 388-538-112 for the hearing process for enrollees).

(4) When the department receives a request from an MCO or PCCM provider to remove an enrollee from enrollment in managed care, the department attempts to contact the enrollee for the enrollee's perspective. If the department approves the request, the department sends a notice at least ten days in advance of the effective date that enrollment will end. The notice includes:

(a) The reason the department approved ending enrollment; and

(b) Information about the enrollee's hearing rights.

(5) The department will exempt a client from mandatory enrollment or end an enrollee's enrollment in managed care when any of the following apply:

(a) The client or enrollee is receiving foster care placement services from the division of children and family services (DCFS);

(b) The client has or the enrollee becomes eligible for Medicare, basic health (BH), CHAMPUS/TRICARE, or any other third-party health care coverage comparable to the department's managed care coverage that would require exemption or involuntarily ending enrollment from:

(i) An MCO, in accordance with the department's managed care contract; or

(ii) A primary care case management (PCCM) provider, according to the department's PCCM contract.

(c) The enrollee is no longer eligible for managed care.

(6) The department will grant a client's request for exemption or an enrollee's request to end enrollment when:

(a) The client or enrollee is American Indian/Alaska native (AI/AN) as specified in WAC 388-538-060(2);

(b) The client or enrollee has been identified by the department as a child who meets the definition of "children with special health care needs";

(c) The client or enrollee is homeless or is expected to live in temporary housing for less than one hundred twenty days from the date of the request; or

(d) The client or enrollee speaks limited English or is hearing impaired and the client or enrollee can communicate with a provider who communicates in the client's or enrollee's language or in American sign language and is not available through the MCO and the MCO does not have a provider available who can communicate in the client's language and an interpreter is not available.

(7) On a case-by-case basis, the department may grant a client's request for exemption or an enrollee's request to end enrollment when, in the department's judgment, the client or enrollee has a documented and verifiable medical condition, and enrollment in managed care could cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(8) Upon request, the department may exempt the client or end enrollment for the period of time the circumstances or conditions that lead to exemption or ending enrollment are expected to exist. The department may periodically review those circumstances or conditions to determine if they continue to exist. If the department approves the request for a limited time, the client or enrollee is notified in writing or by telephone of the time limitation, the process for renewing the exemption or the ending of enrollment.

(9) An MCO may refer enrollees to the department's patients requiring regulation (PRR) program according to WAC 388-501-0135.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-130, filed 1/12/06, effective 2/12/06; 03-18-111, § 388-538-130, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-130, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-130, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-130, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-130, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-130, filed 8/11/93, effective 9/11/93.]

WAC 388-538-140 Quality of care. (1) To assure that managed care enrollees receive quality health care services, the department requires managed care organizations (MCOs) to comply with quality improvement standards detailed in the department's managed care contract. MCO's must:

(a) Have a clearly defined quality organizational structure and operation, including a fully operational quality assessment, measurement, and improvement program;

(b) Have effective means to detect over and under utilization of services;

(c) Maintain a system for provider and practitioner credentialing and recredentialing;

(d) Ensure that MCO subcontracts and the delegation of MCO responsibilities are in accordance with the department standards and regulations;

(e) Ensure MCO oversight of delegated entities responsible for any delegated activity to include:

(i) A delegation agreement with each entity describing the responsibilities of the MCO and the entity;

(ii) Evaluation of the entity prior to delegation;

(iii) An annual evaluation of the entity; and

(iv) Evaluation or regular reports and follow-up on issues out of compliance with the delegation agreement or the department's managed care contract specifications.

(f) Cooperate with a department-contracted, qualified independent external review organization (EQRO) conducting review activities as described in 42 C.F.R. 438.358;

(g) Have an effective mechanism to assess the quality and appropriateness of care furnished to enrollees with special health care needs;

(h) Assess and develop individualized treatment plans for enrollees with special health care needs which ensure integration of clinical and nonclinical disciplines and services in the overall plan of care;

(i) Submit annual reports to the department on performance measures as specified by the department;

(j) Maintain a health information system that:

(i) Collects, analyzes, integrates, and reports data as requested by the department;

(ii) Provides information on utilization, grievances and appeals, enrollees ending enrollment for reasons other than the loss of Medicaid eligibility, and other areas as defined by the department;

(iii) Collects data on enrollees, providers, and services provided to enrollees through an encounter data system, in a standardized format as specified by the department; and

(iv) Ensures data received from providers is adequate and complete by verifying the accuracy and timeliness of reported data and screening the data for completeness, logic, and consistency.

(k) Conduct performance improvement projects designed to achieve significant improvement, sustained over time, in clinical care outcomes and services, and that involve the following:

(i) Measuring performance using objective quality indicators;

(ii) Implementing system changes to achieve improvement in service quality;

(iii) Evaluating the effectiveness of system changes;

(iv) Planning and initiating activities for increasing or sustaining performance improvement;

(v) Reporting each project status and the results as requested by the department; and

(vi) Completing each performance improvement project timely so as to generally allow aggregate information to produce new quality of care information every year.

(l) Ensure enrollee access to health care services;

(m) Ensure continuity and coordination of enrollee care; and

(n) Maintain and monitor availability of health care services for enrollees.

(2) The department may:

(i) Impose intermediate sanctions in accordance with 42 C.F.R. 438.700 and corrective action for substandard rates of clinical performance measures and for deficiencies found in audits and on-site visits;

- (ii) Require corrective action for findings for noncompliance with any contractual state or federal requirements; and
- (iii) Impose sanctions for noncompliance with any contractual, state, or federal requirements not corrected.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-140, filed 1/12/06, effective 2/12/06; 03-18-111, § 388-538-140, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-140, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. 00-04-080, § 388-538-140, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-140, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-140, filed 8/11/93, effective 9/11/93.]

Chapter 388-539 WAC HIV/AIDS RELATED SERVICES

WAC

388-539-0200	AIDS—Health insurance premium payment program.
388-539-0300	Case management for persons living with HIV/AIDS.
388-539-0350	HIV/AIDS case management reimbursement information.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-539-001	Purpose. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-001, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.
388-539-050	Definitions. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-050, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.
388-539-0500	Coordinated community aids service alternatives (CCASA) program services. [00-11-183, recodified as § 388-539-0500, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.08.090. 90-21-124 (Order 3088), § 388-86-018, filed 10/23/90, effective 11/23/90.] Repealed by 01-23-045, filed 11/15/01, effective 12/16/01. Statutory Authority: RCW 74.08.090.
388-539-0550	Payment—Coordinated community aids service alternatives (CCSA) program. [Statutory Authority: RCW 74.08.090. 01-02-075, § 388-539-0550, filed 12/29/00, effective 1/29/01. 00-11-183, recodified as § 388-539-0550, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.08.090. 90-21-124 (Order 3088), § 388-87-048, filed 10/23/90, effective 11/23/90.] Repealed by 01-23-045, filed 11/15/01, effective 12/16/01. Statutory Authority: RCW 74.08.090.
388-539-100	Eligibility. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-100, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.
388-539-150	Premium payment. [Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-150, filed 8/11/93, effective 9/11/93.] Repealed by 00-14-070, filed 7/5/00, effective 8/5/00. Statutory Authority: RCW 74.08.090, 74.09.757.

WAC 388-539-0200 AIDS—Health insurance premium payment program. (1) The purpose of the AIDS health insurance premium payment program is to help individuals who are not eligible for MAA's medical programs and who are diagnosed with AIDS, pay their health insurance premiums.

(2) To be eligible for the AIDS health insurance premium payment program, individuals must:

(a) Be diagnosed with AIDS as defined in WAC 246-100-011;

(b) Be a resident of the state of Washington;

(c) Be responsible for all, or part of, the health insurance premium payment (without MAA's help);

(d) Not be eligible for one of MAA's other medical programs;

(e) Not have personal income that exceeds three hundred seventy percent of the federal poverty level; and

(f) Not have personal assets, after exemptions, exceeding fifteen thousand dollars. The following personal assets are exempt from the personal assets calculation:

(i) A home used as the person's primary residence; and

(ii) A vehicle used as personal transportation.

(3) MAA may contract with a not-for-profit community agency to administer the Aids health insurance premium payment program. MAA or its contractor determines an individual's initial eligibility and redetermines eligibility on a periodic basis. To be eligible, individuals must:

(a) Cooperate with MAA's contractor;

(b) Cooperate with eligibility determination and redetermination process; and

(c) Initially meet and continue to meet the eligibility criteria in subsection (2) of this section.

(4) Individuals, diagnosed with AIDS, who are eligible for one of MAA's medical programs may ask MAA to pay their health insurance premiums under a separate process. The client's community services office (CSO) is able to assist the client with this process.

(5) Once an individual is eligible to participate in the AIDS health insurance premium payment program, eligibility would cease only when one of the following occurs. The individual:

(a) Is deceased;

(b) Voluntarily quits the program;

(c) No longer meets the requirements of subsection (2) of this section; or

(d) Has benefits terminated due to the legislature's termination of the funding for this program.

(6) MAA sets a reasonable payment limit for health insurance premiums. MAA sets its limit by tracking the charges billed to MAA for MAA clients who have AIDS. MAA does not pay health insurance premiums that exceed fifty percent of the average of charges billed to MAA for its clients with AIDS.

[Statutory Authority: RCW 74.08.090, 74.09.757. 00-14-070, § 388-539-0200, filed 7/5/00, effective 8/5/00.]

WAC 388-539-0300 Case management for persons living with HIV/AIDS. MAA provides HIV/AIDS case management to assist persons infected with HIV to: Live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

(1) To be eligible for MAA reimbursed HIV/AIDS case management services, the person must:

(a) Have a current medical diagnosis of HIV or AIDS;

(b) Be eligible for Title XIX (Medicaid) coverage under either the categorically needy program (CNP) or the medically needy program (MNP); and

(c) Require:

(i) Assistance to obtain and effectively use necessary medical, social, and educational services; or

(ii) Ninety days of continued monitoring as provided in WAC 388-539-0350(2).

(2) MAA has an interagency agreement with the Washington state department of health (DOH) to administer the HIV/AIDS case management program for MAA's Title XIX (Medicaid) clients.

(3) HIV/AIDS case management agencies who serve MAA's clients must be approved to perform these services by HIV client services, DOH.

(4) HIV/AIDS case management providers must:

(a) Notify HIV positive persons of their statewide choice of available HIV/AIDS case management providers and document that notification in the client's record. This notification requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services.

(b) Have a current client-signed authorization to release/obtain information form. The provider must have a valid authorization on file for the months that case management services are billed to MAA (see RCW 70.02.030). The fee referenced in RCW 70.02.030 is included in MAA's reimbursement to providers. MAA's clients may not be charged for services or documents related to covered services.

(c) Maintain sufficient contact to ensure the effectiveness of ongoing services per subsection (5) of this section. MAA requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the individual service plan (ISP).

(5) HIV/AIDS case management providers must document services as follows:

(a) Providers must initiate a comprehensive assessment within two working days of the client's referral to HIV/AIDS case management services. Providers must complete the assessment before billing for ongoing case management services. If the assessment does not meet these requirements, the provider must document the reason(s) for failure to do so. The assessment must include the following elements as reported by the client:

(i) Demographic information (e.g., age, gender, education, family composition, housing);

(ii) Physical status, the identity of the client's primary care provider, and current information on the client's medications/treatments;

(iii) HIV diagnosis (both the documented diagnosis at the time of assessment and historical diagnosis information);

(iv) Psychological/social/cognitive functioning and mental health history;

(v) Ability to perform daily activities;

(vi) Financial and employment status;

(vii) Medical benefits and insurance coverage;

(viii) Informal support systems (e.g., family, friends and spiritual support);

(ix) Legal status, durable power of attorney, and any self-reported criminal history; and

(x) Self-reported behaviors which could lead to HIV transmission or re-infection (e.g., drug/alcohol use).

(b) Providers must develop, monitor, and revise the client's individual service plan (ISP). The ISP identifies and

documents the client's unmet needs and the resources needed to assist in meeting the client's needs. The case manager and the client must develop the ISP within two days of the comprehensive assessment or the provider must document the reason this is not possible. An ISP must be:

(i) Signed by the client, documenting that the client is voluntarily requesting and receiving MAA reimbursed HIV/AIDS case management services; and

(ii) Reviewed monthly by the case manager through in-person or telephone contact with the client. Both the review and any changes must be noted by the case manager:

(A) In the case record narrative; or

(B) By entering notations in, initialing and dating the ISP.

(c) Maintained ongoing narrative records - These records must document case management services provided in each month for which the provider bills MAA. Records must:

(i) Be entered in chronological order and signed by the case manager;

(ii) Document the reason for the case manager's interaction with the client; and

(iii) Describe the plans in place or to be developed to meet unmet client needs.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). 00-23-070, § 388-539-0300, filed 11/16/00, effective 12/17/00.]

WAC 388-539-0350 HIV/AIDS case management reimbursement information. (1) MAA reimburses HIV/AIDS case management providers for the following three services:

(a) Comprehensive assessment - The assessment must cover the areas outlined in WAC 388-539-0300 (1) and (5).

(i) MAA reimburses only one comprehensive assessment unless the client's situation changes as follows:

(A) There is a fifty percent change in need from the initial assessment; or

(B) The client transfers to a new case management provider.

(ii) MAA reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is Medicaid eligible and the ongoing case management has been provided.

(b) HIV/AIDS case management, full-month - Providers may request the full-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an individual service plan (ISP) in place for twenty or more days in that month. MAA reimburses only one full-month case management fee per client in any one month.

(c) HIV/AIDS case management, partial-month - Providers may request the partial-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an ISP in place for fewer than twenty days in that month. Using the partial-month reimbursement, MAA may reimburse two different case management providers for services to a client who changes from one provider to a new provider during that month.

(2) MAA limits reimbursement to HIV/AIDS case managers when a client becomes stabilized and no longer needs

an ISP with active service elements. MAA limits reimbursement for monitoring to ninety days past the time the last active service element of the ISP is completed. Case Management providers who are monitoring a stabilized client must meet all of the following criteria in order to bill MAA for up to ninety days of monitoring:

- (a) Document the client's history of recurring need;
- (b) Assess the client for possible future instability; and
- (c) Provide monthly monitoring contacts.

(3) MAA reinstates reimbursement for ongoing case management if a client shifts from monitoring status to active case management status due to documented need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

[Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g), 00-23-070, § 388-539-0350, filed 11/16/00, effective 12/17/00.]

Chapter 388-540 WAC

KIDNEY DISEASE PROGRAM AND KIDNEY CENTER SERVICES

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-540-010	Services. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-010, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-010, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.
388-540-020	Reimbursement. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-020, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-020, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.
388-540-030	KDP eligibility requirements. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-030, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-030, filed 2/24/98, effective 3/27/98.

Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-030, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

388-540-040 Transfer of resources without adequate consideration. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-040, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-040, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

388-540-050 Fiscal information. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-050, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-050, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

388-540-060 KDP eligibility determination. [Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-060, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-060, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-060, filed 7/28/93, effective 8/28/93.] Repealed by 03-21-039, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101.

KIDNEY DISEASE PROGRAM (STATE FUNDED)

WAC 388-540-001 Purpose. This section (WAC 388-540-001 through 388-540-065) contains rules for the state-funded kidney disease program (KDP). The kidney disease program is designed to help clients who have end-stage renal disease, but who do not meet the eligibility standards for Medicaid.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-001, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-001, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-001, filed 7/28/93, effective 8/28/93.]

WAC 388-540-005 Definitions. The following definitions and those found in WAC 388-500-0005, apply to this chapter for the purpose of administering the kidney disease program.

"Adequate consideration" means that the reasonable value of goods or services received in exchange for transferred property approximates the reasonable value of the property transferred;

"Affiliate" means a facility, hospital, unit, business, or person having an agreement with a **kidney center** to provide specified services to **ESRD** patients;

"Application for eligibility" means the form provided by MAA, which the client completes and submits to the contracted kidney center to determine KDP eligibility;

"Application documentation" means either a "Medicaid medical determination" letter from the DSHS community services office, or a KDP "client recertification waiver" form.

"Assets" means income, resources, or any real or personal property that a person or the person's spouse owns and could convert to cash to be used for support or maintenance;

"Certification" means the **kidney center** has determined a client eligible for the KDP for a defined period of time;

"End-stage renal disease (ESRD)" means that stage of renal impairment which is irreversible and permanent, and requires dialysis or kidney transplant to ameliorate uremic symptoms and maintain life;

"KDP application period" means the time between the date the client signed the completed application for eligibility and the date the client is certified for participation in the program;

"KDP client" means a resident of the state who has a diagnosis of ESRD and meets the financial and medical eligibility criteria as determined by a KDP contractor;

"KDP client recertification waiver for Medicaid review" means a KDP eligibility form that may in some circumstances be used in place of a "Medicaid medical assistance determination letter."

"KDP contract manual" means a set of policies and procedures for contracted kidney centers;

"KDP contractor" means a kidney center or other ESRD facility that has contracted with the Washington state department of social and health services (DSHS), kidney disease program to provide ESRD-related services to KDP clients.

"Kidney center" means a facility as defined and certified by the federal government to:

- (1) Provide **ESRD** services;
- (2) Promote and encourage home dialysis for a client when medically indicated; and
- (3) For the purposes of WAC 388-540-032 through 388-540-060, it is a facility that has entered into a contract with Washington state department of social and health services (DSHS), kidney disease program to provide ESRD-related services.

"Kidney disease program (KDP)" means a state-funded program that provides financial assistance to eligible clients with the costs of ESRD-related medical care;

"Medicaid medical assistance determination letter" means a medical assistance client eligibility letter from the DSHS community services office.

"Resident" means a person who lives in Washington state on more than a temporary basis.

"Substantial financial change" means the increase or decrease of income or assets that may affect eligibility.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-005, filed 10/8/03, effective 11/8/03. Statutory Authority: RCW 74.04.050 and 74.08.090. 00-01-088, § 388-540-005, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025. 98-06-025, § 388-540-005, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-005, filed 7/28/93, effective 8/28/93.]

WAC 388-540-015 Client eligibility for kidney disease program (KDP). Clients must meet the following criteria to be considered KDP eligible:

- (1) Be a Washington state resident;
- (2) Be diagnosed with end-stage renal disease (ESRD);
- (3) Be determined ineligible for Medicaid;
- (4) Exhaust or be ineligible for all other resources providing similar benefits;
- (5) Have countable income which is equal to or less than:

(a) Two hundred percent of the federal poverty level (FPL) or;

(b) Three hundred percent of the FPL with an annual deductible required equal to the income amount which is in excess of two hundred percent of the FPL.

(6) Have countable resources that are either equal to or less than fifteen thousand dollars, or are exempt. Exempt resources are:

(a) A home, defined as real property owned by a client as principal place of residence together with surrounding and contiguous property, not to exceed five acres;

(b) Household furnishings; and

(c) An automobile.

(7) The effective date of eligibility is the first day of the month the application for eligibility is signed by the client.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-015, filed 10/8/03, effective 11/8/03.]

WAC 388-540-025 Kidney disease program (KDP) eligibility determination. The kidney center and client must comply with the following rules to determine KDP eligibility:

(1) The KDP contractor must:

(a) Inform the client of the requirements for KDP eligibility as defined in this chapter and provide the client with necessary department forms and instructions;

(b) Determine client eligibility using department policies, rules, and instructions; and

(c) Forward the completed application for eligibility, and the application documentation to the KDP program manager at the medical assistance administration (MAA). (The KDP program manager may amend or terminate a client's certification period within thirty days of receipt if the application is incomplete or inaccurate.)

(2) A person applying for KDP must:

(a) Complete the application for eligibility and submit any necessary documentation to the kidney center;

(b) Apply for Medicaid, obtain a written Medicaid medical assistance determination letter, submit a copy to the kidney center; and

(c) Apply for Medicare.

(3) A client reapplying for continued eligibility must:

(a) Complete the KDP application for eligibility and submit any documentation necessary to determine eligibility to the kidney center;

(b) Apply for Medicaid forty-five days before the end of the KDP certification period, obtain a written Medicaid eligibility determination, and submit a copy to the kidney center; or

(c) Have applied for Medicaid within the previous five years and continue to be ineligible.

(4) The KDP application period is:

(a) One hundred and twenty days for a new client; and

(b) Forty-five days prior to the end of a certification period for a client requesting recertification.

(5) The KDP contractor may request an extension of application time limits from MAA when extenuating circumstances prevent the client from completing the application or recertification process within the specified time limits.

(6) The KDP contractor certifies the client for no more than one year from the first day of the month of application, unless the client:

- (a) Needs medical coverage for less than one year; or
- (b) Has a substantial financial change, in which case the client must complete a new application for eligibility.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-025, filed 10/8/03, effective 11/8/03.]

WAC 388-540-035 Kidney disease program (KDP)—Transfer of resources without adequate consideration. A person may be ineligible for the KDP if the person knowingly and willfully assigns or transfers nonexempt resources at less than fair market value within two years preceding the date of application, for the purpose of qualifying or continuing to qualify for the program.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-035, filed 10/8/03, effective 11/8/03.]

WAC 388-540-045 Kidney disease program (KDP) provider requirements. (1) The KDP contractor must:

- (a) Be a Medicare-certified end-stage renal disease (ESRD) facility; and
- (b) Have a valid KDP client services contract with the department.

(2) The KDP contractor must provide, directly or through an affiliate:

- (a) Professional consultation, personal instructions, medical treatment and care, drug products and all supplies necessary for carrying out a medically-sound end-stage renal disease (ESRD) treatment program;
- (b) Dialysis for clients with ESRD when medically indicated;

- (c) Kidney transplant treatment, either directly or by referral, when medically indicated;
- (d) Treatment for conditions directly related to ESRD such as anemia or venous access infections; and

- (e) Supplies and equipment for home dialysis.

(3) The provider must maintain adequate records for audit and review purposes, including:

- (a) Medical charts and records that meet the requirements of WAC 388-502-0020; and
- (b) Eligibility determination records.

(4) The contractor must meet other obligations as required by their contract with the KDP program.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-045, filed 10/8/03, effective 11/8/03.]

WAC 388-540-055 Kidney disease program (KDP) covered services. The KDP program covers the cost of health care services essential to the treatment of end stage renal disease (ESRD) and its complications. Covered services include:

(1) Mandatory services that must be provided by the KDP contractor:

- (a) Dialysis:

- (i) Center dialysis—Covers the cost of dialysis and related services provided in a kidney center;

- (ii) Home dialysis—Covers the cost of providing dialysis and related services in the home; and

- (iii) Dialysis while hospitalized—Covers the cost of dialysis and related services while the client is confined to an acute care facility and is unable to dialyze at his/her regular site.

(b) Medication—As defined in the approved drug list in the KDP manual.

(2) Optional services that may be provided by the KDP contractor:

- (a) Venous access surgery—Covers costs associated with surgically preparing the client for dialysis and medical complications related to the venous access site;

- (b) Laboratory tests and X rays considered to be part of the overall treatment plan for ESRD;

- (c) Post-transplant visit to assess client's ESRD status; and

- (d) Health insurance premiums including copays and deductibles, when found to be cost-effective.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-055, filed 10/8/03, effective 11/8/03.]

WAC 388-540-065 Kidney disease program (KDP)—Reimbursement. (1) The medical assistance administration (MAA) reimburses KDP contractors:

- (a) Within the limits of legislative funding for the program;

- (b) According to the terms of each kidney center's contract with the department; and

- (c) According to the provisions of the KDP contract manual.

(2) The KDP contractor must submit the following documentation to MAA:

- (a) A description of the services for which reimbursement is requested; and

- (b) Statement of client's financial eligibility for the KDP.

(3) MAA limits KDP reimbursement for out-of-state services to fourteen days per calendar year. Reimbursement is paid only to KDP contractors. Out-of-state dialysis providers must operate under sub-contract or agreement with an in-state KDP contractor in order to receive reimbursement under this program.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-065, filed 10/8/03, effective 11/8/03.]

KIDNEY CENTER SERVICES

WAC 388-540-101 Purpose and scope. This section describes the medical assistance administration (MAA) reimbursement rules for free-standing kidney centers providing dialysis and end-stage renal disease services to MAA clients.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-101, filed 10/8/03, effective 11/8/03.]

WAC 388-540-105 Definitions. The following definitions and those found in WAC 388-500-0005, apply to this chapter.

"Acute dialysis" means dialysis given to patients who are not ESRD patients, but who require dialysis of temporary kidney failure due to a sudden trauma (e.g., traffic accident or ingestion of certain drugs, etc.).

"Affiliate" means a facility, hospital, unit, business, or person having an agreement with a kidney center to provide specified services to ESRD patients.

"Agreement" means a written document executed between an ESRD facility and another facility in which the other facility agrees to assume responsibility for furnishing specified services to patients and for obtaining reimbursement for those services.

"Back-up dialysis" means dialysis given to a patient under special circumstances, in a situation other than the patient's usual dialysis environment. Examples are:

(1) Dialysis of a home dialysis patient in a dialysis facility when patient's equipment fails;

(2) Inhospital dialysis when the patient's illness requires more comprehensive care on an inpatient basis;

(3) Pre- and post-operative dialysis provided to transplant patients.

"Composite rate" means a payment method in which all standard equipment, supplies, and services are calculated into a blended rate. All in-facility dialysis and all home dialysis treatments are billed under the composite rate system.

"Continuous ambulatory peritoneal dialysis (CAPD)" means a type of dialysis where the patient's peritoneal membrane is used as the dialyzer. The patient dialyzes at home, using special supplies, but without the need for a machine. (See "Peritoneal dialysis.")

"Continuous cycling peritoneal dialysis (CCPD)" means a type of peritoneal dialysis where the patient dialyzes at home and utilizes an automated peritonealycler for delivering dialysis.

"Dialysate" means an electrolyte solution, containing elements such as potassium, sodium chloride, etc., surrounding the membrane or fibers and allowing exchange of substances with the patient's blood in the dialyzer.

"Dialysis" means a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane.

"Dialysis session" means the period of time beginning when the patient arrives at the facility and ending when the patient departs from the facility. In the case of home dialysis, the time period beginning when the patient prepares for dialysis and ending when the patient is disconnected from the machine.

"Dialyzer" means the synthetic porous membrane or fibers, contained in a supporting structure, through which blood flows for the purpose of eliminating harmful substances, and replacing them with useful ones.

"Drug-related supplies" means nonpharmaceutical items necessary for administration or delivery of a drug.

"Durable medical equipment (DME)" means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of illness or injury; and

(2007 Ed.)

(4) Is appropriate for use in the client's place of residence.

"End-stage renal disease (ESRD)" means the stage of renal impairment that is irreversible and permanent, and requires dialysis or kidney transplant to ameliorate uremic symptoms and maintain life.

"Epoetin alpha (EPO)" means the biologically engineered protein that stimulates the bone marrow to make new red blood cells. It is used in the treatment of anemia.

"Free-standing kidney center" means a limited care facility, not operated by a hospital, certified by the federal government to provide ESRD services.

"Hemodialysis" means a method of dialysis in which blood from a patient's body is circulated through an external device or machine and then returned to the patient's bloodstream. Hemodialysis is usually done in a kidney center or facility. It can be done at home with a trained dialysis helper.

"Home dialysis" means any dialysis performed at home.

"Home dialysis helper" means a person trained to assist the client in home dialysis.

"In-facility dialysis," for the purpose of this chapter only, in-facility dialysis means dialysis of any type performed on the premises of a kidney center or other free-standing ESRD facility.

"Intermittent peritoneal dialysis (IPD)" means a type of peritoneal dialysis in which dialysis solution is infused into the peritoneal cavity, allowed to remain there for a period of time, and then drained out. IPD is usually done in a kidney center or facility. It can be done at home with a trained home dialysis helper.

"Kidney center" means a facility as defined and certified by the federal government to:

(1) Provide ESRD services;

(2) Provide the services specified in this chapter; and

(3) Promote and encourage home dialysis for a client when medically indicated.

"Maintenance dialysis" means the usual periodic dialysis treatments given to a client who has ESRD.

"Peritoneal dialysis" means a procedure that introduces dialysate into the abdominal cavity to remove waste products through the peritoneum. Three forms of peritoneal dialysis are continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis, and intermittent peritoneal dialysis.

"Self-dialysis unit" means a unit in a free-standing kidney center where dialysis is performed by an ESRD client who has completed training in self-dialysis.

"Standard ESRD lab tests" means certain laboratory tests that the Centers for Medicare and Medicaid include in their composite rate calculations. These tests are identified in MAA's kidney center billing instructions.

"Take home drugs" means outpatient prescription drugs that are administered outside of a provider's office.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-105, filed 10/8/03, effective 11/8/03.]

WAC 388-540-110 Eligibility. (1) To be eligible for the kidney center services described in this section, a client must be diagnosed with end-stage renal disease (ESRD) or acute

renal failure and be covered under one of the following programs:

- (a) Categorically needy program (CNP);
 - (b) Children's health insurance program (CHIP);
 - (c) General assistance-unemployable (GAU);
 - (d) Limited casualty program—Medically needy program (MNP);
 - (e) Alien emergency medical; or
 - (f) Qualified Medicare beneficiary (QMB)—(MAA pays only for Medicare premium, coinsurance and deductible).
- (2) Managed care enrollees must have dialysis services arranged directly through their designated plan.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-110, filed 10/8/03, effective 11/8/03.]

WAC 388-540-120 Provider requirements. To receive reimbursement from the medical assistance administration (MAA) for providing care to MAA clients, a kidney center must:

- (1) Be a Medicare-certified end-stage renal disease (ESRD) facility and have a signed core provider agreement with MAA (see chapter 388-502 WAC);
- (2) Meet requirements found in chapter 388-502 WAC;
- (3) Provide only those services within the scope of their provider's license; and
- (4) Provide, either directly or through an affiliate, all physical facilities, professional consultation, personal instructions, medical treatment, care, and all supplies necessary for carrying out an medically sound ESRD treatment program, including all of the following:
 - (a) Dialysis for ESRD clients;
 - (b) Kidney transplant treatment, either directly or by referral, for ESRD clients when medically indicated;
 - (c) Treatment for conditions directly related to ESRD;
 - (d) Training and supervision of supporting personnel and clients for home dialysis, medical care, and treatment; and
 - (e) Supplies and equipment for home dialysis.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-120, filed 10/8/03, effective 11/8/03.]

WAC 388-540-130 Covered services. (1) The department covers the following services and supplies subject to the restrictions and limitations in this section and other applicable published WAC:

- (a) In-facility dialysis;
 - (b) Home dialysis;
 - (c) Training for self-dialysis;
 - (d) Home dialysis helpers;
 - (e) Dialysis supplies;
 - (f) Diagnostic lab work;
 - (g) Treatment for anemia; and
 - (h) Intravenous drugs.
- (2) Covered services are subject to the limitations specified by the department. Providers must obtain prior authorization (PA) or expedited prior authorization (EPA) before providing services that exceed specified limits in quantity, frequency or duration (refer to WAC 388-501-0165 and 388-501-0169).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-540-130, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-130, filed 10/8/03, effective 11/8/03.]

WAC 388-540-140 Noncovered services. (1) The department does not reimburse kidney centers for the following:

- (a) Blood and blood products (refer to WAC 388-540-190);
- (b) Personal care items such as slippers, toothbrushes, etc.; or
- (c) Additional staff time or personnel costs. Staff time is paid through the composite rate. Home dialysis helpers are the only personnel cost paid outside the composite rate (refer to WAC 388-540-160).

(2) The department evaluates a request for any service listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-540-140, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-140, filed 10/8/03, effective 11/8/03.]

WAC 388-540-150 Reimbursement—General. (1) Kidney center services described in this section are paid by one of two methods:

(a) **Composite rate payments**—This is a payment method in which all standard equipment, supplies and services are calculated into a blended rate.

(i) A single dialysis session and related services are reimbursed through a single composite rate payment (refer to WAC 388-540-160).

(ii) Composite rate payments for continuous ambulatory peritoneal dialysis (CAPD) or continuous cycling peritoneal dialysis (CCPD) are limited to thirty-one per month for an individual client.

(iii) Composite rate payments for all other types of dialysis sessions are limited to fourteen per month for an individual client.

(b) **Noncomposite rate payments**—End-stage renal disease (ESRD) services and items covered by the department but not included in the composite rate are billed and paid separately (refer to WAC 388-540-170).

(2) **Limitation extension request**—The department evaluates billings for covered services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions when medically necessary under the provisions of WAC 388-501-0165 and 388-501-0169.

(3) **Take-home drugs**—The department reimburses kidney centers for take-home drugs only when they meet the conditions described in WAC 388-540-170(1). Other drugs for at-home use must be billed by a pharmacy and be subject to the department's pharmacy rules.

(4) **Medical nutrition**—Medical nutrition products must be billed by a pharmacy or a durable medical equipment (DME) provider.

(5) **Medicare eligible clients**—The department does not reimburse kidney centers as a primary payer for Medicare eligible clients.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-540-150, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-150, filed 10/8/03, effective 11/8/03.]

WAC 388-540-160 Items and services included in the composite rate. (1) The following equipment, supplies, and services for in-facility and home dialysis are included in the composite rate:

- (a) Medically necessary dialysis equipment;
- (b) All dialysis services furnished by the facility's staff;
- (c) Standard end-stage renal disease laboratory tests (refer to WAC 388-540-180);
- (d) Home dialysis support services including delivery, installation, and maintenance of equipment;
- (e) Purchase and delivery of all necessary dialysis supplies;
- (f) Dec clotting of shunts and any supplies used to dec clot shunts;
- (g) Oxygen and the administration of oxygen;
- (h) Staff time used to administer blood and nonroutine parenteral items;

(i) Noninvasive vascular studies; and
 (j) Training for self-dialysis and home dialysis helpers.
 (2) The medical assistance administration (MAA) issues a composite rate payment only when all of the above items and services are furnished or available at each dialysis session.

(3) If the facility fails to furnish or have available any of the above items, MAA does not pay for any part of the items and services that were furnished.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-160, filed 10/8/03, effective 11/8/03.]

WAC 388-540-170 Items and services not included in the composite rate. The following items and services are not included in the composite rate and must be billed separately, subject to the restrictions or limitations in this section and other applicable published WAC:

- (1) Drugs related to treatment, including but not limited to epoetin alpha (EPO) and diazepam. The drug must:
 - (a) Be prescribed by a physician;
 - (b) Meet the rebate requirements described in WAC 388-530-1125; and
 - (c) Meet the requirements of WAC 246-905-020 when provided for home use.
- (2) Supplies used to administer drugs and blood;
- (3) Blood processing fees charged by the blood bank (refer to WAC 388-540-190); and
- (4) Home dialysis helpers.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-170, filed 10/8/03, effective 11/8/03.]

WAC 388-540-180 Laboratory services. (1) Laboratory services included in the composite rate, performed by (2007 Ed.)

either the facility or an independent laboratory, must not be billed separately except as provided for in (b) of this subsection:

(a) Standard end-stage renal disease (ESRD) lab tests are included in the composite rate when performed at recommended intervals (see billing instructions for current list).

(b) The standard ESRD lab tests referred to in (a) of this subsection can be reimbursed separately from the composite rate only when it is medically necessary to test more frequently:

(i) Proof of medical necessity must be documented in the client's medical record when billing for more frequent testing. A diagnosis of end-stage renal disease is not sufficient;

(ii) The claim must include information on the nature of the illness or injury (diagnosis, complaint or symptom) requiring the performance of the test(s); or

(iii) An ICD-9CM diagnosis code may be shown in lieu of a narrative description.

(2) All separately billable, ESRD laboratory services must be billed by and reimbursed to the lab that performs the test.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-180, filed 10/8/03, effective 11/8/03.]

WAC 388-540-190 Blood products and services. (1) The medical assistance administration (MAA) reimburses free-standing kidney centers for:

(a) Blood processing and other fees assessed by non-profit blood centers that do not charge for the blood or blood products themselves; and

(b) Costs incurred by the center to administer its in-house blood procurement program.

(2) MAA does not reimburse centers for blood or blood products (refer to WAC 388-550-6500).

(3) Staff time used to administer blood or blood products is reimbursed only through the composite rate (refer to WAC 388-540-150 and 388-540-160).

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-190, filed 10/8/03, effective 11/8/03.]

WAC 388-540-200 Epoetin alpha (EPO) therapy. The medical assistance administration (MAA) reimburses the kidney center for EPO therapy when:

- (1) Administered in the kidney center to a client:
 - (a) With a hematocrit less than thirty-three percent or a hemoglobin less than eleven when therapy is initiated;
 - (b) Continuing EPO therapy with a hematocrit between thirty and thirty-six percent; or
 - (c) Medical justification documented in the client's record is required for hematocrits greater than thirty-six or hemoglobins greater than twelve. Medical justification includes:
 - (i) Documentation that dose is being titrated downward to bring a patient's hematocrit back within target range; or
 - (ii) Documentation that it is medically necessary for the client to have a target hematocrit greater than thirty-six percent.

(2) Provided to a home dialysis client:

(a) Under the same hematocrit/hemoglobin guidelines as stated in (1)(a) and (b) of this section; and

(b) When permitted by Washington board of pharmacy rules. (Refer to WAC 246-905-020 Home dialysis program—Legend drugs.)

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-200, filed 10/8/03, effective 11/8/03.]

WAC 388-540-210 Injectable drugs given in the kidney center. Injectable drugs administered in the kidney center are reimbursed up to the medical assistance administration's (MAA) published maximum fees.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, 74.09.522, and 42 C.F.R. 405.2101. 03-21-039, § 388-540-210, filed 10/8/03, effective 11/8/03.]

Chapter 388-542 WAC

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

WAC

388-542-0010	Purpose and scope of SCHIP.
388-542-0020	Other rules that apply to SCHIP.
388-542-0050	Definitions for SCHIP terms.
388-542-0300	Waiting period for SCHIP coverage following employer coverage.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-542-0100	CHIP scope of care. [Statutory Authority: RCW 74.08.090, 74.09.450, 74.09.510, 74.09.522. 04-08-018, § 388-542-0100, filed 3/29/04, effective 4/29/04. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0100, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0100, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.
388-542-0125	Access to care. [Statutory Authority: RCW 74.08.090, 74.09.450, 74.09.510, 74.09.522. 04-08-018, § 388-542-0125, filed 3/29/04, effective 4/29/04. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0125, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0125, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.
388-542-0150	Client eligibility requirements for CHIP. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0150, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0150, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.
388-542-0200	CHIP enrollment. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0200, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0200, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.
388-542-0220	Ending CHIP client eligibility. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450,

1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0220, filed 12/14/01, effective 1/14/02.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0250 CHIP client costs. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0250, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0250, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0275 Reimbursement. [Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0275, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0275, filed 3/17/00, effective 4/17/00.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

388-542-0500 Managed care rules that apply to CHIP. [Statutory Authority: RCW 74.08.090, 74.09.450, 74.09.510, 74.09.522. 04-08-018, § 388-542-0500, filed 3/29/04, effective 4/29/04. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0500, filed 12/14/01, effective 1/14/02.] Repealed by 04-16-064, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276.

WAC 388-542-0010 Purpose and scope of SCHIP. (1)

The department administers the state children's health insurance program (SCHIP) to provide access to:

(a) Medical care for children whose family income exceeds the limit for Medicaid eligibility but is not greater than two hundred fifty percent of the federal poverty level (FPL); and

(b) Prenatal care and medical services for a pregnant woman;

(i) Who is ineligible for Medicaid due to immigration status; and

(ii) Whose family income is at or below one hundred eighty-five percent FPL.

(2) SCHIP is authorized by Title XXI of the Social Security Act and by RCW 74.09.450.

[Statutory Authority: RCW 74.08.090, 74.09.050, and Title XXI of the Social Security Act. 06-15-134, § 388-542-0010, filed 7/19/06, effective 8/19/06. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0010, filed 7/30/04, effective 8/30/04.]

WAC 388-542-0020 Other rules that apply to SCHIP. In addition to the rules of this chapter, SCHIP clients are subject to the following rules:

(1) Chapter 388-538 WAC, Managed care (except WAC 388-538-061, 388-538-063, and 388-538-065);

(2) WAC 388-505-0210 (3) and (8), Children's medical eligibility;

(3) WAC 388-505-0211, Premium requirements for SCHIP children;

(4) WAC 388-416-0015(10), Certification periods; and

(5) WAC 388-418-0025 (4) and (5), Change of circumstance.

[Statutory Authority: RCW 74.08.090 and 74.09.522. 06-07-014, § 388-542-0020, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0020, filed 7/30/04, effective 8/30/04.]

WAC 388-542-0050 Definitions for SCHIP terms.

The following definitions, as well as those found in WAC 388-538-050 and in 388-500-0005 Medical definitions, apply to the state children's health insurance program (SCHIP).

"Creditable coverage" means most types of public and private health coverage, except Indian health services, that provides access to physicians, hospitals, laboratory services, and radiology services. This term applies to the coverage whether or not the coverage is equivalent to that offered under SCHIP. "Creditable coverage" is described in 42 U.S.C. Sec. 1397jj.

"Employer-sponsored dependent coverage" means creditable health coverage for dependents offered by a family member's employer or union, for which the employer or union may contribute in whole or part towards the premium. Extensions of such coverage (e.g., COBRA extensions) also qualify as employer-sponsored dependent coverage as long as there remains a contribution toward the premiums by the employer or union.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276, 04-16-064, § 388-542-0050, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0050, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0050, filed 3/17/00, effective 4/17/00.]

WAC 388-542-0300 Waiting period for SCHIP coverage following employer coverage. (1) The medical assistance administration (MAA) requires applicants to serve a waiting period of four full consecutive months before SCHIP coverage if the client or family:

(a) Chooses to end employer sponsored dependent coverage. The waiting period begins the day after the employment-based coverage ends; or

(b) Fails to exercise an optional coverage extension (e.g., COBRA) that meets the following conditions. The waiting period begins on the day there is a documented refusal of the coverage extension when the extended coverage is:

(i) Subsidized in part or in whole by the employer or union;

(ii) Available and accessible to the applicant or family; and

(iii) At a monthly cost to the family meeting the limitation of subsection (2)(b)(iv).

(2) MAA does not require a waiting period prior to SCHIP coverage when:

(a) The client or family member has a medical condition that, without treatment, would be life-threatening or cause serious disability or loss of function; or

(b) The loss of employer sponsored dependent coverage is due to any of the following:

(i) Loss of employment with no postemployment subsidized coverage as described in subsection (1)(b);

(ii) Death of the employee;

(iii) The employer discontinues employer-sponsored dependent coverage;

(iv) The family's total out-of-pocket maximum for employer-sponsored dependent coverage is fifty dollars per month or more;

(v) The plan terminates employer-sponsored dependent coverage for the client because the client reached the maximum lifetime coverage amount;

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(vi) Coverage under a COBRA extension period expired;

(vii) Employer-sponsored dependent coverage is not reasonably available (e.g., client would have to travel to another city or state to access care); or

(viii) Domestic violence caused the loss of coverage for the victim.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276, 04-16-064, § 388-542-0300, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-542-0300, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.450. 00-07-103, § 388-542-0300, filed 3/17/00, effective 4/17/00.]

Chapter 388-543 WAC**DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES****WAC**

388-543-1000	Definitions for durable medical equipment (DME) and related supplies, prosthetics, and orthotics, medical supplies and related services.
388-543-1100	Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services.
388-543-1150	Limits and limitation extensions.
388-543-1200	Providers who are eligible to provide services.
388-543-1225	Provider requirements.
388-543-1300	Equipment, related supplies, or other nonmedical supplies, and devices that are not covered.
388-543-1400	General reimbursement for DME and related services, prosthetics, orthotics, medical supplies and related services.
388-543-1500	When MAA purchases DME and related supplies, prosthetics, and orthotics.
388-543-1600	Items and services which require prior authorization.
388-543-1700	When MAA covers rented DME.
388-543-1800	Prior authorization—General policies for DME and related supplies, prosthetics, orthotics, medical supplies and related services.
388-543-1900	Expedited prior authorization criteria for DME and related supplies, prosthetics, orthotics, medical supplies, and related services.
388-543-2000	Wheelchairs.
388-543-2100	Wheelchairs—Reimbursement methodology.
388-543-2200	Speech generating devices (SGD).
388-543-2300	Bathroom/shower equipment.
388-543-2400	Hospital beds.
388-543-2500	Reimbursement methodology for other durable medical equipment.
388-543-2600	Prosthetics and orthotics.
388-543-2700	Prosthetics and orthotics—Reimbursement.
388-543-2800	Reusable and disposable medical supplies.
388-543-2900	Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology.
388-543-3000	DME and supplies provided in physician's office.

WAC 388-543-1000 Definitions for durable medical equipment (DME) and related supplies, prosthetics, and orthotics, medical supplies and related services. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this chapter.

"Artificial limb" - See "prosthetic device."

"Augmentative communication device (ACD)" - See "speech generating device (SGD)."

"Base year" means the year of the data source used in calculating prices.

"By report (BR)" means a method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees.

"Date of delivery" means the date the client actually took physical possession of an item or equipment.

"Disposable supplies" means supplies which may be used once, or more than once, but are time limited.

"Durable medical equipment (DME)" means equipment that: (1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of illness or injury; and

(4) Is appropriate for use in the client's place of residence.

"EPSDT" - See WAC 388-500-0005.

"Expedited prior authorization (EPA)" means the process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization.

"Fee-for-service (FFS)" means the general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs.

"Health care financing administration common procedure coding system (HCPCS)" means a coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

"House wheelchair" means a nursing facility wheelchair that is included in the nursing facility's per-patient-day rate under chapter 74.46 RCW.

"Limitation extension" means a process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization.

"Nonreusable supplies" are disposable supplies, which are used once and discarded.

"Manual wheelchair" - See "wheelchair - manual."

"Medical supplies" means supplies that are:

(1) Primarily and customarily used to service a medical purpose; and

(2) Generally not useful to a person in the absence of illness or injury.

"Orthotic device" or **"orthotic"** means a corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Personal or comfort item" means an item or service which primarily serves the comfort or convenience of the client.

"Personal computer (PC)" means any of a variety of electronic devices that are capable of accepting data and instructions, executing the instructions to process the data, and presenting the results. A PC has a central processing unit (CPU), internal and external memory storage, and various input/output devices such as a keyboard, display screen, and printer. A computer system consists of hardware (the physical components of the system) and software (the programs used by the computer to carry out its operations).

"Power-drive wheelchair" - See "wheelchair - power."

"Prior authorization" means a process by which clients or providers must request and receive MAA approval for certain medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are types of prior authorization. Also see WAC 388-501-0165.

"Prosthetic device" or **"prosthetic"** means a replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction;

or

(3) Support a weak or deformed portion of the body.

"Resource based relative value scale (RBRVS)" means a scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involve.

"Reusable supplies" are supplies which are to be used more than once.

"Scooter" means a federally-approved, motor-powered vehicle that:

(1) Has a seat on a long platform;

(2) Moves on either three or four wheels;

(3) Is controlled by a steering handle; and

(4) Can be independently driven by a client.

"Specialty bed" means a pressure reducing support surface, such as foam, air, water, or gel mattress or overlay.

"Speech generating device (SGD)" means an electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

"Three- or four-wheeled scooter" means a three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and which has the following minimum features:

(1) Rear drive;

(2) A twenty-four volt system;

(3) Electronic or dynamic braking;

(4) A high to low speed setting; and

(5) Tires designed for indoor/outdoor use.

"Trendelenburg position" means a position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane.

"Usual and customary charge" means the amount the provider typically charges to fifty percent or more of his or her non-Medicaid clients, including clients with other third-party coverage.

"Warranty-wheelchair" means a warranty, according to manufacturers' guidelines, of not less than one year from the date of purchase.

"Wheelchair - manual" means a federally-approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

- (1) Standard:
 - (a) Usually is not capable of being modified;
 - (b) Accommodates a person weighing up to two hundred fifty pounds; and
 - (c) Has a warranty period of at least one year.
 - (2) Lightweight:
 - (a) Composed of lightweight materials;
 - (b) Capable of being modified;
 - (c) Accommodates a person weighing up to two hundred fifty pounds; and
 - (d) Usually has a warranty period of at least three years.
 - (3) High strength lightweight:
 - (a) Is usually made of a composite material;
 - (b) Is capable of being modified;
 - (c) Accommodates a person weighing up to two hundred fifty pounds;
 - (d) Has an extended warranty period of over three years; and
 - (e) Accommodates the very active person.
 - (4) Hemi:
 - (a) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet; and
 - (b) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.
 - (5) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.
 - (6) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.
 - (7) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.
 - (8) Heavy duty:
 - (a) Specifically manufactured to support a person weighing up to three hundred pounds; or
 - (b) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).
 - (9) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.
 - (10) Custom heavy duty:
 - (a) Specifically manufactured to support a person weighing over three hundred pounds; or
 - (b) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).
 - (11) Custom manufactured specially built:
 - (a) Ordered for a specific client from custom measurements; and
 - (b) Is assembled primarily at the manufacturer's factory.
- "Wheelchair - power"** means a federally-approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:
- (1) Custom power adaptable to:
 - (a) Alternative driving controls; and
 - (b) Power recline and tilt-in-space systems.
 - (2) Noncustom power: Does not need special positioning or controls and has a standard frame.

- (3) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

[Statutory Authority: RCW 74.08.090, 74.09.530, 02-16-054, § 388-543-1000, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1000, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1100 Scope of coverage and coverage limitations for DME and related supplies, prosthetics, orthotics, medical supplies and related services. The federal government deems **durable medical equipment (DME)** and related supplies, **prosthetics, orthotics, and medical supplies** as optional services under the **Medicaid** program, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (**EPSDT**) program. The **department** may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

- (1) The department covers DME and related supplies, prosthetics, orthotics, medical supplies, related services, repairs and labor charges when they are:

- (a) Within the scope of an eligible client's medical care program (see WAC 388-501-0060 and 388-501-0065);

- (b) Within accepted medical or physical medicine community standards of practice;

- (c) Prior authorized as described in WAC 388-543-1600, 388-543-1800, and 388-543-1900;

- (d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), or physician assistant certified (PAC). Except for dual eligible Medicare/Medicaid clients, the prescription must:

- (i) Be dated and signed by the prescriber;

- (ii) Be less than six months in duration from the date the prescriber signs the prescription; and

- (iii) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity;

- (e) Billed to the department as the payor of last resort only. The department does not pay first and then collect from Medicare and;

- (f) **Medically necessary** as defined in WAC 388-500-0005. The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:

- (i) A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, ARNP, PAC, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; and/or

- (ii) Video and/or photograph(s) of the client demonstrating the impairments as well and client's ability to use the requested equipment, when applicable.

- (2) The department evaluates a request for any equipment or device listed as noncovered in WAC 388-543-1300 under the provisions of WAC 388-501-0160.

- (3) The department evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165.

(4) The department evaluates requests for covered services in this chapter that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions under the provisions of WAC 388-501-0165 and 388-501-0169.

(5) The department does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under **fee-for-service (FFS)** when the client is any of the following:

- (a) An inpatient hospital client;
- (b) Eligible for both **Medicare** and Medicaid, and is staying in a **nursing facility** in lieu of hospitalization;
- (c) Terminally ill and receiving hospice care; or
- (d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(6) The department covers medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, repairs, and labor charges listed in the department's published issuances, including Washington Administrative Code (WAC), billing instructions, and numbered memoranda.

(7) An interested party may request the department to include new equipment/supplies in the billing instructions by sending a written request plus all of the following:

- (a) Manufacturer's literature;
- (b) Manufacturer's pricing;
- (c) Clinical research/case studies (including FDA approval, if required); and
- (d) Any additional information the requester feels is important.

(8) The department bases the decision to purchase or rent DME for a client, or to pay for repairs to client-owned equipment on medical necessity.

(9) The department covers replacement batteries for purchased medically necessary DME equipment covered within this chapter.

(10) The department covers the following categories of medical equipment and supplies only when they are medically necessary, prescribed by a physician, ARNP, or PAC, are within the scope of his or her practice as defined by state law, and are subject to the provisions of this chapter and related WACs:

- (a) Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;
- (b) Wheelchairs and other DME;
- (c) Prosthetic/orthotic devices;
- (d) Surgical/ostomy appliances and urological supplies;
- (e) Bandages, dressings, and tapes;
- (f) Equipment and supplies for the management of diabetes; and
- (g) Other medical equipment and supplies listed in department published issuances.

(11) The department evaluates a **BR** item, procedure, or service for its medical appropriateness and reimbursement value on a case-by-case basis.

(12) For a client in a **nursing facility**, the department covers only the following when medically necessary. All other DME and supplies identified in the department's billing instructions are the responsibility of the nursing facility, in

accordance with chapters 388-96 and 388-97 WAC. See also WAC 388-543-2900 (3) and (4). The department covers:

(a) The purchase and repair of a speech generating device (SGD), a wheelchair for the exclusive full-time use of a permanently disabled nursing facility resident when the wheelchair is not included in the nursing facility's per diem rate, or a **specialty bed**; and

(b) The rental of a specialty bed.

(13) Vendors must provide instructions for use of equipment; therefore, instructional materials such as pamphlets and video tapes are not covered.

(14) Bilirubin lights are limited to rentals, for at-home newborns with jaundice.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-543-1100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. 05-21-102, § 388-543-1100, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.08.090, 34.05.353. 03-12-005, § 388-543-1100, filed 5/22/03, effective 6/22/03. Statutory Authority: RCW 74.08.090, 74.09.530. 02-16-054, § 388-543-1100, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1100, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1150 Limits and limitation extensions.

The department covers non-DME (MSE), DME, and related supplies, prosthetics, orthotics, medical supplies, and related services as described in WAC 388-543-1100(1). The department limits the amount, frequency, or duration of certain covered MSE, DME, and related supplies, prosthetics, orthotics, medical supplies, and related services, and reimburses up to the stated limit without requiring prior authorization. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client. In order to exceed the stated limits, the provider must request a limitation extension (LE), which is a form of prior authorization (PA). The department evaluates such requests for LE under the provisions of WAC 388-501-0169. Procedures for LE are found in department billing instructions. The following items and quantities do not require prior authorization; requests to exceed the stated quantities require LE:

(1) Antiseptics and germicides:

(a) Alcohol (isopropyl) or peroxide (hydrogen) - one pint per month;

(b) Alcohol wipes (box of two hundred) - one box per month;

(c) Betadine or pHisoHex solution - one pint per month;

(d) Betadine or iodine swabs/wipes (box of one hundred) - one box per month;

(e) Disinfectant spray - one twelve-ounce bottle or can per six-month period; or

(f) Periwash (when soap and water are medically contraindicated) - one five-ounce bottle of concentrate solution per six-month period.

(2) Blood monitoring/testing supplies:

(a) Replacement battery of any type, used with a client-owned, medically necessary home or specialized blood glucose monitor - one in a three-month period; and

(b) Spring-powered device for lancet - one in a six-month period.

(3) Braces, belts and supportive devices:

(a) Custom vascular supports (CVS) - two pair per six-month period. CVS fitting fee - two per six-month period;

(b) Surgical stockings (below-the-knee, above-the-knee, thigh-high, or full-length) - two pair per six-month period;

(c) Graduated compression stockings for pregnancy support (panty hose style) - two per twelve-month period;

(d) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - two per twelve-month period;

(e) Ankle, elbow, or wrist brace - two per twelve-month period;

(f) Lumbosacral brace, rib belt, or hernia belt - one per twelve-month period;

(g) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - one per twelve-month period.

(4) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - one per twelve-month period;

(b) Synthetic or lambs wool sheepskin pad - one per twelve-month period;

(c) Heel or elbow protectors - four per twelve-month period.

(5) Ostomy supplies:

(a) Adhesive for ostomy or catheter: Cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - ten per month.

(c) Adhesive remover or solvent - three ounces per month.

(d) Adhesive remover wipes, fifty per box - one box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - ten per month.

(g) Continent plug for continent stoma - thirty per month.

(h) Continent device for continent stoma - one per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - twenty per month.

(j) Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in one-piece convexity - twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - ten per month.

(m) Irrigation bag - two every six months.

(n) Irrigation cone and catheter, including brush - two every six months.

(o) Irrigation supply, sleeve - one per month.

(p) Ostomy belt (adjustable) for appliance - two every six months.

(q) Ostomy convex insert - ten per month.

(r) Ostomy ring - ten per month.

(s) Stoma cap - thirty per month.

(t) Ostomy faceplate - ten per month. The department does not allow the following to be used on a faceplate in combination with drainable pouches (refer to the billing instructions for further details):

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(6) Supplies associated with client-owned transcutaneous electrical nerve stimulators (TENS):

(a) For a four-lead TENS unit - two kits per month. (A kit contains two leads, conductive paste or gel, adhesive, adhesive remover, skin preparation material, batteries, and a battery charger for rechargeable batteries.)

(b) For a two-lead TENS unit - one kit per month.

(c) TENS tape patches (for use with carbon rubber electrodes only) are allowed when they are not used in combination with a kit(s).

(d) A TENS stand alone replacement battery charger is allowed when it is not used in combination with a kit(s).

(7) Urological supplies - diapers and related supplies:

(a) The standards and specifications in this subsection apply to all disposable incontinent products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments). See subsections (b), (c), (d), and (e) of this section for additional standards for specific products. All of the following apply to all disposable incontinent products:

(i) All materials used in the construction of the product must be safe for the client's skin and harmless if ingested;

(ii) Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage;

(iii) The padding must provide uniform protection;

(iv) The product must be hypoallergenic;

(v) The product must meet the flammability requirements of both federal law and industry standards; and

(vi) All products are covered for client personal use only.

(b) In addition to the standards in subsection (a) of this section, diapers must meet all the following specifications. They must:

(i) Be hourglass shaped with formed leg contours;

(ii) Have an absorbent filler core that is at least one-half inch from the elastic leg gathers;

(iii) Have leg gathers that consist of at least three strands of elasticized materials;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have a backsheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a topsheet that resists moisture returning to the skin;

(vii) Have an inner lining that is made of soft, absorbent material; and

(viii) Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:

(A) For child diapers, at least two tapes, one on each side.

(B) The tape adhesive must release from the backsheet without tearing it, and permit a minimum of three fastening/unfastening cycles.

(c) In addition to the standards in subsection (a) of this section, pull-up pants and briefs must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist or have at least four tapes, two on each side or two large tapes, one on each side;

(ii) Have an absorbent core filler that is at least one-half inch from the elastic leg gathers;

(iii) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling;

(iv) Have leg gathers that consist of at least three strands of elasticized materials;

(v) Have a backsheet that is moisture impervious, is at least 1.00 mm thick, and is designed to protect clothing and linens;

(vi) Have an inner lining made of soft, absorbent material; and

(vii) Have a top sheet that resists moisture returning to the skin.

(d) In addition to the standards in subsection (a) of this section, underpads are covered only for incontinent purposes in a client's bed and must meet the following specifications:

(i) Have an absorbent layer that is at least one and one-half inches from the edge of the underpad;

(ii) Be manufactured with a waterproof backing material;

(iii) Be able to withstand temperatures not to exceed one hundred-forty degrees Fahrenheit;

(iv) Have a covering or facing sheet that is made of non-woven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(vi) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

(i) Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit;

(ii) Have a waterproof backing designed to protect clothing and linens;

(iii) Have an inner liner that resists moisture returning to the skin;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have pressure-sensitive tapes on the reverse side to fasten to underwear; and

(vi) For undergarments only, be contoured for good fit, have at least three elastic leg gathers, and may be belted or unbelted.

(f) The department covers the products in this subsection only when they are used alone; they cannot be used in combination with each other. The department approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use (see department billing instructions for how to specify this when billing). The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit (see subsections (g), (h), (i), (j),

(k), (l), and (m) of this section for product limitations). The following products cannot be used together:

(i) Disposable diapers;

(ii) Disposable pull-up pants and briefs;

(iii) Disposable liners, shields, guards, pads, and undergarments;

(iv) Rented reusable diapers (e.g., from a diaper service); and

(v) Rented reusable briefs (e.g., from a diaper service), or pull-up pants.

(g) Purchased disposable diapers (any size) are limited to:

(i) Three hundred per month for a child three to eighteen years of age; and

(ii) Two hundred forty per month for an adult nineteen years of age and older.

(h) Reusable cloth diapers (any size) are limited to:

(i) Purchased - thirty-six per year; and

(ii) Rented - two hundred forty per month.

(i) Disposable briefs and pull-up pants (any size) are limited to:

(i) Three hundred per month for a child age three to eighteen years of age; and

(ii) One hundred fifty per month for an adult nineteen years of age and older.

(j) Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

(i) Purchased - four per year.

(ii) Rented - one hundred fifty per month.

(k) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred forty per month.

(l) Underpads for beds are limited to:

(i) Disposable (any size) - one hundred eighty per month.

(ii) Purchased, reusable (large) - forty-two per year.

(iii) Rented, reusable (large) - ninety per month.

(8) Urological supplies - urinary retention:

(a) Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - two per month. This cannot be billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adaptor; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adaptor, for use with urinary leg bag or urostomy pouch. This cannot be billed in combination with a vinyl urinary leg bag, with or without tube.

(d) External urethral clamp or compression device (not be used for catheter clamp) - two per twelve-month period.

(e) Indwelling catheters (any type) - three per month.

(f) Insertion trays:

(i) Without drainage bag and catheter - one hundred and twenty per month. These cannot be billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - three per month. These cannot be billed in combination with: Other insertion trays

without drainage bag and/or indwelling catheter; individual indwelling catheters; and/or individual lubricant packets.

(g) Intermittent urinary catheter - one hundred twenty per month. These cannot be billed in combination with: An insertion tray with or without drainage bag and catheter; or other individual intermittent urinary catheters.

(h) Irrigation syringe (bulb or piston) - cannot be billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - thirty per month. These cannot be billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - thirty per month. These cannot be billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric). Allowed as replacement only.

(l) Male external catheter, specialty type, or with adhesive coating or adhesive strip - sixty per month.

(m) Urinary suspensory with leg bag, with or without tube - two per month. This cannot be billed in combination with: a latex urinary leg bag; urinary suspensory without leg bag; extension drainage tubing; or a leg strap.

(n) Urinary suspensory without leg bag, with or without tube - two per month.

(o) Urinary leg bag, vinyl, with or without tube - two per month. This cannot be billed in combination with: A leg strap; or an insertion tray with drainage bag and without catheter.

(p) Urinary leg bag, latex - one per month. This cannot be billed in combination with an insertion tray with drainage bag and with or without catheter.

(9) Miscellaneous supplies:

(a) Bilirubin light therapy supplies - five days' supply. The department reimburses only when these are provided with a prior authorized bilirubin light.

(b) Continuous passive motion (CPM) softgoods kit - one, with rental of CPM machine.

(c) Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - one box of twenty.

(d) Eye patch (adhesive wound cover) - one box of twenty.

(e) Lice comb (e.g., LiceOut TM, or LiesMeister [Lice-Meister] TM, or combs of equivalent quality and effectiveness) - one per year.

(f) Nontoxic gel (e.g., LiceOut TM) for use with lice combs - one bottle per twelve month period.

(g) Syringes and needles ("sharps") disposal container for home use, up to one gallon size - two per month.

(10) Miscellaneous DME:

(a) Bilirubin light or light pad - five days rental per twelve-month period.

(b) Blood glucose monitor (specialized or home) - one in a three-year period.

(c) Continuous passive motion (CPM) machine - up to ten days rental and requires prior authorization.

(d) Diaphragmatic pacing antennae - four per twelve month-period.

(e) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - two per twelve-month period.

(f) Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap w/adjustable buckle

and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - two per twelve-month period.

(11) Prosthetics and orthotics:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - one every five years.

(b) Preparatory, above knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot plaster socket, molded to model - one per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - one per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - one per twelve-month period.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - one per twelve-month period.

(12) Positioning devices:

(a) Deluxe floor sitter/feeder seat (small, medium, or large), including floor sitter wedge, shoulder harness, and hip strap - one in a three-year period.

(b) High-back activity chair, including adjustable footrest, two pairs of support blocks, and hip strap - one in a three-year period.

(c) Positioning system/supine boards (small or large), including padding, straps adjustable armrests, footboard, and support blocks - one in a five-year period.

(d) Prone stander (child, youth, infant or adult size) - one in a five-year period.

(e) Adjustable standing frame (for child/adult thirty - sixty-eight inches tall), including two padded back support blocks, a chest strap, a pelvic strap, a pair of knee blocks, an abductor, and a pair of foot blocks - one in a five-year period.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-543-1150, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. 05-21-102, § 388-543-1150, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-082, § 388-543-1150, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530. 01-16-141, § 388-543-1150, filed 7/31/01, effective 8/31/01.]

WAC 388-543-1200 Providers who are eligible to provide services. (1) MAA requires a provider who supplies DME and related supplies, prosthetics, orthotics, medical supplies and related services to an MAA client to meet all of the following. The provider must:

(a) Have the proper business license;

(b) Have appropriately trained qualified staff; and

(c) Be certified, licensed and/or bonded if required, to perform the services billed to the department. Out-of-state prosthetic and orthotics providers must meet their state regulatory requirements.

(2) MAA may reimburse qualified providers for DME and related supplies, prosthetics, orthotics, medical supplies, repairs, and related services on a fee-for-service (FFS) basis as follows:

(a) DME providers for DME and related repair services;

(b) Medical equipment dealers, pharmacies, and home health agencies under their medical vendor provider number for medical supplies, subject to the limitations in this section;

(c) Licensed prosthetics and orthotics providers who are licensed by the Washington state department of health in

prosthetics and orthotics. This does not apply to medical equipment dealers and pharmacies that do not require licensure to provide selected prosthetics and orthotics;

(d) Physicians who provide medical equipment and supplies in the physician's office. MAA may pay separately for medical supplies, subject to the provisions in MAA's **resource based relative value scale (RBRVS)** fee schedule; and

(e) Out-of-state orthotics and prosthetics providers who meet their state regulations.

(3) MAA terminates from Medicaid participation any provider who violates program regulations and policies, as described in WAC 388-502-0020.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1200, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1225 Provider requirements. (1) Providers and suppliers of durable medical equipment (DME) and related supplies, prosthetics and orthotics, medical supplies and related items must meet the general provider documentation and record retention requirements in WAC 388-502-0020. In addition to these requirements, the medical assistance administration (MAA) requires providers to furnish, upon request, documentation of proof of delivery as stated in subsections (2) and (3) of this section.

(2) When a provider delivers an item directly to the client or the client's authorized representative, the provider must be able to furnish proof of delivery when MAA requests that information. All of the following apply:

(a) MAA requires a delivery slip as proof of delivery, and it must:

(i) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received);

(ii) Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name; and

(iii) For durable medical equipment that would require future repairs, include the serial number.

(b) When the provider or supplier submits a claim for payment to MAA, the date of service on the claim must be one of the following:

(i) For a one-time delivery, the date the item was received by the client or authorized representative; or

(ii) For nondurable medical supplies for which MAA has established a monthly maximum, on or after the date the item was received by the client or authorized representative.

(3) When a provider uses a delivery/shipping service to deliver items which are not fitted to the client, the provider must be able to furnish proof of delivery that the client received the equipment, when MAA requests that information. All of the following apply:

(a) MAA requires the delivery service tracking slip as proof of delivery, and it must include:

(i) The client's name or a reference to the client's package(s);

(ii) The delivery service package identification number; and

(iii) The delivery address.

(b) MAA requires the supplier's shipping invoice as proof of delivery, and it must include:

(i) The client's name;

(ii) The shipping service package identification number;

(iii) The quantity, detailed description(s), and brand name(s) of the items being shipped; and

(iv) For durable medical equipment that would require future repairs, include the serial number.

(c) When the provider submits a claim for payment to MAA, the date of service on the claim must be the shipping date.

(4) A provider must not use a delivery/shipping service to deliver items which must be fitted to the client.

(5) Providers must obtain prior authorization on any item that requires such before delivering that item to the client. The item must be delivered to the client before the provider bills MAA.

(6) MAA does not pay for DME and related supplies, prosthetics and orthotics, medical supplies and related items furnished to MAA clients when:

(a) The medical professional who provides medical justification to MAA for the item provided to the client is an employee of, has a contract with, or has any financial relationship with the provider of the item; or

(b) The medical professional who performs a client evaluation is an employee of, has a contract with, or has any financial relationship with a provider of DME and related supplies, prosthetics and orthotics, medical supplies, and related items.

(7) See WAC 388-502-0100, 388-502-0110, 388-502-0120, and 388-502-0130 for provider payment requirements.

(8) See WAC 388-502-0150 and 388-502-0160 for provider billing requirements.

(9) See WAC 388-502-0220, 388-502-0230, 388-502-0240, and 388-502-0260 for provider appeal requirements.

[Statutory Authority: RCW 74.08.090, 74.09.530. 03-05-051, § 388-543-1225, filed 2/14/03, effective 3/17/03.]

WAC 388-543-1300 Equipment, related supplies, or other nonmedical supplies, and devices that are not covered. (1) MAA pays only for DME and related supplies, medical supplies and related services that are medically necessary, listed as covered in this chapter, and meet the definition of DME and medical supplies as defined in WAC 388-543-1000 and prescribed per WAC 388-543-1100 and 388-543-1200.

(2) MAA pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS), formerly known as HCFA, that meet the definition of prosthetic and orthotic as defined in WAC 388-543-1000 and are prescribed per WAC 388-543-1100 and 388-543-1200.

(3) MAA considers all requests for covered DME, related supplies and services, medical supplies, prosthetics, orthotics, and related services and noncovered equipment, related supplies and services, supplies and devices, under the provisions of WAC 388-501-0165. When MAA considers that a request does not meet the requirement for medical necessity, the definition(s) of covered item(s), or is not covered, the client may appeal that decision under the provisions of WAC 388-501-0165.

(4) MAA specifically excludes services and equipment in this chapter from fee-for-service (FFS) scope of coverage

when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

(a) Included as part of a managed care plan service package;

(b) Included in a waived program;

(c) Part of one of the Medicare programs for qualified Medicare beneficiaries; or

(d) Requested for a child who is eligible for services under the EPSDT program. MAA reviews these requests according to the provisions of chapter 388-534 WAC.

(5) Excluded services and equipment include, but are not limited to:

(a) Services, procedures, treatment, devices, drugs, or the application of associated services that the department of the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the services are provided;

(b) Any service specifically excluded by statute;

(c) A client's utility bills, even if the operation or maintenance of medical equipment purchased or rented by MAA for the client contributes to an increased utility bill (refer to the aging and adult services administration's (AASA) COPES program for potential coverage);

(d) Hairpieces or wigs;

(e) Material or services covered under manufacturers' warranties;

(f) Shoe lifts less than one inch, arch supports for flat feet, and nonorthopedic shoes;

(g) Outpatient office visit supplies, such as tongue depressors and surgical gloves;

(h) Prosthetic devices dispensed solely for cosmetic reasons (refer to WAC 388-531-0150 (1)(d));

(i) Home improvements and structural modifications, including but not limited to the following:

(i) Automatic door openers for the house or garage;

(ii) Saunas;

(iii) Security systems, burglar alarms, call buttons, lights, light dimmers, motion detectors, and similar devices;

(iv) Swimming pools;

(v) Whirlpool systems, such as jacuzzies, hot tubs, or spas; or

(vi) Electrical rewiring for any reason;

(vii) Elevator systems and elevators; and

(viii) Lifts or ramps for the home; or

(ix) Installation of bathtubs or shower stalls.

(j) Nonmedical equipment, supplies, and related services, including but not limited to, the following:

(i) Back-packs, pouches, bags, baskets, or other carrying containers;

(ii) Bed boards/conversion kits, and blanket lifters (e.g., for feet);

(iii) Car seats for children under five, except for positioning car seats that are prior authorized. Refer to WAC 388-543-1700(13) for car seats;

(iv) Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;

(v) Diathermy machines used to produce heat by high frequency current, ultrasonic waves, or microwave radiation;

(vi) Electronic communication equipment, installation services, or service rates, including but not limited to, the following:

(A) Devices intended for amplifying voices (e.g., microphones);

(B) Interactive communications computer programs used between patients and healthcare providers (e.g., hospitals, physicians), for self care home monitoring, or emergency response systems and services (refer to AASA COPES or outpatient hospital programs for emergency response systems and services);

(C) Two-way radios; and

(D) Rental of related equipment or services;

(vii) Environmental control devices, such as air conditioners, air cleaners/purifiers, dehumidifiers, portable room heaters or fans (including ceiling fans), heating or cooling pads;

(viii) Ergonomic equipment;

(ix) Exercise classes or equipment such as exercise mats, bicycles, tricycles, stair steppers, weights, trampolines;

(x) Generators;

(xi) Computer software other than speech generating, printers, and computer accessories (such as anti-glare shields, backup memory cards);

(xii) Computer utility bills, telephone bills, internet service, or technical support for computers or electronic notebooks;

(xiii) Any communication device that is useful to someone without severe speech impairment (e.g., cellular telephone, walkie-talkie, pager, or electronic notebook);

(xiv) Racing strollers/wheelchairs and purely recreational equipment;

(xv) Room fresheners/deodorizers;

(xvi) Bidet or hygiene systems, paraffin bath units, and shampoo rings;

(xvii) Timers or electronic devices to turn things on or off, which are not an integral part of the equipment;

(xviii) Vacuum cleaners, carpet cleaners/deodorizers, and/or pesticides/insecticides; or

(xix) Wheeled reclining chairs, lounge and/or lift chairs (e.g., geri-chair, posture guard, or lazy boy).

(k) Personal and **comfort items** that do not meet the DME definition, including but not limited to the following:

(i) Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizer, mouthwash, powder, shampoo, shaving cream, shower cap, shower curtains, soap (including antibacterial soap), toothpaste, towels, and weight scales;

(ii) Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, pillow cases/covers and sheets;

(iii) Bedside items, such as bed trays, carafes, and over-the-bed tables;

(iv) Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;

(v) Clothing protectors and other protective cloth furniture coverings;

(vi) Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;

(vii) Diverter valves for bathtub;

(viii) Eating/feeding utensils;

(ix) Emesis basins, enema bags, and diaper wipes;

(x) Health club memberships;

(xi) Hot or cold temperature food and drink containers/holders;

(xii) Hot water bottles and cold/hot packs or pads not otherwise covered by specialized therapy programs;

(xiii) Impotence devices;

(xiv) Insect repellants;

(xv) Massage equipment;

(xvi) Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter 388-530 WAC;

(xvii) Medicine cabinet and first-aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;

(xviii) Page turners;

(xix) Radio and television;

(xx) Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and

(xxi) Toothettes and toothbrushes, waterpics, and peridental devices whether manual, battery-operated, or electric.

(l) Certain wheelchair features and options are not considered by MAA to be medically necessary or essential for wheelchair use. This includes, but is not limited to, the following:

(i) Attendant controls (remote control devices);

(ii) Canopies, including those for strollers and other equipment;

(iii) Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels (similar to mud flaps for cars);

(iv) Identification devices (such as labels, license plates, name plates);

(v) Lighting systems;

(vi) Speed conversion kits; and

(vii) Tie-down restraints, except where medically necessary for client-owned vehicles.

[Statutory Authority: RCW 74.08.090, 74.09.530. 02-16-054, § 388-543-1300, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-1300, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1400 General reimbursement for DME and related services, prosthetics, orthotics, medical supplies and related services. (1) MAA reimburses a qualified provider who serves a client who is not enrolled in a department-contracted managed care plan only when all of the following apply:

(a) The provider meets all of the conditions in WAC 388-502-0100; and

(b) MAA does not include the item/service for which the provider is requesting reimbursement in other reimbursement rate methodologies. Other methodologies include, but are not limited to, the following:

(i) Hospice providers' per diem reimbursement;

(ii) Hospitals' diagnosis related group (DRG) reimbursement;

(iii) Managed care plans' capitation rate; and

(iv) Nursing facilities' per diem rate.

(2) MAA sets maximum allowable fees for DME and related supplies, prosthetics, orthotics, medical supplies and related services using available published information, such as:

(a) Commercial data bases for price comparisons;

(b) Manufacturers' catalogs;

(c) Medicare fee schedules; and

(d) Wholesale prices.

(3) MAA may adopt policies, procedure codes, and/or rates that are inconsistent with those set by Medicare if MAA determines that such actions are in the best interest of its clients.

(4) MAA updates the maximum allowable fees for DME and supplies and prosthetic/orthotic devices no more than once per year, unless otherwise directed by the legislature. MAA may update the rates for different categories of medical equipment and prosthetic/orthotic devices at different times during the year.

(5) A provider must not bill MAA for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(6) MAA's maximum payment for medical equipment and supplies is the lesser of either of the following:

(a) Providers' **usual and customary charges**; or

(b) Established rates, except as provided in subsection

(7)(a) of this section.

(7) If a client is eligible for both Medicare and Medicaid, the following apply:

(a) MAA requires a provider to accept Medicare assignment before any Medicaid reimbursement;

(b) If the service provided is covered by Medicare and Medicaid, MAA pays:

(i) The deductible and coinsurance up to Medicare's allowed amount or MAA's allowed amount, whichever is less; or

(ii) For services that are not covered by Medicare but are covered by MAA, if medically necessary.

(8) MAA may pay for medical services rendered to a client only when MAA is the payor of last resort.

(9) MAA does not cover medical equipment and/or services provided to a client who is enrolled in a MAA-contracted managed care plan, but did not use one of the plan's participating provider.

(10) See WAC 388-543-2100, 388-543-2500, 388-543-2700, and 388-543-2900 for other reimbursement methodologies.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1400, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1500 When MAA purchases DME and related supplies, prosthetics, and orthotics. (1) Durable medical equipment (DME) and related supplies, prosthetics, and orthotics purchased by MAA for a client is the client's property.

(2) MAA's reimbursement for covered DME and related supplies, prosthetics, and orthotics includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the **date of delivery**. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Fitting and set-up; and

(c) Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

(3) MAA requires a provider to furnish to MAA clients only new equipment that includes full manufacturer and dealer warranties.

(4) MAA requires a dispensing provider to include a warranty on equipment for one year after the date MAA considers rented equipment to be purchased, as provided under WAC 388-543-1700(3).

(5) MAA charges the dispensing provider for any costs it incurs to have another provider repair equipment if all of the following apply:

(a) Any DME that MAA considers purchased according to WAC 388-543-1700 requires repair during the applicable warranty period;

(b) The dispensing provider is unwilling or unable to fulfill the warranty; and

(c) The client still needs the equipment.

(6) MAA charges the dispensing provider fifty percent of the total amount MAA paid toward rental and eventual purchase of the first equipment if the rental equipment must be replaced during the warranty period. All of the following must apply:

(a) Any medical equipment that MAA considers purchased according to WAC 388-543-1700 requires replacement during the applicable warranty period;

(b) The dispensing provider is unwilling or unable to fulfill the warranty; and

(c) The client still needs the equipment.

(7) Purchase orders:

(a) MAA rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

(i) Dies;

(ii) Loses medical eligibility;

(iii) Becomes covered by a hospice agency; or

(iv) Becomes covered by an MAA managed care plan.

Refer to subsection (7)(c) of this section.

(b) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded per (a) of this subsection, MAA may pay the provider an amount it considers appropriate to help defray these extra costs. MAA requires the provider to submit justification sufficient to support such a claim.

(c) A client may become a managed care plan client before MAA completes the purchase of prescribed medical equipment. If this occurs:

(i) MAA rescinds the purchase order until the managed care primary care provider (PCP) evaluates the client; then

(ii) MAA requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 388-500-0005; then

(iii) The managed care plan's applicable reimbursement policies apply to the purchase or rental of the equipment.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1500, filed 12/13/00, effective 1/13/01.]

(2007 Ed.)

WAC 388-543-1600 Items and services which require prior authorization. (1) MAA bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require **prior authorization (PA)** or **expedited prior authorization (EPA)** on utilization criteria. (See WAC 388-543-1000 for PA and WAC 388-543-1800 for EPA.) MAA considers all of the following when establishing utilization criteria:

(a) High cost;

(b) Potential for utilization abuse;

(c) Narrow therapeutic indication; and

(d) Safety.

(2) MAA requires providers to obtain prior authorization for certain items and services. This includes, but is not limited to, the following:

(a) Augmentative communication devices (ACDs);

(b) Certain by report (BR) DME and supplies as specified in MAA's published issuances, including billing instructions and numbered memoranda;

(c) Blood glucose monitors requiring special features;

(d) Certain equipment rentals and certain prosthetic limbs, as specified in MAA's published issuances, including billing instructions and numbered memoranda;

(e) Decubitus care products and supplies;

(g) Decubitus care mattresses, including flotation or gel mattress, if the provider fails to meet the criteria in WAC 388-543-1900;

(g) Equipment parts and labor charges for repairs or modifications and related services;

(h) Hospital beds, if the provider fails to meet the requirements in WAC 388-543-1900;

(i) Low air loss flotation system, if the provider fails to meet the requirements in WAC 388-543-1900;

(j) Orthopedic shoes and selected orthotics;

(k) Osteogenic stimulator, noninvasive, if the provider fails to meet the requirements in WAC 388-543-1900;

(l) Positioning car seats for children under five years of age;

(m) Transcutaneous electrical nerve stimulators, if the provider fails to meet the requirements in WAC 388-543-1900;

(n) Wheelchairs, wheelchair accessories, wheelchair modifications, air, foam, and gel cushions, and repairs;

(o) Wheelchair-style shower/commode chairs;

(p) Other DME not specifically listed in MAA's published issuances, including billing instructions and numbered memoranda, and submitted as a miscellaneous procedure code; and

(q) Limitation extensions.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1600, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1700 When MAA covers rented DME.

(1) MAA's reimbursement amount for rented durable medical equipment (DME) includes all of the following:

(a) Delivery to the client;

(b) Fitting, set-up, and adjustments;

(c) Maintenance, repair and/or replacement of the equipment; and

(d) Return pickup by the provider.

(2) MAA requires a dispensing provider to ensure the DME rented to a MAA client is both of the following:

- (a) In good working order; and
- (b) Comparable to equipment the provider rents to clients with similar medical equipment needs who are either private pay clients or who have other third-party coverage.

(3) MAA considers rented equipment to be purchased after twelve months' rental unless one of the following apply:

- (a) The equipment is restricted as rental only; or
- (b) Other MAA published issuances state otherwise.

(4) MAA rents, but does not purchase, certain medically necessary equipment for clients. This includes, but is not limited to, the following:

- (a) Bilirubin lights for newborns at home with jaundice; and

- (b) Electric breast pumps.

(5) MAA's minimum rental period for covered DME is one day.

(6) If a fee-for-service (FFS) client becomes a managed care plan client, both of the following apply:

(a) MAA stops paying for any rented equipment on the last day of the month preceding the month in which the client becomes enrolled in the managed care plan; and

(b) The plan determines the client's continuing need for the equipment and is responsible for reimbursing the provider.

(7) MAA stops paying for any rented equipment effective the date of a client's death. MAA prorates monthly rentals as appropriate.

(8) For a client who is eligible for both Medicaid and Medicare, MAA pays only the client's coinsurance and deductibles. MAA discontinues paying client's coinsurance and deductibles for rental equipment when either of the following applies:

(a) The reimbursement amount reaches Medicare's reimbursement cap for the equipment; or

(b) Medicare considers the equipment purchased.

(9) MAA does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a MAA client.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1700, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1800 Prior authorization—General policies for DME and related supplies, prosthetics, orthotics, medical supplies and related services. (1) A provider/vendor may obtain **expedited prior authorization (EPA)** from MAA according to WAC 388-543-1900.

(2) For prior authorization requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

(3) When MAA receives an initial request for prior authorization, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.

(4) MAA authorizes BR items that require prior authorization and are listed in MAA's published issuances, including billing instructions and numbered memoranda, only if medi-

cal necessity is established and the provider furnishes all of the following information to MAA:

(a) A detailed description of the item or service to be provided;

(b) The cost or charge for the item;

(c) A copy of the manufacturer's invoice, price-list or catalog with the product description for the item being provided; and

(d) A detailed explanation of how the requested item differs from an already existing code description.

(5) MAA requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

(a) The manufacturer's name;

(b) The equipment model and serial number;

(c) A detailed description of the item; and

(d) Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

(6) MAA prior authorizes payment for repair and modification of client-owned equipment only when the criteria in subsection (1) of this section are met. Requests for repairs must include the information listed in subsection (5) of this section.

(7) MAA does not reimburse for purchase, rental, or repair of medical equipment that duplicates equipment the client already owns or rents. If the requesting provider makes such a request, MAA requires the provider to submit for prior authorization and explain the following:

(a) Why the existing equipment no longer meets the client's medical needs; or

(b) Why the existing equipment could not be repaired or modified to meet those medical needs.

(8) MAA informs the provider and the client of a less costly alternative from MAA's manufacturers' literature on file when an MAA denial of a request is based on a less costly, equally effective alternative.

(9) A provider may resubmit a request for prior authorization for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

(10) MAA authorizes rental equipment for a specific period of time. The provider must request authorization from MAA for any extension of the rental period.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1800, filed 12/13/00, effective 1/13/01.]

WAC 388-543-1900 Expedited prior authorization criteria for DME and related supplies, prosthetics, orthotics, medical supplies, and related services. (1) The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected DME procedure codes. MAA allows payment during a continuous twelve-month period for this process.

(2) MAA requires a provider to create an authorization number for EPA for selected DME procedure codes. The process and criteria used to create the authorization number is explained in MAA published DME-related billing instructions. The authorization number must be used when the provider bills MAA.

(3) The written or telephonic request for prior authorization process must be used when a situation does not meet the criteria for a selected DME code or a requested rental exceeds the limited rental period indicated.

(4) Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA in subsection (2) of this section.

(5) MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-1900, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2000 Wheelchairs. (1) MAA bases its decisions regarding requests for wheelchairs on medically necessity and on a case-by-case basis.

(2) The following apply when MAA determines that a wheelchair is medically necessary for six months or less:

(a) If the client lives at home, MAA rents a wheelchair for the client; or

(b) If the client lives in a nursing facility, the nursing facility must provide a **house wheelchair** as part of the per diem rate paid by AASA.

(3) MAA considers rental or purchase of a **manual wheelchair** for a home client who is nonambulatory or has limited mobility and requires a wheelchair to participate in normal daily activities. MAA determines the type of manual wheelchair based on the following:

(a) A standard wheelchair if the client's medical condition requires the client to have a wheelchair to participate in normal daily activities;

(b) A standard lightweight wheelchair if the client's medical condition is such that the client:

(i) Cannot self-propel a standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight wheelchair.

(c) A high-strength lightweight wheelchair for a client:

(i) Whose medical condition is such that the client cannot self-propel a lightweight or standard weight wheelchair; or

(ii) Requires custom modifications that cannot be provided on a standard weight or lightweight wheelchair.

(d) A heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing up to three hundred pounds; or

(ii) Accommodate a seat width up to twenty-two inches wide (not to be confused with custom heavy duty wheelchairs).

(e) A custom heavy duty wheelchair for a client who requires a specifically manufactured wheelchair designed to:

(i) Support a person weighing over three hundred pounds; or

(ii) Accommodate a seat width over twenty-two inches wide.

(f) A rigid wheelchair for a client:

(i) With a medical condition that involves severe upper extremity weakness;

(ii) Who has a high level of activity; and

(iii) Who is unable to self-propel any of the above categories of wheelchair.

(g) A custom manufactured wheelchair for a client with a medical condition requiring wheelchair customization that cannot be obtained on any of the above categories of wheelchairs.

(4) MAA considers a **power-drive wheelchair** when the client's medical needs cannot be met by a less costly means of mobility. The prescribing physician must certify that the client can safely and effectively operate a power-drive wheelchair and that the client meets all of the following conditions:

(a) The client's medical condition negates his or her ability to self-propel any of the wheelchairs listed in the manual wheelchair category; and

(b) A power-drive wheelchair will provide the client the only means of independent mobility; or

(c) A power-drive wheelchair will enable a child to achieve age-appropriate independence and developmental milestones.

(d) All other circumstances will be considered based on medical necessity and on a case-by-case basis.

(e) The following additional information is required for a three or four-wheeled power-drive scooter/cart:

(i) The prescribing physician certifies that the client's condition is stable; and

(ii) The client is unlikely to require a standard power-drive wheelchair within the next two years.

(5) MAA considers the power-drive wheelchair to be the client's primary chair when the client has both a power-drive wheelchair and a manual wheelchair.

(6) In order to consider purchasing a wheelchair, MAA requires the provider to submit the following information from the prescribing physician, physical therapist, or occupational therapist:

(a) Specific medical justification for the make and model of wheelchair requested;

(b) Define the degree and extent of the client's impairment (such as stage of decubitus, severity of spasticity or flaccidity, degree of kyphosis or scoliosis); and

(c) Documented outcomes of less expensive alternatives (aids to mobility) that have been tried by the client.

(7) In addition to the basic wheelchair, MAA may consider wheelchair accessories or modifications that are specifically identified by the manufacturer as separate line item charges. The provider must submit specific medical justification for each line item, with the modification request.

(8) MAA considers wheelchair modifications to a medically necessary wheelchair when the provider submits all of the following with the modification request:

(a) The make, model, and serial number of the wheelchair to be modified;

(b) The modification requested; and

(c) Specific information regarding the client's medical condition that necessitates the modification.

(9) MAA may consider wheelchair repairs to a medically necessary wheelchair; the provider must submit to MAA the make, model, and serial number of the wheelchair for which the repairs are requested.

(10) MAA may cover two wheelchairs, a manual wheelchair and a power-drive wheelchair, for a noninstitutional-

ized client in certain situations. One of the following must apply:

(a) The architecture of the client's home is completely unsuitable for a power-drive wheelchair, such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radii;

(b) The architecture of the client's home bathroom is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness;

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities; the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. In these cases, MAA requires the client's situation to meet the following conditions:

(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home; and

(ii) Cabulance, public buses, or personal transit are neither available, practical, nor possible for financial or other reasons.

(iii) All other circumstances will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2000, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2100 Wheelchairs—Reimbursement methodology. (1) MAA reimburses a DME provider for purchased wheelchairs for a home or nursing facility client based on the specific brand and model of wheelchair dispensed. MAA decides which brands and/or models of wheelchairs are eligible for reimbursement based on all of the following:

(a) The client's medical needs;

(b) Product quality;

(c) Cost; and

(d) Available alternatives.

(2) For wheelchair rentals and wheelchair accessories (e.g., cushions and backs), MAA uses either:

(a) The Medicare fees that are current on April 1 of each year; or

(b) MAA's maximum allowable reimbursement is based on a percentage of the manufacturer's list price in effect on January 31 of the **base year**, or the invoice for the specific item. MAA uses the following percentages:

(i) For basic standard wheelchairs, sixty-five percent;

(ii) For add-on accessories and parts, eighty-four percent;

(iii) For upcharge modifications and cushions, eighty percent;

(iv) For all other manual wheelchairs, eighty percent; and

(v) For all other power-drive wheelchairs, eighty-five percent.

(3) MAA determines rental reimbursement for categories of manual and power-driven wheelchairs based on average market rental rates or Medicare rates.

(4) MAA evaluates and updates the wheelchair fee schedule once per year.

(5) MAA implements wheelchair rate changes on April 1 of the base year, and the rates are effective until the next rate change.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-083, § 388-543-2100, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2100, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2200 Speech generating devices (SGD). (1) MAA considers all requests for speech generating devices (SGDs) on a case-by-case basis. The SGD requested must be for a severe expressive speech impairment, and the medical condition must warrant the use of a device to replace verbal communication (e.g., to communicate medical information).

(2) In order for MAA to cover an SGD, the SGD must be a speech device intended for use by the individual who has a severe expressive speech impairment, and have one of the following characteristics. For the purposes of this section, MAA uses the Medicare definitions for "digitized speech" and "synthesized speech" that were in effect as of April 1, 2002. The SGD must have:

(a) Digitized speech output, using pre-recorded messages;

(b) Synthesized speech output requiring message formation by spelling and access by physical contact with the device; or

(c) Synthesized speech output, permitting multiple methods of message formulation and multiple methods of device access.

(3) MAA requires a provider to submit a prior authorization request for SGDs. The request must be in writing and contain all of the following information:

(a) A detailed description of the client's therapeutic history, including, at a minimum:

(i) The medical diagnosis;

(ii) A physiological description of the underlying disorder;

(iii) A description of the functional limitations; and

(iv) The prognosis for improvement or degeneration.

(b) A written assessment by a licensed speech language pathologist (SLP) that includes all of the following:

(i) If the client has a physical disability, condition, or impairment that requires equipment, such as a wheelchair, or a device to be specially adapted to accommodate an SGD, an assessment by the prescribing physician, licensed occupational therapist or physical therapist;

(ii) Documented evaluations and/or trials of each SGD that the client has tried. This includes less costly types/models, and the effectiveness of each device in promoting the client's ability to communicate with health care providers, caregivers, and others;

(iii) The current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment;

(iv) An assessment of whether the client's daily communication needs could be met using other natural modes of communication;

(v) A description of the functional communication goals expected to be achieved, and treatment options;

(vi) Documentation that the client's speaking needs cannot be met using natural communication methods; and
 (vii) Documentation that other forms of treatment have been ruled out.

(c) The provider has shown or has demonstrated all of the following:

(i) The client has reliable and consistent motor response, which can be used to communicate with the help of an SGD;

(ii) The client has demonstrated the cognitive and physical abilities to utilize the equipment effectively and independently to communicate; and

(iii) The client's treatment plan includes a training schedule for the selected device.

(d) A prescription for the SGD from the client's treating physician.

(4) MAA may require trial-use rental. All rental costs for the trial-use will be applied to the purchase price.

(5) MAA covers SGDs only once every two years for a client who meets the criteria in subsection (3) of this section. MAA does not approve a new or updated component, modification, or replacement model for a client whose SGD can be repaired or modified. MAA may make exceptions to the criteria in this subsection based strictly on a finding of unforeseeable and significant changes to the client's medical condition. The prescribing physician is responsible for justifying why the changes in the client's medical condition were unforeseeable.

(6) Clients who are eligible for both Medicare and Medicaid must apply first to Medicare for an SGD. If Medicare denies the request and the client requests an SGD from MAA, MAA evaluates the request based on medical necessity and the requirements in this section. The request for an SGD must meet the authorization requirements in this section.

[Statutory Authority: RCW 74.08.090, 74.09.530, 02-16-054, § 388-543-2200, filed 8/1/02, effective 9/1/02; 01-01-078, § 388-543-2200, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2300 Bathroom/shower equipment.

(1) MAA considers a caster-style shower commode chair as the primary option for clients.

(2) MAA considers a wheelchair-style shower commode chair only if the client meets both of the following:

(a) Is able to propel the equipment; and

(b) Has special positioning needs that cannot be met by a caster-style chair.

(3) All other circumstances will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-2300, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2400 Hospital beds. (1) Beds covered by MAA are limited to hospital beds for rental or purchase. MAA bases the decision to rent or purchase a manual, semi-electric, or full electric hospital bed on the length of time the client needs the bed, as follows:

(a) MAA initially authorizes a maximum of two months rental for a short-term need. Upon request, MAA may allow limitation extensions as medically necessary;

(b) MAA determines rental on a month-to-month basis if a client's prognosis is poor;

(2007 Ed.)

(c) MAA considers a purchase if the need is for more than six months;

(d) If the client continues to have a medical need for a hospital bed after six months, MAA may approve rental for up to an additional six months. MAA considers the equipment to be purchased after a total of twelve months' rental.

(2) MAA considers a manual hospital bed the primary option when the client has full-time caregivers.

(3) MAA considers a full electric hospital bed only if the client meets all of the following criteria:

(a) The client's medical need requires the client to be positioned in a way that is not possible in a regular bed;

(b) The position cannot be attained through less costly alternatives (e.g., the use of bedside rails, a trapeze, pillows, bolsters, rolled up towels or blankets);

(c) The client's medical condition requires immediate position changes;

(d) The client is able to operate the controls independently; and

(e) The client needs to be in the **Trendelenburg position**.

(4) All other circumstances for hospital beds will be considered on a case-by-case basis, based on medical necessity.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-2400, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2500 Reimbursement methodology for other durable medical equipment. (1) For the purposes of this section, MAA uses the following terms:

(a) **"Other durable medical equipment (other DME)"** means all durable medical equipment, excluding wheelchairs and related items.

(b) **"Pricing cluster"** means a group of discounted manufacturers' list prices and/or dealer's costs for brands/models of other DME that MAA uses to calculate the reimbursement rate for a procedure code that does not have a fee established by Medicare. MAA uses the discounted manufacturer list price for a brand/model unless that price is not available.

(2) MAA establishes reimbursement rates for purchased other DME.

(a) For other durable medical equipment that have a Medicare rate established for a new purchase, MAA uses the rate that is in effect on January first of the year in which MAA sets the reimbursement.

(b) For other durable medical equipment that do not have a Medicare rate established for a new purchase, MAA uses a pricing cluster to establish the rate.

(3) Establishing a pricing cluster and reimbursement rates.

(a) In order to make up a pricing cluster for a procedure code, MAA determines which brands/models of other DME its clients most frequently use. MAA obtains prices for these brands/models from manufacturer catalogs or commercial data bases. MAA may change or otherwise limit the number of brands/models included in the pricing cluster, based on the following:

(i) Client medical needs;

(ii) Product quality;

(iii) Introduction of new brands/models;

(iv) A manufacturer discontinuing or substituting a brand/model; and/or

(v) Cost.

(b) If a manufacturer list price is not available for any of the brands/models used in the pricing cluster, MAA calculates the reimbursement rate at the manufacturer's published cost to providers plus a thirty-five percent mark-up.

(c) For each brand used in the pricing cluster, MAA discounts the manufacturer's list price by twenty percent.

(i) If six or more brands/models are used in the pricing cluster, MAA calculates the reimbursement rate at the seventh percentile of the pricing cluster.

(ii) If five brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the fourth highest discounted list price, as described in (b) of this subsection.

(iii) If four brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in (b) of this subsection.

(iv) If three brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the third highest discounted list price, as described in (b) of this subsection.

(v) If two or fewer brands/models are used in the pricing cluster, MAA establishes the reimbursement rate at the highest discounted list price, as described in (b) of this subsection.

(4) Rental reimbursement rates for other DME.

(a) MAA sets monthly rental rates at one-tenth of the purchase reimbursement rate as it would be calculated as described in subsections (2) and (3) of this section.

(b) MAA sets daily rental rates at one-three hundredth of the purchase reimbursement rate as it would be calculated as described in subsections (2) and (3) of this section.

(5) MAA annually evaluates and updates reimbursement rates for other DME.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, 03-19-083, § 388-543-2500, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-2500, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2600 Prosthetics and orthotics. (1)

MAA reimburses for prosthetics and orthotics to licensed prosthetic and orthotic providers only. This does not apply to:

(a) Selected prosthetics and orthotics that do not require specialized skills to provide; and

(b) Out-of-state providers, who must meet the licensure requirements of that state.

(2) MAA does not cover prosthetics dispensed for purely cosmetic reasons.

(3) MAA covers a replacement prosthesis only when the purchase of a replacement prosthesis is less costly than repairing or modifying a client's current prosthesis.

(4) MAA requires the client to take responsibility for routine maintenance of a prosthetic or orthotic. If the client does not have the physical or mental ability to perform the task, MAA requires the client's caregiver to be responsible. MAA authorizes extensive maintenance that the manufacturer recommends be performed by an authorized dealer.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-2600, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2700 Prosthetics and orthotics—

Reimbursement. (1) MAA determines reimbursement for prosthetics and orthotics according to a set fee schedule. MAA considers Medicare's current fee schedule when deter-

mining maximum allowable fees. For BR codes, MAA reimburses eighty-five percent of the agreed upon fee.

(2) MAA's reimbursement for a prosthetic or orthotic includes the cost of any necessary molds.

(3) MAA's hospital reimbursement rate includes any prosthetics and/or orthotics required for surgery and/or placed during the hospital stay.

(4) MAA evaluates and updates the maximum allowable fees for prosthetics and orthotics at least once per year, independent of scheduled legislatively authorized vendor rate increases. Rates remain effective until the next rate change.

(5) Reimbursement for prosthetics and orthotics is limited to HCPC/National Codes with the same level of coverage as Medicare.

(6) Reimbursement for gender dyphoria surgery includes payment for all related prosthetics and supplies.

[Statutory Authority: RCW 74.08.090, 74.09.530, 01-01-078, § 388-543-2700, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2800 Reusable and disposable medical supplies. (1)

MAA requires that a physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PAC) prescribe reusable and disposable medical supplies. Except for dual eligible Medicare/Medicaid clients, the prescription must:

(a) Be dated and signed by the prescriber;

(b) Be less than six months in duration from the date the prescriber signs the prescription; and

(c) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(2) MAA bases its determination about which DME and related supplies, prosthetics, orthotics, medical supplies and related services require prior authorization (PA) or expedited prior authorization (EPA) on utilization criteria (see WAC 388-543-1000 for PA and WAC 388-543-1800 for EPA). MAA considers all of the following when establishing utilization criteria:

(a) High cost;

(b) The potential for utilization abuse;

(c) A narrow therapeutic indication; and

(d) Safety.

(3) MAA requires a provider to obtain a limitation extension in order to exceed the stated limits for nondurable medical equipment and medical supplies. See WAC 388-501-0165.

(4) MAA categorizes medical supplies and non-DME (MSE) as follows (see WAC 388-543-1150, 388-543-1600, and MAA's billing instructions for further information about specific limitations and requirements for PA and EPA):

(a) Antiseptics and germicides;

(b) Bandages, dressings, and tapes;

(c) Blood monitoring/testing supplies;

(d) Braces, belts, and supportive devices;

(e) Decubitus care products;

(f) Ostomy supplies;

(g) Pregnancy-related testing kits and nursing equipment supplies;

(h) Supplies associated with transcutaneous electrical nerve stimulators (TENS);

(i) Syringes and needles;

- (j) Urological supplies (e.g., diapers, urinary retention catheters, pant liners, and doublers); and
- (k) Miscellaneous supplies.

[Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. 05-21-102, § 388-543-2800, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.08.090, 74.09.530. 01-16-141, § 388-543-2800, filed 7/31/01, effective 8/31/01; 01-01-078, § 388-543-2800, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2900 Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology. (1) MAA determines rates for each category of medical supplies and non-DME (MSE) using either the:

- (a) Medicare fee schedule; or
 - (b) Manufacturers' catalogs and commercial data bases for price comparisons.
- (2) MAA evaluates and updates the maximum allowable fees for MSE as follows:

(a) MAA sets the maximum allowable fees for new MSE using one of the following:

- (i) Medicare's fee schedule; or
- (ii) For those items without a Medicare fee, commercial data bases to identify brands to make up MAA's pricing cluster. MAA establishes the fee for products in the pricing cluster by using the lesser of either:

- (A) Eighty-five percent of the average manufacturer's list price; or
- (B) One hundred twenty-five percent of the average dealer cost.

(b) All the brands for which MAA obtains pricing information make up MAA's pricing cluster. However, MAA may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients. MAA considers all of the following:

- (i) A client's medical needs;
 - (ii) Product quality;
 - (iii) Cost; and
 - (iv) Available alternatives.
- (3) MAA's nursing facility per diem rate includes any reusable and disposable medical supplies that may be required for a nursing facility client. MAA may reimburse the following medical supplies separately for a client in a nursing facility:

(a) Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to the following:

- (i) Colostomy and other ostomy bags and necessary supplies; and
 - (ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies;
- (b) Supplies for intermittent catheterization programs, for the following purposes:

- (i) Long term treatment of atonic bladder with a large capacity; and
 - (ii) Short term management for temporary bladder atony; and
- (c) Surgical dressings required as a result of a surgical procedure, for up to six weeks after surgery.

(2007 Ed.)

(4) MAA considers decubitus care products to be included in the nursing facility per diem rate and does not reimburse for these separately.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-083, § 388-543-2900, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2900, filed 12/13/00, effective 1/13/01.]

WAC 388-543-3000 DME and supplies provided in physician's office. MAA does not pay a DME provider for medical supplies used in conjunction with a physician office visit. MAA pays the office physician for these supplies, as stated in the RBRVS, when it is appropriate.

[Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-3000, filed 12/13/00, effective 1/13/01.]

Chapter 388-544 WAC

VISION AND HEARING AID SERVICES

WAC

VISION CARE

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HEARING AID SERVICES

388-544-1010	Definitions.
388-544-1100	Hearing aid services—General.
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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-544-0200	Vision care services MAA covers without MAA's prior authorization. [Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0200, filed 12/6/00, effective 1/6/01.] Repealed by 05-13-038, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225.
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VISION CARE

WAC 388-544-0010 Vision care—General. (1) The department covers vision care services subject to the exceptions, restrictions, and limitations listed in this chapter. Vision care is covered when it is:

- (a) Within the scope of the eligible client's medical care program (see WAC 388-501-0060 and 388-501-0065); and
- (b) Medically necessary as defined in WAC 388-500-0005.

(2) The department evaluates a request for any service that is listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

(3) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions under the provisions of WAC 388-501-0169.

(4) The department evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational under WAC 388-531-0550, under the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-544-0010, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0010, filed 6/6/05, effective 7/7/05.]

WAC 388-544-0050 Vision care—Definitions. The following definitions and those found in WAC 388-500-0005 apply to this chapter. Unless otherwise defined in this chapter, medical terms are used as commonly defined within the scope of professional medical practice in the state of Washington.

"Blindness" - A diagnosis of visual acuity for distance vision of twenty/two hundred or worse in the better eye with best correction or a limitation of the client's visual field (widest diameter) subtending an angle of less than twenty degrees from central.

"Conventional soft contact lenses" or **"rigid gas permeable contact lenses"** - FDA-approved contact lenses that do not have a scheduled replacement (discard and replace with new contacts) plan. The soft lenses usually last one year, and the rigid gas permeable lenses usually last two years. Although some of these lenses are designed for extended wear, MAA generally approves only those lenses that are designed to be worn as daily wear (remove at night).

"Disposable contact lenses" - FDA-approved contact lenses that have a planned replacement schedule (e.g., daily, every two weeks, monthly, quarterly). The contacts are then discarded and replaced with new ones as scheduled. Although many of these lenses are designed for extended wear, MAA generally approves only those lenses that are designed to be worn as daily wear (remove at night).

"Extended wear soft contacts" - Contact lenses that are designed to be worn for longer periods than daily wear (remove at night) lenses. These can be conventional soft contact lenses or disposable contact lenses designed to be worn for several days and nights before removal.

"Hardware" - Eyeglass frames and lenses and contact lenses.

"Specialty contact lens design" - Custom contact lenses that have a more complex design than a standard spherical lens. These specialty contact lenses (e.g., lenticular, aspheric, or myodisc) are designed for the treatment of specific disease processes, such as keratoconus, or are required due to high refractive errors. This definition of specialty contact lens does not include lenses used for surgical implantation.

"Stable visual condition" - A client's eye condition has no acute disease or injury; or the client has reached a point after any acute disease or injury where the variation in need

for refractive correction has diminished or steadied. The client's vision condition has stabilized to the extent that eyeglasses or contact lenses are appropriate and that any prescription for refractive correction is likely to be sufficient for one year or more.

"Visual field exams or testing" - A process to determine defects in the field of vision and test the function of the retina, optic nerve and optic pathways. The process may include simple confrontation to increasingly complex studies with sophisticated equipment.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0050, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0050, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0100 Vision care—Eligible clients. (1) Clients who receive services under the following medical assistance programs are eligible for covered vision care:

- (a) **Categorically needy** program (CN or CNP);
- (b) **Categorically needy** program - children's health insurance program (CNP-CHIP);
- (c) **Limited casualty** program - medically needy program (LCP-MNP);
- (d) **General assistance** (GA-U/ADATSA) (within Washington state or designated border cities); and
- (e) **Emergency medical only** programs when the services are directly related to an emergency medical condition only.

(2) Clients who are enrolled in an MAA managed care plan are eligible under fee-for-service for covered vision care services that are not covered by their plan, subject to the provisions of chapter 388-544 WAC and other applicable WAC.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0100, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0100, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0150 Vision care—Provider requirements. (1) Enrolled/contracted eye care providers must:

- (a) Meet the requirements in chapter 388-502 WAC;
- (b) Provide only those services that are within the scope of the provider's license;
- (c) Obtain all hardware and contact lenses for MAA clients from MAA's contracted supplier; and
- (d) Return all unclaimed hardware and contact lenses to MAA's contracted supplier using a postage-paid envelope furnished by the contractor.

(2) The following providers are eligible to enroll/contract with MAA to provide and bill for vision care services furnished to eligible clients:

- (a) Ophthalmologists;
- (b) Optometrists;
- (c) Opticians; and
- (d) Ocularists.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0150, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0150, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0250 Vision care—Covered eye services (examinations and refractions). (1) The medical assistance administration (MAA) covers eye examinations and refraction services for asymptomatic clients under the

following conditions and limitations, unless the circumstances in subsections (2) or (3) of this section apply:

(a) For clients twenty-one years of age or older, once every twenty-four months;

(b) For clients twenty years of age or younger, once every twelve months; or

(c) For clients with developmental disabilities, regardless of age, once every twelve months.

(2) MAA covers eye examinations and refraction services as often as medically necessary when:

(a) The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease; or

(b) The client is on medication that affects vision.

(3) MAA covers eye examinations/refractions outside the time limitations in subsection (1) of this section when the eye examination/refraction is necessary due to lost or broken eyeglasses/contacts. In this situation, MAA does not require authorization for children. To receive payment for an adult client, providers must:

(a) Follow the expedited prior authorization process; and

(b) Document the following in the client's file:

(i) The eyeglasses or contacts are lost or broken; and

(ii) The last examination was at least eighteen months ago.

(4) MAA covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. To receive payment, providers must document all of the following in the client's record:

(a) The extent of the testing;

(b) Why the testing was reasonable and necessary for the client; and

(c) The medical basis for the frequency of testing.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0250, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0250, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0300 Vision care—Covered eyeglasses (frames and/or lenses) and repair services. (1) The medical assistance administration (MAA) covers eyeglasses for asymptomatic clients:

(a) Under the following conditions and limitations:

(i) For clients twenty-one years of age or older, once every twenty-four months;

(ii) For clients twenty years of age or younger, once every twelve months; or

(iii) For clients with developmental disabilities, regardless of age, once every twelve months.

(b) When:

(i) The client has a stable visual condition;

(ii) The client's treatment is stabilized;

(iii) The prescription is less than eighteen months old; and

(iv) One of the following minimum correction needs in a least one eye is documented in the client's file:

(A) Sphere power equal to, or greater than, plus or minus 0.50 diopter;

(B) Astigmatism power equal to, or greater than, plus or minus 0.50 diopter; or

(2007 Ed.)

(C) Add power equal to, or greater than, 1.0 diopter for bifocals and trifocals.

(2) MAA covers eyeglasses and/or lenses for clients who are twenty years of age or younger with a diagnosis of accommodative esotropia or any strabismus correction. In this situation, the client is not subject to the requirements in subsection (1)(b) of this section.

(3) MAA covers selected frames called "durable" or "flexible" frames through MAA's contracted supplier when a client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a twelve-month period. To receive payment, providers must follow the expedited prior authorization process.

(4) MAA covers the cost of coating contract eyeglass frames to make the frames nonallergenic if the client has a medically diagnosed and documented allergy to the materials in the available eyeglass frames.

(5) MAA pays for incidental repairs to a client's eyeglass frames when all of the following apply:

(a) The provider typically charges the general public for the repair or adjustment;

(b) The contractor's one year warranty period has expired; and

(c) The cost of the repair does not exceed MAA's cost for replacement frames.

(6) MAA covers replacement eyeglass frames and/or lenses that have been lost or broken. To receive payment, providers must follow the expedited prior authorization process for clients twenty-one years of age and older. MAA does not require authorization for clients who are twenty years of age and younger or for clients with developmental disabilities, regardless of age. (See WAC 388-544-0350 for additional coverage of lens replacement.)

(7) MAA covers one pair of back-up eyeglasses when contact lenses are medically necessary and the contact lenses are the client's primary visual correction aid as described in WAC 388-544-0400(1). MAA limits coverage for back-up eyeglasses as follows:

(a) For clients twenty-one years of age and older, once every six years;

(b) For clients twenty years of age or younger, once every two years; or

(c) For clients with developmental disabilities, regardless of age, once every two years.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0300, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0300, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0350 Vision care—Covered plastic scratch-resistant eyeglass lenses and services. (1) The medical assistance administration (MAA) covers the following plastic scratch-resistant eyeglass lenses:

(a) Single vision lenses;

(b) Round or flat top D-style bifocals;

(c) Flat top trifocals; and

(d) Slab-off and prism lenses (including Fresnel lenses).

(2) MAA allows bifocal lenses to be replaced with single vision or trifocal lenses or trifocal lenses to be replaced with bifocal or single vision lenses when all of the following apply:

- (a) A client has attempted to adjust to the bifocals or trifocals for at least sixty days;
- (b) The client is unable to make the adjustment; and
- (c) The bifocal or trifocal lenses being replaced are returned to the provider.

(3) MAA covers high index lenses for clients who require one of the following in at least one eye:

- (a) A spherical refractive correction of plus or minus eight diopters or greater; or
- (b) A cylinder correction of plus or minus three diopters or greater.

To receive payment, providers must follow the expedited prior authorization process.

(4) MAA covers the tinting of plastic lenses through MAA's contracted lens supplier. The client's medical need must be diagnosed and documented as one or more of the following chronic (expected to last longer than three months) eye conditions causing photophobia:

- (a) Blindness;
- (b) Chronic corneal keratitis;
- (c) Chronic iritis, iridocyclitis;
- (d) Diabetic retinopathy;
- (e) Fixed pupil;
- (f) Glare from cataracts;
- (g) Macular degeneration;
- (h) Migraine disorder;
- (i) Ocular albinism;
- (j) Optic atrophy and/or optic neuritis;
- (k) Rare photo-induced epilepsy conditions; or
- (l) Retinitis pigmentosa.

(5) MAA covers plastic photochromatic lenses when the client's medical need is diagnosed as relating to ocular albinism or retinitis pigmentosa.

(6) MAA covers polycarbonate lenses as follows:

- (a) For clients who are blind in one eye and need protection for the other eye, regardless of whether a vision correction is required;
- (b) Infants and toddlers with motor ataxia;
- (c) For clients twenty years of age or younger who are diagnosed with strabismus or amblyopia; or
- (d) For clients with developmental disabilities.

(7) MAA covers requests for lenses only when the client owns frames not purchased by MAA, when:

- (a) The eyeglass frames are serviceable (MAA and MAA's contractor do not accept responsibility for these frames); and
- (b) The size and style of the required lenses meet MAA's contract requirements.

(8) MAA covers replacement lenses as follows:

- (a) Due to lost or broken lenses according to WAC 388-544-0300(6); and
- (b) Due to refractive changes, without regard to time limits, when caused by one of the following:

(i) Eye surgery, the effects of prescribed medication, or one or more diseases affecting vision. In this case, all of the following must be documented in the client's file:

- (A) The client has a stable visual condition;
- (B) The client's treatment is stabilized;
- (C) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; and

(D) The previous and new refraction.

(ii) Headaches, blurred vision, or difficulty with school or work. In this case, all of the following must be documented in the client's file:

(A) Copy of current prescription (less than eighteen months old);

(B) Date of last dispensing, if known;

(C) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g., diabetes, pregnancy, etc.); and

(D) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

(c) To receive payment for replacement lenses, providers must follow the expedited prior authorization process.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520, and 42 C.F.R. 440.120 and 440.225. 05-17-153, § 388-544-0350, filed 8/22/05, effective 9/22/05; 05-13-038, § 388-544-0350, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0350, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0400 Vision care—Covered contact lenses and services. (1) The medical assistance administration (MAA) covers the following types of contact lenses as the client's primary refractive correction method when a client has a spherical correction of plus or minus 6.0 diopters or greater in at least one eye. In order to qualify for the spherical correction, the prescription may be from either the glasses or the contact lenses prescriptions and/or written in either "minus cyl" or "plus cyl" form. See subsection (2) of this section for exception to the plus or minus 6.0 diopter criteria.

(a) Conventional soft contact lenses or rigid gas permeable contact lenses that are prescribed for daily wear; or

(b) Disposable contact lenses that are prescribed for daily wear and have a monthly or quarterly planned replacement schedule, as follows:

- (i) Twelve pairs of monthly replacement contact lenses; or
- (ii) Four pairs of three-month replacement contact lenses.

(2) For clients diagnosed with high anisometropia, MAA covers the contact lenses in subsection (1) of this section when the client's refractive error difference between the two eyes is plus or minus 3.0 diopters and eyeglasses cannot reasonably correct the refractive errors.

(3) A client who qualifies for contact lenses as the primary refractive correction method must choose one style of contact lenses from those listed in subsection (1) of this section for each twelve-month period of coverage.

(4) MAA covers soft toric contact lenses for clients with astigmatism requiring a cylinder correction of plus or minus 1.0 diopter in at least one eye and the client also meets the spherical correction listed in subsection (1) of this section.

(5) MAA covers specialty contact lens designs for clients who are diagnosed with one or more of the following:

- (a) Aphakia;
 - (b) Keratoconus; or
 - (c) Corneal softening.
- (6) MAA covers replacement contact lenses as follows:
- (a) Once every twelve months for lost or damaged contact lenses; or

(b) As often as medically necessary when all of the following apply:

(i) One of the following caused the vision change:

- (A) Eye surgery;
- (B) The effect(s) of prescribed medication; or
- (C) One or more diseases affecting vision.

(ii) The client has a stable visual condition;

(iii) The client's treatment is stabilized; and

(iv) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction. The previous and new refraction must be documented in the client's record.

(c) To receive payment for adults, providers must follow the expedited prior authorization process. Prior authorization is not required for children or for clients with developmental disabilities.

(7) MAA covers therapeutic contact bandage lenses only when needed immediately after eye injury or eye surgery.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0400, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0400, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0450 Vision care—Prior authorization. (1) The department requires a provider to follow the prior authorization and expedited prior authorization (EPA) process for certain vision care services as identified in this chapter.

(2) For prior authorization (PA), a provider must call or send the department a fax using the appropriate telephone or fax number listed in the department's published vision care billing instructions.

(3) For expedited prior authorization (EPA), a provider must create an EPA number. The process and criteria used to create this authorization number are explained in the department's published vision care billing instructions. The EPA number must be used when the provider bills the department.

(4) The department denies payment for vision care submitted without the required PA or EPA number, or the appropriate diagnosis or procedure code as indicated by the EPA number.

(5) Upon request, a provider must provide documentation to the department showing how the client's condition met the criteria for PA or EPA.

(6) The department may recoup any payment made to a provider under this chapter if the department later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 388-502-0100 (1)(c).

(7) When a client's situation does not meet the EPA criteria for vision care, or a requested service or item exceeds the limit indicated in this chapter, a provider must follow the requirements of WAC 388-501-0165 and 388-501-0169.

(8) The department evaluates a request for any service that is listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-544-0450, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0450, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0450, filed 12/6/00, effective 1/6/01.]

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WAC 388-544-0475 Vision care—Noncovered services, eyeglasses, and contact lenses. The medical assistance administration (MAA) does not cover the following:

- (1) Executive style eyeglass lenses;
- (2) Bifocal contact lenses;
- (3) Daily and two week disposable contact lenses;
- (4) Extended wear soft contact lenses, except when used as therapeutic contact bandage lenses or for aphakic clients;
- (5) Services for cosmetic purposes only;
- (6) Glass lenses including those that darken when exposed to light;
- (7) Group vision screening for eyeglasses;
- (8) Nonglare or anti-reflective lenses;
- (9) Orthoptics and visual training therapy;
- (10) Progressive lenses;
- (11) Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens corrections. This does not include intraocular lens implantation following cataract surgery.

(12) Sunglasses and accessories that function as sunglasses (e.g., "clip-ons");

(13) Upgrades at private expense to avoid MAA's contract limitations (e.g., frames that are not available through MAA's contract or noncontract frames or lenses for which the client or other person pays the difference between MAA's payment and the total cost).

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0475, filed 6/6/05, effective 7/7/05.]

WAC 388-544-0500 Vision care—Ocular prosthetics. The medical assistance administration (MAA) covers medically necessary ocular prosthetics when provided by any of the following:

- (1) An ophthalmologist;
- (2) An ocularist; or
- (3) An optometrist who specializes in orthotics.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0500, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0550 Vision care—Surgery. (1) The medical assistance administration (MAA) covers cataract surgery when:

- (a) It is included in the scope of care for the client's medical program;
- (b) It is medically necessary as defined in subsection (2) of this section; and
- (c) The provider clearly documents the need in the client's record.

(2) MAA considers cataract surgery to be medically necessary when the client has:

- (a) Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or
- (b) One or more of the following conditions:
 - (i) Dislocated or subluxated lens;
 - (ii) Intraocular foreign body;
 - (iii) Ocular trauma;
 - (iv) Phacogenic glaucoma;

- (v) Phacogenic uveitis;
- (vi) Phacoanaphylactic endophthalmitis; or
- (vii) Increased ocular pressure in a person who is blind and is experiencing ocular pain.

(3) MAA covers strabismus surgery as follows:

(a) For clients seventeen years of age and younger, when medically necessary. The provider must clearly document the need in the client's record.

(b) For clients eighteen years of age and older when:

- (i) The client has double vision; and
- (ii) The surgery is not performed for cosmetic reasons.

(c) To receive payment for clients eighteen years of age and older, providers must follow MAA's expedited prior authorization process listed in WAC 388-544-0450. MAA does not require authorization for clients seventeen years of age and younger.

(4) MAA covers blepharoplasty or blepharoptosis surgery for noncosmetic reasons when:

(a) The excess upper eyelid skin impairs the vision by blocking the superior visual field; and

(b) The vision is blocked to within ten degrees of central fixation using a central visual field test.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0550, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0550, filed 12/6/00, effective 1/6/01.]

WAC 388-544-0600 Vision care—Payment methodology. (1) In order to receive payment, vision care providers must bill the medical assistance administration (MAA) according to the conditions of payment under WAC 388-502-0020 (1)(a) through (c) and WAC 388-502-0100 and MAA's published billing instructions.

(2) MAA covers one hundred percent of the MAA contract price for eyeglass frames, lenses, and contact lenses when these items are obtained through MAA's approved contract(s).

(3) See WAC 388-531-1850 for professional fee payment methodology.

[Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.520 and 42 C.F.R. 440.120 and 440.225. 05-13-038, § 388-544-0600, filed 6/6/05, effective 7/7/05. Statutory Authority: RCW 74.08.090, 74.09.510 and 74.09.520. 01-01-010, § 388-544-0600, filed 12/6/00, effective 1/6/01.]

HEARING AID SERVICES

WAC 388-544-1010 Definitions. "Expedited prior authorization" (EPA) means a process designed by MAA to eliminate the need for written prior authorization (see definition for "prior authorization"). MAA establishes authorization criteria and identifies these criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

"FM systems" means a hearing device that uses a frequency modulated radio signal. FM systems are sometimes referred to as radio frequency (RF) aids.

"Limitation extension" (LE) means prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in WAC or in MAA billing instructions.

[Title 388 WAC—p. 1080]

"Maximum allowable fee" means the maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

"Prior authorization" means MAA and/or department of health approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1010, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1100 Hearing aid services—General.

(1) The department covers only the hearing aid services listed in this chapter, subject to the exceptions, restrictions, and limitations listed in this chapter.

(2) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 388-501-0169.

(3) The department evaluates requests for any service listed as noncovered in this chapter under the provisions in WAC 388-501-0160.

(4) The department reimburses providers at the maximum allowable rates established by the department.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.-700. 06-24-036, § 388-544-1100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1100, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1200 Hearing aid services—For adults. This section applies to medical assistance clients eighteen years of age or older:

(1) MAA covers the purchase of one new, nonrefurbished hearing aid for an adult client every five years if all of the following conditions are met:

(a) The client must be:

- (i) Eighteen years of age or older; and
- (ii) Eligible for the categorically needy program or the medical care services program.

(b) The client must either:

(i) Have an average hearing of fifty decibel hearing level (dBHL) in the better ear based on auditory screening by a certified audiologist or licensed hearing instrument fitter/dispatcher at one thousand, two thousand, three thousand, and four thousand Hertz (Hz) with effective masking as indicated; or

(ii) Be referred by a screening provider under the Healthy Kids/early and periodic screening, diagnosis, and treatment (EPSDT) program (only for clients eighteen to twenty years old).

(c) The client's current hearing aid, if the client has one, is not sufficient for the hearing loss in the better ear.

(d) The hearing aid must be:

(i) Medically necessary as defined in WAC 388-500-0005; and

(ii) Warranted for one year.

(2) Reimbursement for hearing aids includes:

- (a) A prefitting evaluation;
- (b) An ear mold; and
- (c) A minimum of three post-fitting consultations.

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- (3) MAA covers the repair of a hearing aid when the:
 - (a) Initial one-year warranty has expired;
 - (b) Client continues to meet the criteria in subsection (1) of this section;
 - (c) Cost of repair is less than fifty percent of the cost of a new hearing aid;
 - (d) Provider has documented the repair and replacement costs; and
 - (e) Repair is warranted for ninety days.
- (4) MAA covers the cost of renting a hearing aid for up to two months while the client's own hearing aid is being repaired.
- (5) MAA covers one replacement hearing aid in a five year period when the:
 - (a) Hearing aid is lost or broken beyond repair;
 - (b) Client continues to meet the criteria in subsection (1) of this section; and
 - (c) Provider has documented the necessity for the replacement.
- (6) MAA covers replacement of ear molds as follows:
 - (a) Once a year for soft ear molds; and
 - (b) Once every three years for hard ear molds.
- (7) Prior MAA authorization is required for the following services for adults:
 - (a) Bone conduction hearing aids; and
 - (b) Binaural hearing aids.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1200, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1300 Hearing aid services—For children. This section applies to medical assistance clients seventeen years of age or younger:

- (1) MAA covers the purchase of new, nonrefurbished hearing aids for children if all of the following conditions in subsections (1)(a) and (1)(b) are met:
 - (a) The child must:
 - (i) Be seventeen years of age or under;
 - (ii) Be eligible for any MAA medical program, except medically indigent program (MIP) and family planning only program; and
 - (iii) Have prior authorization from the child's local department of health's (DOH) children with special health care needs (CSHCN) coordinator to receive a hearing aid.
 - (b) The hearing aid must be:
 - (i) Medically necessary as defined in WAC 388-500-0005; and
 - (ii) Warranted for one year.
- (2) Reimbursement for hearing aids includes:
 - (a) A prefitting evaluation;
 - (b) An ear mold for in-the-ear (ITE) hearing aids; and
 - (c) A minimum of three post-fitting consultations.
- (3) MAA covers the repair of a hearing aid when the:
 - (a) Client's local CSHCN coordinator authorizes the repair;
 - (b) Initial one-year warranty has expired;
 - (c) Client continues to meet the criteria in subsection (1) of this section;
 - (d) Cost of repair is less than fifty percent of the cost of a new hearing aid;
 - (e) Provider has documented the repair and replacement costs; and

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- (f) Repair is warranted for ninety days.
- (4) MAA covers the cost of renting a hearing aid while the client's own hearing aid is being repaired when the rental is authorized for ninety days.
- (5) MAA covers replacement of a hearing aid when the:
 - (a) Client's local CSHCN coordinator authorizes the replacement;
 - (b) Client continues to meet the criteria in subsection (1) of this section;
 - (c) Hearing aid is lost or broken beyond repair; and
 - (d) Provider has documented the necessity for the replacement.
- (6) MAA covers replacement of hard and soft ear molds when the replacement is authorized by the client's local CSHCN coordinator.
- (7) All hearing aid equipment and services for children require prior authorization from the client's local CSHCN coordinator, except FM systems which require prior authorization from MAA.

[Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1300, filed 11/15/00, effective 12/16/00.]

WAC 388-544-1400 Hearing aid services—Noncovered services. (1) The department does not cover any of the following:

- (a) The purchase of batteries, ear trumpets, or tinnitus maskers;
- (b) Group screenings for hearing loss, except as provided under the Healthy Kids/EPSDT program under WAC 388-534-0100;
- (c) Computer-aided hearing devices used in school;
- (d) Hearing aid charges reimbursed by insurance or other payer source;
- (e) Digital hearing aids; or
- (f) FM systems or programmable hearing aids for:
 - (i) Adults;
 - (ii) Children when the device is used in school; or
 - (iii) Children whose hearing loss is adequately improved with hearing aids.

(2) The department evaluates a request for any service listed in this section as noncovered under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-544-1400, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1400, filed 11/15/00, effective 12/16/00.]

Chapter 388-545 WAC THERAPIES

WAC

388-545-300	Occupational therapy.
388-545-500	Physical therapy.
388-545-700	Speech/audiology services.
388-545-900	Neurodevelopmental centers.

WAC 388-545-300 Occupational therapy. (1) The following providers are eligible to enroll with medical assistance administration (MAA) to provide occupational therapy services:

- (a) A licensed occupational therapist;

(b) A licensed occupational therapy assistant supervised by a licensed occupational therapist; and

(c) An occupational therapy aide, in schools, trained and supervised by a licensed occupational therapist.

(2) Clients in the following MAA programs are eligible to receive occupational therapy services described in this chapter:

(a) Categorically needy;

(b) Children's health;

(c) General assistance unemployable (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program for emergency hospital-based services only; or

(f) Medically needy program only when the client is either:

(i) Twenty years of age or younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program (healthy kids program) as described in chapter 388-534 WAC; or

(ii) Receiving home health care services as described in chapter 388-551 WAC, subchapter II.

(3) Occupational therapy services received by MAA eligible clients must be provided:

(a) As part of an outpatient treatment program for adults and children;

(b) By a home health agency as described under chapter 388-551 WAC, subchapter II;

(c) As part of the physical medicine and rehabilitation (PM&R) program as described in WAC 388-550-2551;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education program or individualized family service plan as described in WAC 388-537-0100; or

(f) When prescribed by a provider for clients age twenty-one or older. The therapy must:

(i) Prevent the need for hospitalization or nursing home care;

(ii) Assist a client in becoming employable;

(iii) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(iv) Be a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(4) MAA pays only for covered occupational therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary, when prescribed by a provider; and

(c) Begun within thirty days of the date prescribed.

(5) MAA covers the following occupational therapy services per client, per calendar year:

(a) Unlimited occupational therapy program visits for clients twenty years of age or younger;

(b) One occupational therapy evaluation. The evaluation is in addition to the twelve program visits allowed per year;

(c) Two durable medical equipment needs assessments. The assessments are in addition to the twelve program visits allowed per year;

(d) Twelve occupational therapy program visits;

(e) Twenty-four additional outpatient occupational therapy program visits when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement;

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(f) Twenty-four additional occupational therapy program visits following a completed and approved inpatient PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of function due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quads only;

(ix) Bilateral limb loss; or

(x) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(g) Additional medically necessary occupational therapy services, regardless of the diagnosis, must be approved by MAA.

(6) MAA will pay for one visit to instruct in the application of transcutaneous neurostimulator (TENS), per client, per lifetime.

(7) MAA does not cover occupational therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-545-300, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520, 99-16-068, § 388-545-300, filed 8/2/99, effective 9/2/99.]

WAC 388-545-500 Physical therapy. (1) The following providers are eligible to provide physical therapy services:

(a) A licensed physical therapist or physiatrist; or

(b) A physical therapist assistant supervised by a licensed physical therapist.

(2) Clients in the following MAA programs are eligible to receive physical therapy services described in this chapter:

(a) Categorically needy (CN);

(b) Children's health;

(c) General assistance-unemployable (GA-U) (within Washington state or border areas only);

(d) Alcoholism and drug addiction treatment and support act (ADATSA) (within Washington state or border areas only);

(e) Medically indigent program (MIP) for emergency hospital-based services only; or

(f) Medically needy program (MNP) only when the client is either:

(i) Twenty years of age or younger and referred under the early and periodic screening, diagnosis and treatment program (EPSDT/healthy kids program) as described in WAC 388-86-027; or

(ii) Receiving home health care services as described in chapter 388-551 WAC.

(3) Physical therapy services that MAA eligible clients receive must be provided as part of an outpatient treatment program:

(a) In an office, home, or outpatient hospital setting;

(b) By a home health agency as described in chapter 388-551 WAC;

(c) As part of the acute physical medicine and rehabilitation (acute PM&R) program as described in the acute PM&R subchapter under chapter 388-550 WAC;

(d) By a neurodevelopmental center;

(e) By a school district or educational service district as part of an individual education or individualized family service plan as described in WAC 388-537-0100; or

(f) For disabled children, age two and younger, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

(4) MAA pays only for covered physical therapy services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary and ordered by a physician, physician's assistant (PA), or an advanced registered nurse practitioner (ARNP);

(c) Begun within thirty days of the date ordered;

(d) For conditions which are the result of injuries and/or medically recognized diseases and defects; and

(e) Within accepted physical therapy standards.

(5) Providers must document in a client's medical file that physical therapy services provided to clients age twenty-one and older are medically necessary. Such documentation may include justification that physical therapy services:

(a) Prevent the need for hospitalization or nursing home care;

(b) Assist a client in becoming employable;

(c) Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or

(d) Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(6) MAA determines physical therapy program units as follows:

(a) Each fifteen minutes of timed procedure code equals one unit; and

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(7) MAA does not limit coverage for physical therapy services listed in subsections (8) through (10) of this section if the client is twenty years of age or younger.

(8) MAA covers, without requiring prior authorization, the following ordered physical therapy services per client, per diagnosis, per calendar year, for clients twenty-one years of age and older:

(a) One physical therapy evaluation. The evaluation is in addition to the forty-eight program units allowed per year;

(b) Forty-eight physical therapy program units;

(c) Ninety-six additional outpatient physical therapy program units when the diagnosis is any of the following:

(i) A medically necessary condition for developmentally delayed clients;

(ii) Surgeries involving extremities, including:

(A) Fractures; or

(B) Open wounds with tendon involvement.

(iii) Intracranial injuries;

(iv) Burns;

(v) Traumatic injuries;

(vi) Meningomyelocele;

(vii) Down's syndrome;

(viii) Cerebral palsy; or

(ix) Symptoms involving nervous and musculoskeletal systems and lack of coordination;

(d) Two durable medical equipment (DME) needs assessments. The assessments are in addition to the forty-eight physical therapy program units allowed per year. Two program units are allowed per DME needs assessment; and

(e) One wheelchair needs assessment in addition to the two durable medical needs assessments. The assessment is in addition to the forty-eight physical therapy program units allowed per year. Four program units are allowed per wheelchair needs assessment.

(f) The following services are allowed, per day, in addition to the forty-eight physical therapy program units allowed per year:

(i) Two program units for orthotics fitting and training of upper and/or lower extremities.

(ii) Two program units for checkout for orthotic/prosthetic use.

(iii) One muscle testing procedure. Muscle testing procedures cannot be billed in combination with each other.

(g) Ninety-six additional physical therapy program units are allowed following a completed and approved inpatient acute PM&R program. In this case, the client no longer needs nursing services but continues to require specialized outpatient physical therapy for any of the following:

(i) Traumatic brain injury (TBI);

(ii) Spinal cord injury (paraplegia and quadriplegia);

(iii) Recent or recurrent stroke;

(iv) Restoration of the levels of functions due to secondary illness or loss from multiple sclerosis (MS);

(v) Amyotrophic lateral sclerosis (ALS);

(vi) Cerebral palsy (CP);

(vii) Extensive severe burns;

(viii) Skin flaps for sacral decubitus for quadriplegics only;

(ix) Bilateral limb loss;

(x) Open wound of lower limb; or

(xi) Acute, infective polyneuritis (Guillain-Barre' syndrome).

(9) For clients age twenty-one and older, MAA covers physical therapy services which exceed the limitations estab-

lished in subsection (8) of this section if the provider requests prior authorization and MAA approves the request.

(10) MAA will pay for one visit to instruct in the application of transcutaneous neurostimulator (TENS) per client, per lifetime.

(11) Duplicate services for occupational therapy and physical therapy are not allowed for the same client when both providers are performing the same or similar procedure(s).

(12) MAA does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

(13) MAA does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be billed by the hospital.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-545-500, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520, 00-04-019, § 388-545-500, filed 1/24/00, effective 2/24/00.]

WAC 388-545-700 Speech/audiology services. (1)

The following providers are eligible to enroll with medical assistance administration (MAA) to provide, and be reimbursed for, speech/audiology services:

(a) A speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Hearing and Language Association;

(b) A speech-language pathologist who has completed the equivalent educational and work experience necessary for such a certificate;

(c) An audiologist who is appropriately licensed or registered to perform audiology services within their state of residence; and

(d) School districts or educational service districts. Services must be noted in the client's individual educational program or individualized family service plan as described under WAC 388-537-0100.

(2) Clients in the following MAA programs are eligible to receive speech/audiology services described in this chapter:

(a) Categorically needy, children's health, general assistance unemployable, and Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) programs within Washington state or border areas only; or

(b) Medically needy program only when the client is either:

(i) Twenty years of age or under; or

(ii) Receiving home health care services as described under chapter 388-551 WAC, subchapter II;

(c) Medically indigent program only for emergency hospital-based services.

(3) MAA pays only for covered speech/audiology services listed in this section when they are:

(a) Within the scope of an eligible client's medical care program;

(b) For conditions which are the result of medically recognized diseases and defects; and

(c) Medically necessary, as determined by a health professional.

(4) The following speech/audiology services are covered per client, per calendar year, per provider:

(a) Unlimited speech/audiology program visits for clients twenty years of age and younger;

(b) One medical diagnostic evaluation for clients twenty-one years of age and older. The medical diagnostic evaluation is in addition to the twelve program visits allowed per year;

(c) One second medical diagnostic evaluation at the time of discharge for any of the following:

(i) Anoxic brain damage;

(ii) Acute, ill-defined, cerebrovascular disease;

(iii) Subarachnoid, subdural, and extradural hemorrhage following injury; or

(iv) Intracranial injury of other and unspecified nature;

(d) Twelve speech/audiology program visits for clients twenty-one years of age and older;

(e) Twenty-four additional speech/audiology visits if the speech/audiology service is for any of the following:

(i) Medically necessary conditions for developmentally delayed clients;

(ii) Neurofibromatosis;

(iii) Severe oral or motor dyspraxia;

(iv) Amyotrophic lateral sclerosis (ALS);

(v) Multiple sclerosis;

(vi) Cerebral palsy;

(vii) Quadriplegia;

(viii) Acute, infective polyneuritis (Guillain-Barre' syndrome);

(ix) Acute, but ill-defined, cerebrovascular disease;

(x) Meningomyelocele;

(xi) Cleft palate and cleft lip;

(xii) Down's syndrome;

(xiii) Lack of coordination;

(xiv) Severe aphasia;

(xv) Severe dysphagia;

(xvi) Fracture of the:

(A) Vault or base of the skull;

(B) Multiple fracture involving skull or face with other bones;

(C) Cervical column;

(D) Larynx and trachea; or

(E) Other and unqualified skull fractures;

(xvii) Head injuries as follows:

(A) Cerebral laceration and contusion;

(B) Subarachnoid, subdural, and extradural hemorrhage following injury;

(C) Other and unspecified intracranial hemorrhage following injury;

(D) Injury to blood vessels of the head and neck; or

(E) Intracranial injury of other second unspecified nature;

(xviii) Burns of:

(A) The face, head, and neck, when severe;

(B) Multiple, specified sites; or

(C) Internal organs;

(xix) Cervical spinal cord injury without evidence of spinal bone injury; or

(xx) Other speech disturbances (e.g., severe dysarthria).

(f) Additional medically necessary speech/audiology program visits beyond the initial twelve visits and additional

twenty-four visits for clients twenty-one years of age and older if approved by MAA.

(5) MAA limits:

(a) Caloric vestibular testing to four units for each ear, and

(b) Sinusoidal vertical axis rotational testing to three units for each direction.

(6) MAA does not cover speech/audiology services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-545-700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090 and 74.09.520, 99-16-071, § 388-545-700, filed 8/2/99, effective 9/2/99.]

WAC 388-545-900 Neurodevelopmental centers. (1)

This section describes:

(a) Neurodevelopmental centers that may be reimbursed by the department;

(b) Clients who may receive covered services at a neurodevelopmental center; and

(c) Covered services that may be provided at and reimbursed to a neurodevelopmental center.

(2) In order to provide and be reimbursed for the services listed in subsection (4) of this section, the department requires a neurodevelopmental center provider to do all of the following:

(a) Be contracted with the department of health (DOH) as a neurodevelopmental center;

(b) Provide documentation of the DOH contract to the department;

(c) Sign a core provider agreement with the department; and

(d) Receive a neurodevelopmental center provider number from the department.

(3) Clients who are twenty years of age or younger and who meet the following eligibility criteria may receive covered services from neurodevelopmental centers:

(a) For occupational therapy, refer to WAC 388-545-300(2);

(b) For physical therapy, refer to WAC 388-545-500(2);

(c) For speech therapy and audiology services, refer to WAC 388-545-700(2); and

(d) For early and periodic screening, diagnosis and treatment (EPSDT) screening by physicians, refer to WAC 388-534-0100.

(4) The department reimburses neurodevelopmental centers for providing the following services to clients who meet the requirements in subsection (3) of this section:

(a) Occupational therapy services as described in WAC 388-545-300;

(b) Physical therapy services as described in WAC 388-545-500;

(c) Speech therapy and audiology services as described in WAC 388-545-700; and

(d) Specific pediatric evaluations and team conferences that are:

(i) Attended by the center's medical director; and

(ii) Identified as payable in the department's billing instructions.

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(5) In order to be reimbursed, neurodevelopmental centers must meet the department's billing requirements in WAC 388-502-0020, 388-502-0100 and 388-502-0150.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700, 06-24-036, § 388-545-900, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.09.080, 74.09.520 and 74.09.530, 01-20-114, § 388-545-900, filed 10/3/01, effective 11/3/01.]

Chapter 388-546 WAC TRANSPORTATION SERVICES

WAC

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WAC 388-546-0001 Definitions. The following definitions and abbreviations, and those found in WAC 388-500-0005, apply to this chapter unless otherwise specified.

"Advanced life support (ALS)" means that level of care that calls for invasive emergency medical services requiring advanced medical treatment skills.

"Advanced life support (ALS) assessment" means an assessment performed by an ALS crew as part of an emergency response that was necessary because the client's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the client requires an ALS level of service.

"Advanced life support (ALS) intervention" means a procedure that is beyond the scope of care of an emergency medical technician (EMT).

"Aid vehicle" means a vehicle used to carry aid equipment and individuals trained in first aid or emergency medical procedures.

"Air ambulance" means a helicopter or airplane designed and used to provide transportation for the ill and injured, and to provide personnel, facilities, and equipment to

treat clients before and during transportation. Air ambulance is considered an ALS service.

"Ambulance" means a ground or air vehicle designed and used to provide transportation to the ill and injured; and to provide personnel, facilities, and equipment to treat clients before and during transportation; and licensed per RCW 18.73.140.

"Base rate" means the medical assistance administration's (MAA) minimum payment amount per covered trip, which includes allowances for emergency medical personnel and their services, the costs of standing orders, reusable supplies and equipment, hardware, stretchers, oxygen and oxygen administration, intravenous supplies and IV administration, disposable supplies, normal waiting time, and the normal overhead costs of doing business. The base rate excludes mileage.

"Basic life support (BLS)" means that level of care that justifies ambulance transportation but requires only basic medical treatment skills. It does not include the need for or delivery of invasive medical procedures/services.

"Bed-confined" means the client is unable to perform all of the following actions:

- (1) Get up from bed without assistance;
- (2) Ambulate; and
- (3) Sit in a chair or wheelchair.

"Bordering city hospital" means a licensed hospital in a designated bordering city (see WAC 388-501-0175).

"Broker" (see "transportation broker").

"Brokered transportation" means nonemergency transportation arranged by a broker, under contract with MAA, to or from covered medical services for an eligible client (also, see "transportation broker").

"By report" means a method of payment in which MAA determines the amount it will pay for a service that is covered but does not have an established maximum allowable fee. Providers must submit a report describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

"Emergency medical service" means medical treatment and care that may be rendered at the scene of any medical emergency or while transporting any client in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities.

"Emergency medical transportation" means ambulance transportation during which a client receives needed emergency medical services en route to an appropriate medical facility.

"Ground ambulance" means a ground vehicle (including a water ambulance) designed and used to provide transportation to the ill and injured and to provide personnel, facilities, and equipment to treat clients before and during transportation.

"Invasive procedure" means a medical intervention that intrudes on the client's person or breaks the skin barrier.

"Lift-off fee" means either of the two base rates MAA pays to air ambulance providers for transporting a client. MAA establishes separate lift-off fees for helicopters and airplanes.

"Loaded mileage" means the number of miles the client is transported in the ambulance vehicle.

"Medical control" means the medical authority upon whom an ambulance provider relies to coordinate prehospital emergency services, triage and trauma center assignment/destination for the person being transported. The medical control is designated in the trauma care plan by the approved medical program director of the region in which the service is provided.

"Nonemergency ambulance transportation" means the use of a ground ambulance to carry a client who may be confined to a stretcher but typically does not require the provision of emergency medical services en route, or the use of an air ambulance when prior authorized by MAA. Nonemergency ambulance transportation is usually scheduled or prearranged. See also "prone or supine transportation," and "scheduled transportation."

"Point of destination" means a facility generally equipped to provide the needed medical or nursing care for the injury, illness, symptoms, or complaint involved.

"Point of pickup" means the location of the client at the time he or she is placed on board the ambulance or transport vehicle.

"Prone or supine transportation" means transporting a client confined to a stretcher or gurney, with or without emergency medical services being provided en route.

"Scheduled transportation" means prearranged transportation for an eligible client, typically in a vehicle other than an ambulance, with no emergency medical services being required or provided en route to or from a covered medical service.

"Specialty care transport (SCT)" means interfacility transportation of a critically injured or ill client by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the paramedic.

"Standing order" means an order remaining in effect indefinitely until canceled or modified by an approved medical program director (regional trauma system) or the ambulance provider's medical control.

"Transportation broker" means a person or organization contracted by MAA to arrange, coordinate and manage the provision of necessary but nonemergency transportation services for eligible clients to and from covered medical services.

"Trip" means transportation one-way from the point of pickup to the point of destination by an authorized transportation provider.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0001, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0001, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0100 The MAA ambulance transportation program. (1) The provisions of this chapter take precedence with respect to ambulance coverage in cases of ambiguity in, or conflict with, other rules governing eligibility for medical services.

(2) The medical assistance administration (MAA) covers medically necessary ambulance transportation to and from the provider of MAA covered services that is closest and most appropriate to meet the client's medical need. See WAC 388-546-0150 through 388-546-4000 for ambulance trans-

portation and WAC 388-546-5000 through 388-546-5600 for brokered/nonemergency transportation.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0100, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0100, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0150 Client eligibility for ambulance transportation. (1) Except for clients in the Family Planning Only program, MAA fee-for-service clients are eligible for ambulance transportation to MAA covered services with the following limitations:

(a) Clients in the following programs are eligible for ambulance services within Washington state or bordering cities only, as designated in WAC 388-501-0175:

- (i) General assistance-unemployable (GA-U);
- (ii) General assistance-expedited medical (GA-X);
- (iii) General assistance-pregnancy (GA-S);
- (iv) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA);

(v) Emergency medical programs, including alien emergency medical (AEM);

(vi) LCP-MNP emergency medical only; and

(vii) State Children's Health Insurance Program (CHIP) when the client is not enrolled in a managed care plan.

(b) Clients in the categorically needy/qualified Medicare beneficiary (CN/QMB) and medically needy/qualified Medicare beneficiary (MN/QMB) programs are covered by Medicare and Medicaid, with the payment limitations described in WAC 388-546-0400(5).

(2) Clients enrolled in an MAA managed care plan receive all ambulance services through their designated plan, subject to the plan's coverages and limitations.

(3) Clients enrolled in MAA's primary care case management (PCCM) program are eligible for ambulance services that are emergency medical services or that are approved by the PCCM in accordance with MAA requirements. MAA pays for covered services for these clients according to MAA's published billing instructions.

(4) Clients under the Involuntary Treatment Act (ITA) are not eligible for ambulance transportation coverage outside the state of Washington. This exclusion from coverage applies to individuals who are being detained involuntarily for mental health treatment and being transported to or from bordering cities. See also WAC 388-546-4000.

(5) See WAC 388-546-0800 and 388-546-2500 for additional limitations on out-of-state coverage and coverage for clients with other insurance.

(6) Jail inmates and persons living in a correctional facility are not eligible for MAA ambulance coverage. See WAC 388-503-0505(5).

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0150, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0150, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0200 Scope of coverage for ambulance transportation. (1) The ambulance program is a medical transportation service. The medical assistance administration (MAA) pays for ambulance transportation to and from covered medical services when the transportation is:

(a) Within the scope of an eligible client's medical care program (see WAC 388-501-0060);

(b) Medically necessary as defined in WAC 388-500-0005 based on the client's condition at the time of the ambulance trip and as documented in the client's record;

(c) Appropriate to the client's actual medical need; and

(d) To one of the following destinations:

(i) The nearest appropriate MAA-contracted medical provider of MAA-covered services; or

(ii) The designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual.

(2) MAA limits coverage to medically necessary ambulance transportation that is required because the client cannot be safely or legally transported any other way. If a client can safely travel by car, van, taxi, or other means, the ambulance trip is not medically necessary and the ambulance service is not covered by MAA. See WAC 388-546-0250 (1) and (2) for noncovered ambulance services.

(3) If Medicare or another third party is the client's primary health insurer and that primary insurer denies coverage of an ambulance trip due to a lack of medical necessity, MAA requires the provider when billing MAA for that trip to:

(a) Report the third party determination on the claim; and

(b) Submit documentation showing that the trip meets the medical necessity criteria of MAA. See WAC 388-546-1000 and 388-546-1500 for requirements for nonemergency ambulance coverage.

(4) MAA covers the following ambulance transportation:

(a) Ground ambulance when the eligible client:

(i) Has an emergency medical need for the transportation;

(ii) Needs medical attention to be available during the trip; or

(iii) Must be transported by stretcher or gurney.

(b) Air ambulance when justified under the conditions of this chapter or when MAA determines that air ambulance is less costly than ground ambulance in a particular case. In the latter case, the air ambulance transportation must be prior authorized by MAA. See WAC 388-546-1500 for nonemergency air ambulance coverage.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-546-0200, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0200, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0200, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0250 Ambulance services the department does not cover. (1) The department does not cover ambulance services when the transportation is:

(a) Not medically necessary based on the client's condition at the time of service (see exception at WAC 388-546-1000);

(b) Refused by the client (see exception for ITA clients in WAC 388-546-4000(2));

(c) For a client who is deceased at the time the ambulance arrives at the scene;

(d) For a client who dies after the ambulance arrives at the scene but prior to transport and the ambulance crew pro-

vided minimal to no medical interventions/supplies at the scene (see WAC 388-546-0500(2));

(e) Requested for the convenience of the client or the client's family;

(f) More expensive than bringing the necessary medical service(s) to the client's location in nonemergency situations;

(g) To transfer a client from a medical facility to the client's residence (except when the residence is a nursing facility);

(h) Requested solely because a client has no other means of transportation;

(i) Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars); or

(j) Not to the nearest appropriate medical facility.

(2) If transport does not occur, the department does not cover the ambulance service, except as provided in WAC 388-546-0500(2).

(3) The department evaluates requests for services that are listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

(4) For ambulance services that are otherwise covered under this chapter but are subject to one or more limitations or other restrictions, the department evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions. The department approves such requests when medically necessary, according to the provisions of WAC 388-501-0165 and 388-501-0169.

(5) An ambulance provider may bill a client for noncovered services as described in this section, if the requirements of WAC 388-502-0160 are met.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-546-0250, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0250, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0250, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0300 General requirements for ambulance providers. (1) Ambulances must be licensed, operated, and equipped according to federal, state, and local statutes, ordinances and regulations.

(2) Ambulances must be staffed and operated by appropriately trained and certified personnel. Personnel who provide any invasive procedure/emergency medical services for a client during an ambulance trip must be properly authorized and trained per RCW 18.73.150 and 18.73.170.

(3) The medical assistance administration (MAA) requires providers of ambulance services to document medical justification for transportation and related services billed to MAA. Documentation in the provider's client record must include adequate descriptions of the severity and complexity of the client's condition (including the circumstances that made the conditions acute and emergent) at the time of the transportation. MAA may review the client record to ensure MAA's criteria were met.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0300, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0300, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0400 General limitations on payment for ambulance services. (1) In accordance with WAC 388-

502-0100(8), the medical assistance administration (MAA) pays providers the lesser of the provider's usual and customary charges or the maximum allowable rate established by MAA. MAA's fee schedule payment for ambulance services includes a base rate or lift-off fee plus mileage.

(2) MAA does not pay providers under fee-for-service for ambulance services provided to a client who is enrolled in an MAA managed care plan. Payment in such cases is the responsibility of the prepaid managed care plan.

(3) MAA does not pay providers for mileage incurred traveling to the point of pickup or any other distances traveled when the client is not on board the ambulance. MAA pays for loaded mileage only as follows:

(a) MAA pays ground ambulance providers for the actual mileage incurred for covered trips by paying from the client's point of pickup to the point of destination.

(b) MAA pays air ambulance providers for the statute miles incurred for covered trips by paying from the client's point of pickup to the point of destination.

(4) MAA does not pay for ambulance services if:

(a) The client is not transported;

(b) The client is transported but not to an appropriate treatment facility; or

(c) The client dies before the ambulance trip begins (see the single exception for ground ambulance providers at WAC 388-546-0500(2)).

(5) For clients in the categorically needy/qualified Medicare beneficiary (CN/QMB) and medically needy/qualified Medicare beneficiary (MN/QMB) programs MAA's payment is as follows:

(a) If Medicare covers the service, MAA will pay the lesser of:

(i) The full coinsurance and deductible amounts due, based upon Medicaid's allowed amount; or

(ii) MAA's maximum allowable for that service minus the amount paid by Medicare.

(b) If Medicare does not cover or denies ambulance services that MAA covers according to this chapter, MAA pays at MAA's maximum allowable; except MAA does not pay for clients on the qualified Medicare beneficiaries (QMB) only program.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0400, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0400, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0425 Ambulance coverage during inpatient hospital stays. (1) The medical assistance administration (MAA) does not cover ambulance transportation services under fee-for-service when a client remains as an inpatient client in a hospital and the transportation to and/or from another facility is for diagnostic or treatment services (e.g., MRI scanning, kidney dialysis). Transportation of an inpatient client for such services is the responsibility of the hospital, whether MAA pays the hospital under the diagnosis-related group (DRG) or ratio of costs-to-charges (RCC) method.

(2) Except as provided in subsections (3) and (5) of this section, MAA does not cover hospital to hospital transfers of clients under fee-for-service when ambulance transportation is requested solely to:

(a) Accommodate a physician's or other health care provider's preference for facilities;

(b) Move the client closer to family or home (i.e., for personal convenience); or

(c) Meet insurance requirements or hospital/insurance agreements.

(3) MAA covers under fee-for-service ambulance transportation for a client being transferred from one hospital to another when the transferring or discharging hospital has inadequate facilities to provide the necessary medical services required by the client. MAA covers air ambulance transportation for hospital transfers only if transportation by ground ambulance would endanger the client's life or health. The reason for transferring a client from one hospital to another, as well as the need for air ambulance transport, if applicable, must be clearly documented in the client's hospital chart and in the ambulance trip report.

(4) MAA does not cover under fee-for-service ambulance transportation for a client being transferred from a hospital providing a higher level of care to a hospital providing a lower level of care, except as allowed under subsection (5) of this section.

(5) MAA considers requests for fee-for-service ambulance coverage under the provisions of WAC 388-501-0160 (exception to rule) for transportation of a client from an intervening hospital to the discharging hospital. MAA evaluates such requests based on clinical considerations and cost-effectiveness. MAA's decision under the provisions of WAC 388-501-0160 is final. The reason for transferring a client from a hospital to another medical facility must be clearly documented in the client's hospital chart and in the ambulance trip record.

(6) Specialty care transport (SCT) is hospital-to-hospital transportation by ground ambulance of a critically injured or ill client, at a level of service beyond the scope of a paramedic. MAA pays an ambulance provider the advanced life support (ALS) rate for an SCT-level transport, provided:

(a) The criteria for covered hospital transfers under fee-for-service are met; and

(b) There is a written reimbursement agreement between the ambulance provider and SCT personnel. If there is no written reimbursement agreement between the ambulance provider and SCT personnel, MAA pays the provider at the basic life support (BLS) rate.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0425, filed 8/17/04, effective 9/17/04.]

WAC 388-546-0450 Payment for ground ambulance services. (1) The medical assistance administration (MAA) pays for two levels of service for ground ambulance transportation: Basic life support (BLS) and advanced life support (ALS):

(a) A BLS ambulance trip is one in which the client requires and receives basic medical services at the scene and/or en route from the scene of the acute and emergent illness or injury to a hospital or other appropriate treatment facility. Examples of basic medical services are: Controlling bleeding, splinting fracture(s), treating for shock, and performing cardiopulmonary resuscitation (CPR).

(b) An ALS trip is one in which the client requires and receives more complex services at the scene and/or en route

from the scene of the acute and emergent illness or injury to a hospital. To qualify for payment at the ALS level, certified paramedics or other ALS-qualified personnel on-board must provide the advanced medical services in a properly equipped vehicle as defined by chapter 18.83 RCW. Examples of complex medical services or ALS procedures are:

(i) Administration of medication by intravenous push/bolus or by continuous infusion;

(ii) Airway intubation;

(iii) Cardiac pacing;

(iv) Chemical restraint;

(v) Chest decompression;

(vi) Creation of surgical airway;

(vii) Initiation of intravenous therapy;

(viii) Manual defibrillation/cardioversion;

(ix) Placement of central venous line; and

(x) Placement of intraosseous line.

(2) MAA pays for ambulance services (BLS or ALS) based on the client's actual medical condition and the level of medical services needed and provided during the trip.

(a) Local ordinances or standing orders that require all ambulance vehicles be ALS-equipped do not qualify a trip for MAA payment at the ALS level of service unless ALS services were provided.

(b) A ground ambulance trip is classified and paid at a BLS level, even if certified paramedics or ALS-qualified personnel are on board the ambulance, if no ALS-type interventions were provided en route.

(c) An ALS assessment does not qualify as an ALS transport if no ALS-type interventions were provided to the client en route to the treatment facility.

(3) MAA's base rate includes: Necessary personnel and services; oxygen and oxygen administration; intravenous supplies and IV administration reusable supplies, disposable supplies, required equipment, and waiting time. MAA does not pay separately for chargeable items/services that are provided to the client based on standing orders.

(4) MAA pays ground ambulance providers the same mileage rate, regardless of the level of service. Ground ambulance mileage is paid when the client is transported to and from medical services within the local community only, unless necessary medical care is not available locally. The provider must fully document in the client's record the circumstances that make medical care outside of the client's local community necessary.

(5) MAA pays for extra mileage when sufficient justification is documented in the client's record and the ambulance trip report. Acceptable reasons for allowable extra mileage include, but are not limited to:

(a) A hospital was on "divert" status and not accepting patients; or

(b) A construction site caused a detour, or had to be avoided to save time.

(6) When multiple ambulance providers respond to an emergency call, MAA pays only the ambulance provider that actually furnishes the transportation.

(7) MAA pays for an extra attendant, when the ground ambulance provider documents in the client's file the justification for the extra attendant, and that the extra attendant is on-board for the trip because of one or more of the following:

(a) The client weighs three hundred pounds or more;

(b) The client is violent or difficult to move safely;
 (c) The client is being transported for Involuntary Treatment Act (ITA) purposes and the client must be restrained during the trip; or

(d) More than one client is being transported, and each requires medical attention and/or close monitoring.

(8) MAA pays ambulance providers "by report" for ferry and bridge tolls incurred when transporting MAA clients. To be paid, providers must document the toll(s) by attaching the receipt(s) for the toll(s) to the claim.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0450, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0450, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0500 Payment for ground ambulance services in special circumstances. (1) When more than one client is transported in the same ground ambulance at the same time, the provider must bill the medical assistance administration (MAA):

- (a) At a reduced base rate for the additional client, and
- (b) No mileage charge for the additional client.

(2) MAA pays an ambulance provider at the appropriate base rate (BLS or ALS) if no transportation takes place because the client died at the scene of the illness or injury but the ambulance crew provided medical interventions/supplies to the client at the scene prior to the client's death. See WAC 388-546-0450(1) for examples of medical interventions associated with each base rate. The intervention(s)/supplies provided must be documented in the client's record. No mileage charge is allowed with the base rate when the client dies at the scene of the illness or injury after medical interventions/supplies are provided but before transport takes place.

(3) In situations where a BLS entity provides the transport of the client and an ALS entity provides a service that meets MAA's fee schedule definition of an ALS intervention, the BLS provider may bill MAA the ALS rate for the transport, provided a written reimbursement agreement between the BLS and ALS entities exists. The provider must give MAA a copy of the agreement upon request. If there is no written agreement between the BLS and ALS entities, MAA will pay only for the BLS level of service.

(4) In areas that distinguish between residents and non-residents, MAA must be billed the same rate for ambulance services provided to a client in a particular jurisdiction as would be billed by that provider to the general public in the same jurisdiction.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0500, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0500, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0600 Procedure code modifiers. Ambulance providers must use procedure code modifiers published by MAA when billing MAA for ambulance trips. The appropriate modifiers must be used for all services related to the same trip for the same client.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0600, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0600, filed 1/16/01, effective 2/16/01.]

[Title 388 WAC—p. 1090]

WAC 388-546-0700 Payment limitations for air ambulance services. (1) MAA pays for air ambulance services only when all of the following apply:

(a) The necessary medical treatment is not available locally or the client's point of pick up is not accessible by ground ambulance;

(b) The vehicle and crew meet the provider requirements in WAC 388-546-0300 and 388-546-0800;

(c) The client's destination is an acute care hospital; and

(d) The client's physical/medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance; or

(e) The client's physical or medical condition is such that traveling on a commercial flight is not safe.

(2) MAA pays providers for one lift-off fee per client, per trip.

(3) Air mileage is based on loaded miles flown, as expressed in statute miles.

(4) Except as provided in WAC 388-546-0800(6), MAA pays for extra air mileage with sufficient justification. The reason for the added mileage must be documented in the client's record and the ambulance trip report. Acceptable reasons include, but are not limited to:

(a) Having to avoid a "no fly zone"; or

(b) Being forced to land at an alternate destination due to severe weather.

(5) MAA pays a lift-off fee for each client when two or more clients are transported on a single air ambulance trip. In such a case, the provider must divide equally the total air mileage by the number of clients transported and bill MAA for the mileage portion attributable to each eligible client.

(6) If a client's transportation requires use of more than one ambulance to complete the trip to the hospital or other approved facility, MAA limits its payment as follows:

(a) If air ambulance is used and the trip involves more than one lift off, MAA pays only one lift-off fee per client and the total of air miles. If an air ambulance transport for the same client involves both rotary and fixed wing aircraft, the lift-off fee and mileage payment will be based on the mode of air transport used for the greater distance traveled.

(b) If both air and ground ambulances are used, MAA pays one lift-off fee and total air miles to the air ambulance provider, and the applicable base rate and ground mileage to each ground ambulance provider involved in the trip, except when ground ambulance fees are included in the negotiated trip payment as provided in WAC 388-546-0800(6).

(7) MAA does not pay separately for individual services or an extra attendant for air ambulance transportation. MAA's lift-off fee and mileage payment includes all personnel, services, supplies, and equipment related to the transport.

(8) MAA does not pay private organizations for volunteer medical air ambulance transportation services, unless the organization has MAA's prior authorization for the transportation services and fees. If authorized, MAA's payment is based on the actual cost to provide the service or at MAA's established rates, whichever is lower. MAA does not pay separately for items or services that MAA includes in the established rate(s).

(9) If MAA determines, upon review, that an air ambulance trip was not:

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(a) Medically necessary, MAA may deny or recoup its payment and/or limit payment based on MAA's established rate for a ground ambulance trip provided ground ambulance transportation was medically necessary; or

(b) To the nearest available and appropriate hospital, MAA may deny or recoup its payment and/or limit its maximum payment for the trip based on the nearest available and appropriate facility.

(10) Providers must have prior authorization from MAA for any nonemergency air transportation, whether by air ambulance or other mode of air transportation. Nonemergency air transportation includes scheduled transports to or from out-of-state treatment facilities.

(11) MAA uses commercial airline companies (i.e., MAA does not authorize air ambulance transports) whenever the client's medical condition permits the client to be transported by nonmedical and/or scheduled carriers.

(12) MAA does not pay for air ambulance services if no transportation is provided.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0700, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0700, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0800 Payment for ambulance services outside the state of Washington. (1) The medical assistance administration (MAA) pays for emergency transportation provided to MAA's eligible fee-for-service clients who are out-of-state at the time of service (see WAC 388-546-0150 for exceptions).

MAA requires out-of-state ambulance providers who provide covered medical services to eligible MAA clients to:

(a) Meet the licensing requirements of the ambulance provider's home state (United States of America and its territories only); and

(b) Complete and sign an MAA core provider agreement.

(2) MAA does not pay for an out-of-state ambulance transport for a fee-for-service client when:

(a) The client's medical eligibility program covers medical services within Washington state and/or designated bordering cities only. See WAC 388-546-0150 and 388-546-0200(5);

(b) The ambulance transport is taking the client to an out-of-state treatment facility for a medical service, treatment or procedure that is available from a facility within Washington state or in a designated bordering city; or

(c) The transport was nonemergency and was not prior authorized by MAA.

(3) Except as provided in subsection (6) of this section, MAA pays out-of-state medical transportation ambulance providers at the lower of:

(a) The provider's billed amount; or

(b) The rate established by MAA.

(4) MAA requires any out-of-state ground ambulance provider who is transporting MAA clients within the state of Washington to comply with RCW 18.73.180 regarding stretcher transportation.

(5) Ambulance providers who provide medical transportation that takes a client out-of-state or that brings a client in state from an out-of-state location must obtain MAA's prior

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authorization. Under no circumstances are such transports covered for clients under the Involuntary Treatment Act (ITA).

(6) MAA pays ambulance providers the agreed upon amount for each medically necessary interstate ambulance trip that has MAA's prior authorization. The provider is responsible for ensuring that all necessary services associated with the transport are available and provided to the client. In transports involving negotiated rates, the provider is responsible for the costs of all services included in the contractual amount. The contractual amount for an air ambulance transport may include ground ambulance fees at the point of pickup and the point of destination.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0800, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-0800, filed 1/16/01, effective 2/16/01.]

WAC 388-546-0900 Ambulance coverage in Canada, Mexico, and other countries. The medical assistance administration (MAA) covers ambulance transportation for eligible fee-for-service clients traveling outside of the United States and U.S. territories, subject to the provisions and limitations of this chapter.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-0900, filed 8/17/04, effective 9/17/04.]

WAC 388-546-1000 Coverage for nonemergency ground ambulance transportation. (1) The medical assistance administration (MAA) pays for nonemergency ground ambulance transportation at the BLS ambulance level of service under the following conditions:

(a) The client is bed-confined and must be transported by stretcher or gurney (in the prone or supine position) for medical or safety reasons. Justification for stretcher or gurney must be documented in the client's record; or

(b) The client's medical condition requires that he or she have basic ambulance level medical attention available during transportation, regardless of bed confinement.

(2) MAA requires ambulance providers to thoroughly document the circumstances requiring nonemergency ground ambulance transportation as follows:

(a) For nonemergency, scheduled ambulance services that are repetitive in nature, the ambulance provider must obtain a written physician certification statement (PCS) from the client's attending physician certifying that the ambulance services are medically necessary. The PCS must specify the expected duration of treatment or span of dates during which the client requires repetitive nonemergency ambulance services. The PCS must be dated no earlier than sixty days before the first date of service. A PCS for repetitive, non-emergency ambulance services is valid for sixty days as long as the client's medical condition does not improve. Kidney dialysis clients may receive nonemergency ground ambulance transportation to and from outpatient kidney dialysis services for up to three months per authorization span.

(b) For nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider must obtain from the client's attending physician a signed PCS within forty-eight hours after the transport.

The PCS must certify that the ambulance services are medically necessary.

(c) If the ambulance provider is not able to obtain a signed PCS from the attending physician, a signed certificate of medical necessity form must be obtained from a qualified provider who is employed by the client's attending physician or by the hospital or facility where the client is being treated and who has personal knowledge of the client's medical condition at the time the ambulance service was furnished. In lieu of the attending physician, one of the following may sign the certification form: a physician assistant, a nurse practitioner, a registered nurse, a clinical nurse specialist, or a hospital discharge planner. The signed certificate must be obtained from the alternate provider no later than twenty-one calendar days from the date of service.

(d) If, after twenty-one days, the ambulance provider is unable to obtain the signed PCS from the attending physician or alternate provider for nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider may submit a claim to MAA, as long as the provider is able to show acceptable documentation of the attempts to obtain the PCS.

(e) In addition to the signed certification statement of medical necessity, all other program criteria must be met in order for MAA to pay for the service.

(3) Ground ambulance providers may choose to enter into contracts with MAA's transportation brokers to provide nonemergency transportation at a negotiated payment rate. Any such subcontracted rate may not exceed the costs MAA would incur under subsection (1) of this section.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-1000, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-03-084, § 388-546-1000, filed 1/16/01, effective 2/16/01.]

WAC 388-546-1500 Coverage for nonemergency air ambulance transportation. (1) The medical assistance administration (MAA) pays for a nonemergency air ambulance transport only when the transport is prior authorized by MAA.

(2) MAA authorizes a nonemergency air ambulance transport only when the following conditions are met:

(a) The client's destination is an acute care hospital or approved rehabilitation facility; and

(b) The client's physical or medical condition is such that travel by any other means endangers the client's health; or

(c) Air ambulance is less costly than ground ambulance under the circumstances.

(3) MAA requires providers to thoroughly document the circumstances requiring a nonemergency air ambulance transport. The medical justification must be submitted to MAA prior to transport and must be documented in the client's medical record and ambulance trip report. Documentation must include adequate descriptions of the severity and complexity of the client's condition at the time of transportation.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-1500, filed 8/17/04, effective 9/17/04.]

[Title 388 WAC—p. 1092]

WAC 388-546-2500 Transportation to or from out-of-state treatment facilities—Coordination of benefits. (1) The medical assistance administration (MAA) does not pay for a client's transportation to or from an out-of-state treatment facility when the medical service, treatment, or procedure sought by the client is available from an in-state facility or in a designated bordering city, whether or not the client has other insurance coverage.

(2) For clients who are otherwise eligible for out-of-state coverage under WAC 388-546-0150, but have other third-party insurance, MAA does not pay for transportation to or from out-of-state treatment facilities when the client's primary insurance:

(a) Denies the client's request for medical services out-of-state for lack of medical necessity; or

(b) Denies the client's request for transportation for lack of medical necessity.

(3) For clients who are otherwise eligible for out-of-state coverage under WAC 388-546-0150, but have other third-party insurance, MAA does not consider requests for transportation to or from out-of-state treatment facilities unless the client has tried all of the following:

(a) Requested coverage of the benefit from his/her primary insurer and been denied;

(b) Appealed the denial of coverage by the primary insurer; and

(c) Exhausted his/her administrative remedies through the primary insurer.

(4) If MAA authorizes transportation to or from an out-of-state treatment facility for a client with other third-party insurance, MAA's liability is limited to the cost of the least costly means of transportation that does not jeopardize the client's health, as determined by MAA in consultation with the client's referring physician.

(5) For clients eligible for out-of-state coverage but have other third-party insurance, MAA considers requests for transportation to or from out-of-state treatment facilities under the provisions of WAC 388-501-0165.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-2500, filed 8/17/04, effective 9/17/04.]

WAC 388-546-3000 Transporting qualified trauma cases. (1) The medical assistance administration (MAA) does not pay ambulance providers an additional amount for transports involving qualified trauma cases described in WAC 388-550-5450.

(2) Ambulance providers may apply to the department of health (DOH) for possible grants related to transports of qualified trauma cases.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-3000, filed 8/17/04, effective 9/17/04.]

WAC 388-546-4000 Transportation coverage under the Involuntary Treatment Act (ITA). (1) For purposes of this section, the following definitions apply:

(a) "Nearest and most appropriate destination" means the nearest facility able and willing to accept the involuntarily detained individual for treatment, not the closest facility based solely on driving distance.

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(b) "County-designated mental health professional (CD-MHP)" means a person who, under the guidelines specified by the Involuntary Treatment Act (ITA):

(i) Assesses a client's level of need for transportation according to procedures established by the county in which the client being assessed resides; and

(ii) Decides, following the assessment, how a client should be transported to an inpatient psychiatric treatment facility.

(c) "Involuntary Treatment Act" means, for adults, chapter 71.05 RCW; for juveniles, chapter 71.34 RCW. See also chapter 388-865 WAC.

(d) "Regional support network (RSN)" means a county authority or group of county authorities recognized by the secretary of the department of social and health services (DSHS) and which contracts with DSHS to implement a locally managed community mental health program.

(2) The medical assistance administration (MAA) covers transportation under ITA for an individual who is being involuntarily detained for mental health treatment, after that individual has been assessed by a CD-MHP and found to be:

(a) A danger to self;

(b) A danger to others; or

(c) Gravely disabled.

(3) Transportation under ITA may be provided to an eligible individual by an organization designated as an ITA provider by the local community mental health center and/or RSN. Designated ITA providers must comply with the department's requirements for drivers, driver training, vehicle and equipment standards and maintenance.

(4) Transportation under the ITA for an individual described in subsection (2) is covered from:

(a) The site of the initial detention;

(b) An evaluation and treatment facility designated by the department; or

(c) A court hearing.

(5) Transportation under the ITA for an individual described in subsection (2) is covered when provided to:

(a) An evaluation and treatment facility;

(b) A less restrictive alternative setting, except when ambulance transport to a client's home is not covered; or

(c) A court hearing.

(6) The CD-MHP authorizes the level of transportation provided under ITA to and from covered facilities based on the individual's need. A copy of the authorization by the CD-MHP must be kept in the individual's file.

(7) MAA pays for ITA transports to the nearest and most appropriate destination. The reason for the diversion to a more distant facility must be clearly documented in the individual's file.

(8) The department's mental health division (MHD) establishes payment for ITA transports. Providers must clearly identify ITA transports on the claim form when submitting claims to MAA.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.510. 04-17-118, § 388-546-4000, filed 8/17/04, effective 9/17/04.]

WAC 388-546-5000 Nonemergency transportation program definitions. The following terms apply to WAC 388-546-5000, 388-546-5100, 388-546-5200, 388-546-5300, 388-546-5400, and 388-546-5500:

"Broker" means an organization or entity contracted with the department of social and health services (DSHS)/**medical assistance administration (MAA)** to arrange nonemergency transportation services for MAA's clients.

"Drop off point" means the place authorized by the transportation broker for the client's trip to end.

"Escort" means a person authorized by the broker to be transported with a client to a medical service. An escort may be authorized depending on the client's age, mental state or capacity, safety requirements, mobility requirements, communication or translation requirements, or cultural issues.

"Guardian" means a person who is legally responsible for a client and who may be required to be present when a client is receiving medical services.

"Local provider of type" means the medical provider within the client's local community who fulfills the requirements of the medical appointment. The provider may vary by medical specialty, the provider's acceptance of MAA's clients, and whether managed care, primary care case management or third party participation is involved.

"Noncompliance" means a client:

(1) Engages in violent, seriously disruptive, or illegal conduct;

(2) Poses a direct threat to the health and/or safety of self or others; or

(3) Fails to be present at the pickup point of the trip.

"Pickup point" means the place authorized by MAA's transportation broker for the client's trip to begin.

"Return trip" means the return of the client to the client's home, or another authorized return point, from the location where a covered medical service has occurred.

"Service mode" means the method of transportation the transportation broker selects to use for an MAA client.

"Stretcher trip" means a transportation service that requires a client to be transported in a prone or supine position. This may be by stretcher, board or gurney (reclined and with feet elevated). Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

"Trip" means transportation one-way from the **pickup point** to the **drop off point** by an authorized transportation provider.

"Urgent care" means an unplanned appointment for a covered medical service with verification from an attending physician or facility that the client must be seen that day.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5000, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5100 Nonemergency transportation program scope of coverage. (1) MAA covers transportation that is necessary for its clients to receive **medically necessary** MAA covered services. See WAC 388-546-0100 through 388-546-1000 for Ambulance transportation that covers emergency ambulance transportation and limited non-emergency ground ambulance transportation as medical services.

(2) Licensed ambulance providers, who contract with MAA's transportation brokers, may be reimbursed for non-emergency transportation services under WAC 388-546-5200 as administrative services.

(3) MAA covers nonemergency transportation under WAC 388-546-5000 through 388-546-5500 as an administrative service as provided by the Code of Federal Regulations (42 CFR 431.53 and 42 CFR 440.170 (a)(2)). As a result, clients may not select the transportation provider(s) or the mode of transportation (**service mode**).

(4) Prior authorization by MAA is required for all out-of-state nonemergency transportation. Border areas as defined by WAC 388-501-0175 are considered in-state under this section and subsequent sections.

(5) MAA requires all nonemergency transportation to and from covered services to meet the following:

(a) The covered service must be medically necessary as defined in WAC 388-500-0005;

(b) It must be the lowest cost available service mode that is both appropriate and accessible to the client's medical condition and personal capabilities; and

(c) Be limited to the **local provider of type** as follows:

(i) Clients receiving services provided under MAA's fee-for-service program may be transported only to the local provider of type. MAA's transportation **broker** is responsible for considering and authorizing exceptions.

(ii) Clients enrolled in MAA's managed care (healthy options) program may be transported to any **provider** supported by the client's managed care plan. Clients may be enrolled in a managed care plan but are obtaining a specific service not covered under the plan. The requirements in subsection (5)(c)(i) apply to these fee-for-service services.

(6) MAA does not cover nonemergency transportation services if the covered medical services are within three-quarters of a mile walking distance from the client's residence. Exceptions to this rule may be granted by MAA's transportation broker based on the client's documented medical condition or personal capabilities, or based on safety or physical accessibility concerns, as described in WAC 388-546-5400(1).

(7) A client must use personal or informal transportation alternatives if they are available and appropriate to the client's needs.

(8) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed-route public transportation system unless the need for more specialized transportation is present and documented. Examples of such a need are the client's use of a portable ventilator, a walker or a quad cane.

(9) MAA does not cover any nonemergency transportation service that is not addressed in WAC 388-546-1000 or in 388-546-5000 through 388-546-5500. See WAC 388-501-0160 for information about obtaining approval for noncovered transportation services, known as exception to rule (ETR).

(10) If a medical service is approved by ETR, both the broker and MAA must separately prior approve transportation to that service.

(11) MAA may exempt members of federally recognized Indian tribes from the brokered transportation program. Where MAA approves the request of a tribe or a tribal agency to administer or provide transportation services under WAC 388-546-5000 through 388-546-5400, tribal members obtain

their transportation services as provided by the tribe or tribal agency.

(12) A client who is denied service under this chapter may request a fair hearing per chapter 388-02 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5100, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5200 Nonemergency transportation program broker and provider requirements. (1) MAA requires that all nonambulance transportation providers serving MAA clients be under subcontract with the department's contracted transportation broker. MAA's transportation brokers may subcontract with ambulance providers for nonemergency trips in licensed ground ambulance vehicles as administrative services. See WAC 388-546-5100(2).

(2) MAA requires all contracted and subcontracted transportation providers under this chapter to be licensed, equipped, and operated in accordance with applicable federal, state, and local laws.

(3) MAA's transportation brokers determine the level of transportation service needed by the client and the mode of transportation to be used for each authorized **trip**.

(4) MAA's transportation brokers must comply with the terms specified in their contracts.

(5) MAA's transportation brokers may require up to forty-eight hours advance notice of a requested trip (see WAC 388-546-5300(2)) with the exception of hospital requests or **urgent care** trips. MAA allows its transportation brokers to accommodate requests that provide less than forty-eight hours advance notice, within the limits of the resources available to a broker at the time of the request.

(6) If MAA's transportation broker is not open for business and unavailable to give advance approval for a hospital discharge or urgent care request as described in subsection (5), the subcontracted transportation provider must either:

(a) Provide the transportation in accordance with the broker's instructions and request an after-the-fact authorization from the transportation broker within seventy-two hours of the transport; or

(b) Deny the transportation, if the requirements of this section cannot be met.

(7) If the subcontracted transportation provider provides transportation as described in subsection (6), the broker may agree to grant retroactive authorization as provided in WAC 388-546-5300(3). Such retroactive authorization must be:

(a) Documented as to the reasons retroactive authorization is needed; and

(b) Agreed to by the broker within seventy-two hours after the transportation to a medical appointment.

(8) MAA, through its transportation brokers, does not pay for transportation under the following conditions:

(a) Clients are not eligible for transportation services when medical services are within reasonable walking distance (normally three-quarters of a mile actual traveling distance), taking into account the client's documented medical condition and personal capabilities (see WAC 388-546-5100(6));

(b) Clients must use personal or informal transportation alternatives if they are available and appropriate to the clients' needs (see WAC 388-546-5100(7));

(c) If a fixed-route public transportation service is available to the client within three-quarters of a mile walking distance, the broker may require the client to use the fixed route public transportation under the terms of WAC 388-546-5100(8);

(d) MAA or MAA's transportation broker may deny transportation services requested if the request is not necessary, suitable, or appropriate to the client's medical condition (see WAC 388-546-5100 (1) and (5)(a));

(e) The medical services requiring transportation must be services that are covered by the client's medical program (see WAC 488-546-5100(1)); or

(f) The transportation selected by the broker for the client must be the lowest cost available alternative that is both appropriate and accessible to the client's medical condition and personal capabilities.

(9) The transportation broker mails a written notice of denial to each client who is denied coverage of transportation within three business days of the denial.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5200, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5300 Nonemergency transportation program client requirements. (1) Clients must be compliant with MAA's transportation brokers, the brokers' subcontracted transportation providers, and MAA's medical services providers. A client who is in **noncompliance** may have limited transportation service mode options available. The broker mails the client a written notice of limited transportation service mode options within three business days of the broker's decision that transportation service mode options are limited.

(2) Clients must request, arrange and obtain authorization for transportation forty-eight hours in advance of a medical appointment. Exceptions to the forty-eight-hour advance arrangements are described in subsection (3) of this section and in WAC 388-546-5200 (5) and (6).

(3) If MAA's contracted broker is not open for business at the time nonemergency transportation is needed, the client must follow the transportation broker's instructions to obtain transportation service.

(4) MAA will cover a client's transportation to medically necessary covered services with local providers of type. Transportation services will be covered to nonlocal providers of type in the following circumstances:

(a) The client is enrolled in a healthy options managed health care plan and the client's primary care provider (PCP) or a PCP referred provider is not the closest available provider;

(b) The client's service is covered by a **third party** payer and the payer requires or refers the client to a specific provider;

(c) A charitable or other voluntary program (e.g., Shriners) is paying for the client's medical service;

(d) The medical service required by the client is not available within the local healthcare service area;

(e) The total cost to MAA is lower when the services are obtained outside of the local healthcare service area; or

(f) The out-of-area service is required to provide continuity of care for the client's ongoing care as:

(i) Documented by the client's primary care provider; and
(ii) Agreed to by MAA's contracted transportation broker.

(5) MAA may require transportation brokers to refer any of the exception categories listed in subsection (4) to MAA's medical director or the medical director's designee for review and/or prior authorization of the medical service.

(6) If local medical services are not available to a client because of **noncompliance** with MAA's transportation brokers, the brokers' subcontracted transportation providers, or MAA's medical services providers, MAA does not cover nonemergency transportation to out-of-area medical services for the client. MAA's contracted broker mails a written notice to the client within three business days of the broker's determination that the client's documented noncompliance results in a denial to out-of-area transportation services.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5300, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5400 Nonemergency transportation program general reimbursement limitations. (1) To be reimbursed, MAA requires that a trip be a minimum of three-quarters of a mile from pick-up point to drop off point (see WAC 388-546-5100(6)). MAA's transportation broker may grant exceptions to the minimum distance requirement for any of the following conditions:

(a) When there is medical justification for a shorter trip;

(b) When the trip involves an area that MAA's contracted broker considers to be unsafe for the client, other riders, or the driver; or

(c) When the trip involves an area that the broker determines is not physically accessible to the client.

(2) MAA reimburses for **return trips** from covered medical services if the return trips are directly related to the original trips. MAA, through its transportation broker, may deny coverage of a return trip if any delays in the return trip are for reasons not directly related to the original trip.

(3) MAA does not reimburse any costs related to intermediate stops that are not directly related to the original approved trip.

(4) MAA's transportation broker may authorize intermediate stops that are directly related to the original approved trip if the broker determines that the intermediate stop is likely to limit or eliminate the need for supplemental covered trips. MAA considers the following reasons to be related to the original trip:

(a) Transportation to and from an immediate subsequent medical referral; or

(b) Transportation to a pharmacy to obtain one or more prescriptions when the pharmacy is within a reasonable distance of the original medical appointment route.

(5) MAA may pay the costs of meals and lodging for clients who must be transported to out-of-area medical services. MAA's transportation brokers make the determination that meals and lodging are necessary based on client need and the reasonableness of costs (as measured against state per diem rates).

(6) MAA may pay transportation costs, including meals and lodging, for authorized **escorts**. MAA's transportation brokers make the determination that the costs of escorts are

necessary based on client need and reasonableness of costs (as measured against state per diem rates).

(7) MAA does not provide escorts or pay the wages of escorts. MAA does not pay for the transportation of an escort when the client is not present unless the broker documents exceptional circumstances causing the broker to determine that the service is necessary to ensure that the client has access to medically necessary care.

(8) MAA may reimburse for the transportation of a **guardian** with or without the presence of the client if the broker documents its determination that such a service is necessary to ensure that the client has access to medically necessary care.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5400, filed 3/2/01, effective 4/2/01.]

WAC 388-546-5500 Modifications of privately owned vehicles. (1) MAA may cover and reimburse the purchase of vehicle driving controls, a vehicle wheelchair lift conversion, or the purchase or repair of a vehicle wheelchair lift, when:

(a) The requested item is necessary for the client's transportation to medically necessary MAA-covered services; and

(b) The client owns a vehicle that MAA determines is suitable for modification; and

(c) Medical transportation provided under WAC 388-546-5000 through 388-546-5400 cannot meet the client's need for transportation to and from medically necessary covered services at a lower total cost to the department (including anticipated costs); and

(d) Prior approval from MAA is obtained.

(2) Any vehicle driving controls, vehicle wheelchair lift conversion or vehicle wheelchair lift purchased by MAA under this section becomes the property of the client on whose behalf the purchase is made. MAA assumes no continuing liability associated with the ownership or use of the device.

(3) MAA limits the purchase of vehicle driving control(s), vehicle wheelchair lift conversion or vehicle wheelchair lift to one purchase per client. If a device purchased under this section becomes inoperable due to wear or breakage and the cost of repair is more than the cost of replacement, MAA will consider an additional purchase under this section as long as the criteria in subsection (1) of this section are met.

(4) MAA must remain the payer of last resort under this section.

(5) MAA does not cover the purchase of any new or used vehicle under this section or under this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.04.050, 74.04.055, and 74.04.057. 01-06-029, § 388-546-5500, filed 3/2/01, effective 4/2/01.]

Chapter 388-550 WAC

HOSPITAL SERVICES

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-550-1750 Services requiring approval. [Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1750, filed 12/18/97, effective 1/18/98.] Repealed by 04-20-058, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090 and 74.09.500.
 388-550-2300 Payment—PM&R. [Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2300, filed 12/18/97, effective 1/18/98.] Repealed by 99-17-111, filed 8/18/99, effective 9/18/99. Statutory Authority: RCW 74.08.090 and 74.09.520.
 388-550-2700 Substance abuse detoxification services. [Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2700, filed 12/18/97, effective 1/18/98.] Repealed by 01-16-142, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652.
 388-550-3401 How MAA pays acute PM&R facilities for Level B services. [Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-3401, filed 8/18/99, effective 9/18/99.] Repealed by 03-06-047, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56.
 388-550-5100 Payment method—MIDSH. [Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-5100, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-5100, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5100, filed 12/18/97, effective 1/18/98.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.090.

388-550-5250 Payment method—THAPDSH. [Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5250, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5250, filed 12/18/97, effective 1/18/98.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.090.
 388-550-5300 Payment method—STHFPDSH. [Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 02-21-019, § 388-550-5300, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5300, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5300, filed 12/18/97, effective 1/18/98.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.090.
 388-550-5350 Payment method—CTHFPDSH. [Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 02-21-019, § 388-550-5350, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4. 99-14-025, § 388-550-5350, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5350, filed 12/18/97, effective 1/18/98.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.090.
 388-550-5900 Prior authorization—Outpatient services. [Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5900, filed 12/18/97, effective 1/18/98.] Repealed by 04-20-058, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090 and 74.09.500.
 388-550-6800 Proportionate share payments for inpatient hospital services. [Statutory Authority: RCW 74.04.050, 74.08.090. 05-12-132, § 388-550-6800, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-6800, filed 6/12/03, effective 7/13/03.] Repealed by 06-08-046, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500.
 388-550-6900 Proportionate share payments for outpatient hospital services. [Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-6900, filed 6/12/03, effective 7/13/03.] Repealed by 05-12-132, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.04.050, 74.08.090.

WAC 388-550-1000 Applicability. The department shall pay for hospital services provided to eligible clients when:

- (1) The eligible client is a patient in a general hospital and the hospital meets the definition in RCW 70.41.020;
- (2) The services are medically necessary as defined under WAC 388-500-0005; and
- (3) The conditions, exceptions and limitations in this chapter are met.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1050 Hospital services definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions, apply to this chapter.

"Accommodation costs" means the expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made. These expenses include, but are not limited to, room and board, medical

social services, psychiatric social services, and the use of certain hospital equipment and facilities.

"Acute" means a medical condition of severe intensity with sudden onset.

"Acute care" means care provided for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional in order to maintain their health status (see WAC 248-27-015).

"Acute physical medicine and rehabilitation (Acute PM&R)" means a twenty-four hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation.

"ADATSA/DASA assessment center" means an agency contracted by the division of alcohol and substance abuse (DASA) to provide chemical dependency assessment for clients and pregnant women in accordance with the alcoholism and drug addiction treatment and support act (ADATSA). Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

"Add-on procedure(s)" means secondary procedure(s) that are performed in addition to another procedure.

"Administrative day" means a day of a hospital stay in which an acute inpatient level of care is no longer necessary, and noninpatient hospital placement is appropriate.

"Admitting diagnosis" means the medical condition before study, which is initially responsible for the client's admission to the hospital, as defined by the ICD-9-CM diagnostic code.

"Advance directive" means a document, such as a living will executed by a client. The advanced directive tells the client's health care providers and others the client's decisions regarding the client's medical care, particularly whether the client or client's representative wishes to accept or refuse extraordinary measures to prolong the client's life.

"Aggregate capital cost" means the total cost or the sum of all capital costs.

"Aggregate cost" means the total cost or the sum of all constituent costs.

"Aggregate operating cost" means the total cost or the sum of all operating costs.

"Alcoholism and drug addiction treatment and support act (ADATSA)" means the law and the state-funded program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

"Alcoholism and/or alcohol abuse treatment" means the provision of medical social services to an eligible client designed to mitigate or reverse the effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families.

"All-patient grouper (AP-DRG)" means a computer program that determines the DRG assignments.

"Allowed charges" means the maximum amount for any procedure that the department allows as the basis for payment computation.

"Ambulatory surgery" means a surgical procedure that is not expected to require an inpatient hospital admission.

"Ancillary hospital costs" means the expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. See **"ancillary services."**

"Ancillary services" means additional or supporting services provided by a hospital to a patient during the patient's hospital stay. These services include, but are not limited to, laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services.

"Appropriate level of care" means the level of care required to best manage a client's illness or injury based on the illness presentation and the services received.

"Approved treatment facility" means a treatment facility, either public or private, profit or nonprofit, approved by DSHS.

"Audit" means an assessment, evaluation, examination, or investigation of a health care provider's accounts, books and records, including:

(1) Medical, financial and billing records pertaining to billed services paid by the department through Medicaid or other state programs, by a person not employed or affiliated with the provider, for the purpose of verifying the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical and medical records, including mathematical computations and special studies conducted supporting Medicare cost reports, HCFA Form 2552, submitted to MAA for the purpose of establishing program rates of reimbursement to hospital providers.

"Audit claims sample" means a subset of the universe of paid claims from which the sample is drawn, whether based upon judgmental factors or random selection. The sample may consist of any number of claims in the population up to one hundred percent. See also **"random claims sample"** and **"stratified random sample."**

"Authorization" - See **"prior authorization"** and **"expedited prior authorization (EPA)."**

"Average hospital rate" means the average of hospital rates for any particular type of rate that MAA uses.

"Bad debt" means an operating expense or loss incurred by a hospital because of uncollectible accounts receivables.

"Beneficiary" means a recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits.

"Billed charge" means the charge submitted to the department by the provider.

"Blended rate" means a mathematically weighted average rate.

"Border area hospital" means a hospital located outside Washington state and located in one of the bordering cities listed in WAC 388-501-0175.

"BR" - See **"by report."**

"Bundled services" mean interventions which are integral to the major procedure and are not reimbursable separately.

"Buy-in premium" means a monthly premium the state pays so a client is enrolled in part A and/or part B Medicare.

"By report (BR)" means a method of reimbursement in which MAA determines the amount it will pay for a service when the rate for that service is not included in MAA's published fee schedules. Upon request the provider must submit a "report" which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Callback" means keeping hospital staff members on duty beyond their regularly scheduled hours, or having them return to the facility after hours to provide unscheduled services which are usually associated with hospital emergency room, surgery, laboratory and radiology services.

"Capital-related costs" mean the component of operating costs related to capital assets, including, but not limited to:

- (1) Net adjusted depreciation expenses;
- (2) Lease and rentals for the use of depreciable assets;
- (3) The costs for betterment and improvements;
- (4) The cost of minor equipment;
- (5) Insurance expenses on depreciable assets;
- (6) Interest expense; and
- (7) Capital-related costs of related organizations that provide services to the hospital.

Capital costs due solely to changes in ownership of the provider's capital assets are excluded.

"Case mix complexity" means, from the clinical perspective, the condition of the treated patients and the difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution.

"Case mix index (CMI)" means the arithmetical index that measures the average relative weight of a case treated in a hospital during a defined period.

"Charity care" means necessary hospital health care rendered to indigent persons, to the extent that these persons are unable to pay for the care or to pay the deductibles or coinsurance amounts required by a third-party payer, as determined by the department.

"Chemical dependency" means an alcohol or drug addiction; or dependence on alcohol and one or more other psychoactive chemicals.

"Children's hospital" means a hospital primarily serving children.

"Client" means a person who receives or is eligible to receive services through department of social and health services (DSHS) programs.

"Comorbidity" means of, relating to, or caused by a disease other than the principal disease.

"Complication" means a disease or condition occurring subsequent to or concurrent with another condition and aggravating it.

"Comprehensive hospital abstract reporting system (CHARS)" means the department of health's hospital data collection, tracking and reporting system.

"Contract hospital" means a licensed hospital located in a selective contracting area, which is awarded a contract to participate in MAA's hospital selective contracting program.

"Contractual adjustment" means the difference between the amount billed at established charges for the services provided and the amount received or due from a third-

party payer under a contract agreement. A contractual adjustment is similar to a trade discount.

"Cost proxy" means an average ratio of costs to charges for ancillary charges or per diem for accommodation cost centers used to determine a hospital's cost for the services where the hospital has Medicaid claim charges for the services, but does not report costs in corresponding centers in its Medicare cost report.

"Cost report" means the HCFA Form 2552, Hospital and Hospital Health Care Complex Cost Report, completed and submitted annually by a provider:

(1) To Medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and

(2) To Medicaid to establish appropriate DRG and RCC reimbursement.

"Costs" mean MAA-approved operating, medical education, and capital-related costs as reported and identified on the HCFA 2552 form.

"Cost-based conversion factor (CBCF)" means a hospital-specific dollar amount that reflects a hospital's average cost of treating Medicaid clients. It is calculated from the hospital's cost report by dividing the hospital's costs for treating Medicaid clients during a base period by the number of Medicaid discharges during that same period and adjusting for the hospital's case mix. See also **"hospital conversion factor"** and **"negotiated conversion factor."**

"County hospital" means a hospital established under the provisions of chapter 36.62 RCW.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Customary charge payment limit" means the limit placed on aggregate DRG payments to a hospital during a given year to assure that DRG payments do not exceed the hospital's charges to the general public for the same services.

"Day outlier" means a case that requires MAA to make additional payment to the hospital provider but which does not qualify as a high-cost outlier. See **"day outlier payment"** and **"day outlier threshold."**

"Day outlier payment" means the additional amount paid to a disproportionate share hospital for a client five years old or younger who has a prolonged inpatient stay which exceeds the day outlier threshold but whose covered charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate.

"Day outlier threshold" means the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus twenty days.

"Deductible" means the amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

"Department" means the state department of social and health services (DSHS).

"Detoxification" means treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Diabetic education program" means a comprehensive, multidisciplinary program of instruction offered by an MAA-approved facility to diabetic clients on dealing with diabetes, including instruction on nutrition, foot care, medication and insulin administration, skin care, glucose monitoring, and recognition of signs/symptoms of diabetes with appropriate treatment of problems or complications.

"Diagnosis code" means a set of numeric or alphanumeric characters assigned by the ICD-9-CM, or successor document, as a shorthand symbol to represent the nature of a disease.

"Diagnosis-related group (DRG)" means a classification system which categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases (ICD-9), the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

"Direct medical education costs" means the direct costs of providing an approved medical residency program as recognized by Medicare.

"Discharging hospital" means the institution releasing a client from the acute care hospital setting.

"Disproportionate share payment" means additional payment(s) made by the department to a hospital which serves a disproportionate number of Medicaid and other low-income clients and which qualifies for one or more of the disproportionate share hospital programs identified in the state plan.

"Disproportionate share program" means a program that provides additional payments to hospitals which serve a disproportionate number of Medicaid and other low-income clients.

"Dispute conference" - See **"hospital dispute conference."**

"Distinct unit" means a Medicare-certified distinct area for psychiatric or rehabilitation services within an acute care hospital or a department-designated unit in a children's hospital.

"Division of alcohol and substance abuse (DASA)" is the division within DSHS responsible for providing alcohol and drug-related services to help clients recover from alcoholism and drug addiction.

"DRG" - See **"diagnosis-related group."**

"DRG-exempt services" means services which are paid for through other methodologies than those using cost-based conversion factors (CBCF) or negotiated conversion factors (NCF).

"DRG payment" means the payment made by the department for a client's inpatient hospital stay. This payment calculated by multiplying the hospital-specific conversion factor by the DRG relative weight for the client's medical diagnosis.

"DRG relative weight" means the average cost or charge of a certain DRG divided by the average cost or charge, respectively, for all cases in the entire data base for all DRGs.

"Drug addiction and/or drug abuse treatment" means the provision of medical and rehabilitative social ser-

vices to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities to detoxified addicts and their families.

"DSHS" means the department of social and health services.

"Elective procedure or surgery" means a nonemergent procedure or surgery that can be scheduled at convenience.

"Emergency room" or **"emergency facility"** means an organized, distinct hospital-based facility available twenty-four hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and is capable of providing emergency services including trauma care.

"Emergency services" means medical services required by and provided to a patient after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. For hospital reimbursement purposes, inpatient maternity services are treated as emergency services.

"Equivalency factor (EF)" means a conversion factor used, in conjunction with two other factors (cost-based conversion factor and the ratable factor), to determine the level of state-only program payment.

"Exempt hospital—DRG payment method" means a hospital that for a certain patient category is reimbursed for services to MAA clients through methodologies other than those using cost-based or negotiated conversion factors.

"Exempt hospital—Hospital selective contracting program" means a hospital that is either not located in a selective contracting area or is exempted by the department from the selective contracting program.

"Expedited prior authorization (EPA)" means the MAA-delegated process of creating an authorization number for selected medical/dental procedures and related supplies and services in which providers use a set of numeric codes to indicate which MAA-acceptable indications, conditions, diagnoses, and/or MAA-defined criteria are applicable to a particular request for service.

"Expedited prior authorization (EPA) number" means an authorization number created by the provider that certifies that MAA-published criteria for the medical/dental procedures and related supplies and services have been met.

"Experimental" means a term to describe a procedure, or course of treatment, which lacks scientific evidence of safety and effectiveness. See WAC 388-531-0500. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the FDA or other requisite government body if such approval is required.

"Facility triage fee" means the amount MAA will pay a hospital for a medical evaluation or medical screening examination, performed in the hospital's emergency department,

for a nonemergent condition of a *healthy options* client covered under the primary care case management (PCCM) program. This amount corresponds to the professional care level A or level B service.

"Fee-for-service" means the general payment method the department uses to reimburse providers for covered medical services provided to medical assistance clients when these services are not covered under MAA's *healthy options* program.

"Fiscal intermediary" means Medicare's designated fiscal intermediary for a region and/or category of service.

"Fixed per diem rate" means a daily amount used to determine payment for specific services.

"Global surgery days" means the number of preoperative and follow-up days that are included in the reimbursement to the physician for the major surgical procedure.

"Graduate medical education costs" means the direct and indirect costs of providing medical education in teaching hospitals.

"Grouper" - See **"all-patient grouper (AP-DRG)."**

"HCFA 2552" - See **"cost report."**

"Health care team" means a group of health care providers involved in the care of a client.

"High-cost outlier" means a claim paid under the DRG method that did not meet the definition of "administrative day," and has extraordinarily high costs when compared to other claims in the same DRG, in which the allowed charges, before January 1, 2001, exceed three times the applicable DRG payment and exceed twenty-eight thousand dollars. For dates of service January 1, 2001 and after, to qualify as a high-cost outlier, the allowed charges must exceed three times the applicable DRG payment and exceed thirty-three thousand dollars.

"Hospice" means a medically-directed, interdisciplinary program of palliative services for terminally ill clients and the clients' families. Hospice is provided under arrangement with a Title XVIII Washington state-licensed and Title XVIII-certified Washington state hospice.

"Hospital" means an entity which is licensed as an acute care hospital in accordance with applicable state laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

"Hospital base period" means, for purposes of establishing a provider rate, a specific period or timespan used as a reference point or basis for comparison.

"Hospital base period costs" means costs incurred in or associated with a specified base period.

"Hospital conversion factor" means a hospital-specific dollar amount that reflects the average cost for a DRG paid case of treating Medicaid clients in a given hospital. See cost-based conversion factor (CBCF) and negotiated conversion factor (NCF).

"Hospital covered service" means a service that is provided by a hospital, included in the medical assistance program and is within the scope of the eligible client's medical care program.

"Hospital cost report" - See **"cost report."**

"Hospital dispute resolution conference" means a meeting for deliberation during a provider administrative appeal.

(1) The first dispute resolution conference is usually a meeting between medical assistance administration and hospital staff, to discuss a department action or audit finding(s). The purpose of the meeting is to clarify interpretation of regulations and policies relied on by the department or hospital, provide an opportunity for submission and explanation of additional supporting documentation or information, and/or to verify accuracy of calculations and application of appropriate methodology for findings or administrative actions being appealed. Issues appealed by the provider will be addressed in writing by the department.

(2) At the second level of dispute resolution:

(a) For hospital rates issues, the dispute resolution conference is an informal administrative hearing conducted by an MAA administrator for the purpose of resolving contractor/provider rate disagreements with the department's action at the first level of appeal. The dispute resolution conference in this regard is not a formal adjudicative process held in accordance with the Administrative Procedure Act.

(b) For hospital audit issues, the audit dispute resolution hearing will be held by the office of administrative hearings in accordance with WAC 388-560-1000. This hearing is a formal proceeding and is governed by chapter 34.05 RCW.

"Hospital facility fee" - See **"facility triage fee."**

"Hospital market basket index" means a measure, expressed as a percentage, of the annual inflationary costs for hospital services, as measured by Data Resources, Inc. (DRI).

"Hospital peer group" means the peer group categories adopted by the former Washington state hospital commission for rate-setting purposes:

(1) Group A - rural hospitals paid under a ratio of costs-to-charges (RCC) methodology (same as peer group 1);

(2) Group B - urban hospitals without medical education programs (same as peer group 2);

(3) Group C - urban hospitals with medical education programs; and

(4) Group D - specialty hospitals and/or hospitals not easily assignable to the other three peer groups.

"Hospital selective contracting program" or **"selective contracting"** means a negotiated bidding program for hospitals within specified geographic areas to provide inpatient hospital services to medical assistance clients.

"Indigent patient" means a patient who has exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below two hundred percent of the federal poverty standards (adjusted for family size), or is otherwise not sufficient to enable the individual to pay for his or her care, or to pay deductibles or coinsurance amounts required by a third-party payor.

"Indirect medical education costs" means the indirect costs of providing an approved medical residency program as recognized by Medicare.

"Inflation adjustment" means, for cost inflation, the hospital inflation adjustment. This adjustment is determined by using the inflation factor method and guidance indicated by the legislature in the budget notes to the biennium appropriations bill. For charge inflation, it means the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) standard reports three and four.

"Informed consent" means that an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

- (1) Disclosed and discussed the patient's diagnosis;
- (2) Offered the patient an opportunity to ask questions about the procedure and to request information in writing;
- (3) Given the patient a copy of the consent form;
- (4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. 441.257; and

(5) Given the patient oral information about all of the following:

- (a) The patient's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;
- (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
- (c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital" means a hospital authorized by the department of health to provide inpatient services.

"Inpatient hospital admission" means an admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

"Inpatient services" means healthcare services provided directly or indirectly to a client subsequent to the client's inpatient hospital admission and prior to discharge.

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Edition" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alpha numerical designations (coding).

"Length of stay (LOS)" means the number of days of inpatient hospitalization. See also **"PAS length of stay (LOS)."**

"Length of stay extension request" means a request from a hospital provider for the department, or in the case of psychiatric admission, the appropriate regional support network (RSN), to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age.

"Lifetime hospitalization reserve" means, under the Medicare Part A benefit, the nonrenewable sixty hospital days that a beneficiary is entitled to use during his or her lifetime for hospital stays extending beyond ninety days per benefit period. See also **"reserve days."**

"Low-cost outlier" means a case with extraordinarily low costs when compared to other cases in the same DRG, in which the allowed charges before January 1, 2001, are less than ten percent of the applicable DRG payment or less than four hundred dollars. For dates of service on and after January 1, 2001, to qualify as a low-cost outlier, the allowed charges must be less than ten percent of the applicable DRG payment or less than four hundred and fifty dollars.

"Low income utilization rate" means a formula represented as $(A/B)+(C/D)$ in which:

(1) The numerator A is the hospital's total patient services revenue under the state plan, plus the amount of cash subsidies for patient services received directly from state and local governments in a period;

(2) The denominator B is the hospital's total patient services revenue (including the amount of such cash subsidies) in the same period as the numerator;

(3) The numerator C is the hospital's total inpatient service charge attributable to charity care in a period, less the portion of cash subsidies described in (1) of this definition in the period reasonably attributable to inpatient hospital services. The amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the state plan); and

(4) The denominator D is the hospital's total charge for inpatient hospital services in the same period as the numerator.

"Major diagnostic category (MDC)" means one of the twenty-five mutually exclusive groupings of principal diagnosis areas in the DRG system. The diagnoses in each MDC correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.

"Market basket index" - See **"hospital market basket index."**

"MDC" - See **"major diagnostic category."**

"Medicaid" is the state and federally funded aid program that covers the categorically needy (CNP) and medically needy (MNP) programs.

"Medicaid cost proxy" means a figure developed to approximate or represent a missing cost figure.

"Medicaid inpatient utilization rate" means a formula represented as X/Y in which:

(1) The numerator X is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan in a period.

(2) The denominator Y is the hospital's total number of inpatient days in the same period as the numerator's. Inpatient day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

"Medical assistance administration (MAA)" is the administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI children's health insurance program (CHIP), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

"Medical assistance program" means both Medicaid and medical care services programs.

"Medical care services" means the limited scope of care financed by state funds and provided to general assistance-unemployable (GAU) and ADATSA clients.

"Medical education costs" means the expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

"Medical screening evaluation" means the service(s) provided by a physician or other practitioner to determine whether an emergent medical condition exists. See also **"facility triage fee."**

"Medical stabilization" means a return to a state of constant and steady function. It is commonly used to mean the patient is adequately supported to prevent further deterioration.

"Medically indigent person" means a person certified by the department of social and health services as eligible for the limited casualty program-medically indigent (LCP-MI) program. See also **"indigent patient."**

"Medicare cost report" means the annual cost data reported by a hospital to Medicare on the HCFA form 2552.

"Medicare crossover" means a claim involving a client who is eligible for both Medicare benefits and Medicaid.

"Medicare fee schedule (MFS)" means the official HCFA publication of Medicare policies and relative value units for the resource based relative value scale (RBRVS) reimbursement program.

"Medicare Part A" means that part of the Medicare program that helps pay for inpatient hospital services, which may include, but are not limited to:

- (1) A semi-private room;
- (2) Meals;
- (3) Regular nursing services;
- (4) Operating room;
- (5) Special care units;
- (6) Drugs and medical supplies;
- (7) Laboratory services;
- (8) X-ray and other imaging services; and
- (9) Rehabilitation services.

Medicare hospital insurance also helps pay for post-hospital skilled nursing facility care, some specified home health care, and hospice care for certain terminally ill beneficiaries.

"Medicare Part B" means that part of the Medicare program that helps pay for, but is not limited to:

- (1) Physician services;
- (2) Outpatient hospital services;
- (3) Diagnostic tests and imaging services;
- (4) Outpatient physical therapy;
- (5) Speech pathology services;
- (6) Medical equipment and supplies;
- (7) Ambulance;
- (8) Mental health services; and
- (9) Home health services.

"Medicare buy-in premium" - See **"buy-in premium."**

"Medicare payment principles" means the rules published in the federal register regarding reimbursement for services provided to Medicare clients.

"Mentally incompetent" means a person who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the person has been declared competent for purposes which include the ability to consent to sterilization.

"Multiple occupancy rate" means the rate customarily charged for a hospital room with two to four patient beds.

"Negotiated conversion factor (NCF)" means a negotiated hospital-specific dollar amount which is used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also **"hospital conversion factor"** and **"cost-based conversion factor."**

"Nonallowed service or charge" means a service or charge that is not recognized for payment by the department, and cannot be billed to the client.

"Noncontract hospital" means a licensed hospital located in a selective contracting area (SCA) but which does not have a contract to participate in the hospital selective contracting program.

"Noncovered service or charge" means a service or charge that is not reimbursed by the department.

"Nonemergent hospital admission" means any inpatient hospitalization of a patient who does not have an emergent condition, as defined in WAC 388-500-0005, Emergency services.

"Nonparticipating hospital" means a noncontract hospital. See **"noncontract hospital."**

"Observation services" means healthcare services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Operating costs" means all expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs.

"OPPS" - See **"outpatient prospective payment system."**

"OPPS adjustment" means the legislative mandated reduction in the outpatient adjustment factor made to account for the delay of OPPS implementation.

"OPPS outpatient adjustment factor" means the outpatient adjustment factor reduced by the OPPS and adjustment factor as a result of legislative mandate.

"Orthotic device" or **"orthotic"** means a corrective or supportive device that:

- (1) Prevents or corrects physical deformity or malfunction; or
- (2) Supports a weak or deformed portion of the body.

"Out-of-state hospital" means any hospital located outside the state of Washington and outside the designated border areas in Oregon and Idaho.

"Outlier set-aside factor" means the amount by which a hospital's cost-based conversion factor is reduced for payments of high cost outlier cases.

"Outlier set-aside pool" means the total amount of payments for high cost outliers which are funded annually based on payments for high cost outliers during the year.

"Outliers" means cases with extraordinarily high or low costs when compared to other cases in the same DRG.

"Outpatient" means a patient who is receiving medical services in other than an inpatient hospital setting.

"Outpatient care" means medical care provided other than inpatient services in a hospital setting.

"Outpatient hospital" means a hospital authorized by the department of health to provide outpatient services.

"Outpatient hospital services" means those healthcare services that are within a hospital's licensure and provided to a client who is designated as an outpatient.

"Outpatient observation" - See **"observation services."**

"Outpatient prospective payment system (OPPS)" means the payment system used by MAA to calculate reim-

bursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Outpatient short stay" - See **"observation services"** and **"outpatient hospital services."**

"Outpatient surgery" means a surgical procedure that is not expected to require an inpatient hospital admission.

"Pain treatment facility" means an MAA-approved inpatient facility for pain management, in which a multidisciplinary approach is used to teach clients various techniques to live with chronic pain.

"Participating hospital" means a licensed hospital that accepts MAA clients.

"PAS length of stay (LOS)" means the average length of an inpatient hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled *Length of Stay by Diagnosis, Western Region*. See also **"professional activity study (PAS)."**

"Patient consent" means the informed consent of the patient and/or the patient's legal guardian, as evidenced by the patient's or guardian's signature on a consent form, for the procedure(s) to be performed upon or for the treatment to be provided to the patient.

"Peer group" - See **"hospital peer group."**

"Peer group cap" means the reimbursement limit set for hospital peer groups B and C, established at the seventieth percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs.

"Per diem charge" means the daily room charge, per client, billed by the facility for room and board services that are covered by the department. This is sometimes referred to as "room rate."

"Personal comfort items" means items and services which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member.

"PM&R" - See **"Acute PM&R."**

"Physician standby" means physician attendance without direct face-to-face patient contact and does not involve provision of care or services.

"Physician's current procedural terminology (CPT)" - See **"CPT."**

"Plan of treatment" or **"plan of care"** means the written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

"Pregnant and postpartum women (PPW)" means eligible female clients who are pregnant or until the end of the month which includes the sixtieth day following the end of the pregnancy.

"Principal diagnosis" means the condition established after study to be chiefly responsible for the admission of the patient to the hospital for care.

"Principal procedure" means a procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

"Prior authorization" means a process by which clients or providers must request and receive MAA approval for

certain medical services, equipment, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization.

"Private room rate" means the rate customarily charged by a hospital for a one-bed room.

"Professional activity study (PAS)" means the compilation of inpatient hospital data by diagnosis and age, conducted by the Commission of Professional and Hospital Activities, which resulted in the determination of an average length of stay for patients. The data are published in a book entitled *Length of Stay by Diagnosis, Western Region*.

"Professional component" means the part of a procedure or service that relies on the physician's professional skill or training, or the part of a reimbursement that recognizes the physician's cognitive skill.

"Prognosis" means the probable outcome of a patient's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the patient's probable life span as a result of the illness.

"Prolonged service" means direct face-to-face patient services provided by a physician, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services.

"Prospective payment system (PPS)" means a system that sets payment rates for a predetermined period for defined services, before the services are provided. The payment rates are based on economic forecasts and the projected cost of services for the predetermined period.

"Prosthetic device" or **"prosthetic"** means a replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

- (1) Artificially replace a missing portion of the body;
- (2) Prevent or correct physical deformity or malfunction;
- (3) Support a weak or deformed portion of the body.

"Psychiatric hospitals" means Medicare-certified distinct part psychiatric units, Medicare-certified psychiatric hospitals, and state-designated pediatric distinct part psychiatric units in acute care hospitals. State-owned psychiatric hospitals are excluded.

"Public hospital district" means a hospital district established under chapter 70.44 RCW.

"Random claims sample" means a sample in which all of the items are selected randomly, using a random number table or computer program, based on a scientific method of assuring that each item has an equal chance of being included in the sample. See also **"audit claims sample"** and **"stratified random sample."**

"Ratable" means a hospital-specific adjustment factor applied to the cost-based conversion factor (CBCF) to determine state-only program payment rates to hospitals.

"Ratio of costs-to-charges (RCC)" means a method used to pay hospitals for services exempt from the DRG payment method. It also refers to the factor applied to a hospital's allowed charges for medically necessary services to determine payment to the hospital for these DRG-exempt services.

"RCC" - See **"ratio of costs-to-charges."**

"Rebasing" means the process of recalculating the hospital cost-based conversion factors or RCC using historical data.

"Recalibration" means the process of recalculating DRG relative weights using historical data.

"Regional support network (RSN)" means a county authority or a group of county authorities recognized and certified by the department, that contracts with the department per chapters 38.52, 71.05, 71.24, 71.34, and 74.09 RCW and chapters 275-54, 275-55, and 275-57 WAC.

"Rehabilitation units" means specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals that meet Medicare criteria for distinct part rehabilitation units.

"Relative weights" - See **"DRG relative weights."**

"Remote hospitals" means hospitals that meet the following criteria during the hospital selective contracting (HSC) waiver application period:

- (1) Are located within Washington state;
- (2) Are more than ten miles from the nearest hospital in the HSC competitive area; and
- (3) Have fewer than seventy-five beds; and
- (4) Have fewer than five hundred Medicaid admissions within the previous waiver period.

"Reserve days" means the days beyond the ninetieth day of hospitalization of a Medicare patient for a benefit period or spell of illness. See also **"lifetime hospitalization reserve."**

"Retrospective payment system" means a system that sets payment rates for defined services according to historic costs. The payment rates reflect economic conditions experienced in the past.

"Revenue code" means a nationally-assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" means the services a hospital facility provides a patient during the patient's hospital stay. These services include, but are not limited to, a routine or special care hospital room and related furnishings, routine supplies, dietary and nursing services, and the use of certain hospital equipment and facilities.

"Rural health clinic" means a clinic that is located in areas designed by the Bureau of Census as rural and by the Secretary of the Department of Health, Education and Welfare (DHEW) as medically underserved.

"Rural hospital" means a rural health care facility capable of providing or assuring availability of health services in a rural area.

"Secondary diagnosis" means a diagnosis other than the principal diagnosis for which an inpatient is admitted to a hospital.

"Selective contracting area (SCA)" means an area in which hospitals participate in negotiated bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by Medicaid patients.

"Semi-private room rate" means a rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

"Seven-day readmission" means the situation in which a client who was admitted as an inpatient and discharged

from the hospital has returned to inpatient status to the same or a different hospital within seven days.

"Special care unit" means a department of health (DOH) or Medicare-certified hospital unit where intensive care, coronary care, psychiatric intensive care, burn treatment or other specialized care is provided.

"Specialty hospitals" means children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of patients or diseases.

"Spenddown" means the process of assigning excess income for the medically needy program, or excess income and/or resources for the medically indigent program, to the client's cost of medical care. The client must incur medical expenses equal to the excess income (spenddown) before medical care can be authorized.

"Stat laboratory charges" means the charges by a laboratory for performing a test or tests immediately. "Stat." is the abbreviation for the Latin word "statim" meaning immediately.

"State plan" means the plan filed by the department with the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS), outlining how the state will administer Medicaid services, including the hospital program.

"Stratified random sample" means a sample consisting of claims drawn randomly, using statistical formulas, from each stratum of a universe of paid claims stratified according to the dollar value of the claims. See also **"audit claims sample"** and **"random claims sample."**

"Subacute care" means care provided to a patient which is less intensive than that given at an acute care hospital. Skilled nursing, nursing care facilities and other facilities provide subacute care services.

"Surgery" means the medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999.

"Swing-bed day" means a day in which an inpatient is receiving skilled nursing services in a hospital designated swing bed at the hospital's census hour. The hospital swing bed must be certified by the health care financing administration (HCFA) for both acute care and skilled nursing services.

"Teaching hospital" means, for purposes of the teaching hospital assistance program disproportionate share hospital (THAPDSH), the University of Washington Medical Center and Harborview Medical Center.

"Technical component" means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of a reimbursement that recognizes the equipment cost and technician time.

"Tertiary care hospital" means a specialty care hospital providing highly specialized services to clients with more complex medical needs than acute care services.

"Total patient days" means all patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

"Transfer" means to move a client from one acute care facility or distinct unit to another.

"Transferring hospital" means the hospital or distinct unit that transfers a client to another acute care facility.

"Trauma care facility" means a facility certified by the department of health as a level I, II, III, IV, or V facility. See chapter 246-976 WAC.

"Trauma care service" - See department of health's WAC 246-976-935.

"UB-92" means the uniform billing document intended for use nationally by hospitals, nonhospital-based acute PM&R (Level B) nursing facilities, hospital-based skilled nursing facilities, home health, and hospice agencies in billing third party payers for services provided to patients.

"Unbundled services" means services which are excluded from the DRG payment to a hospital.

"Uncompensated care" - See **"charity care."**

"Uniform cost reporting requirements" means a standard accounting and reporting format as defined by Medicare.

"Uninsured indigent patient" means an individual who has no health insurance coverage or has insufficient health insurance or other resources to cover the cost of provided inpatient and/or outpatient services.

"Usual and customary charge (UCC)" means the charge customarily made to the general public for a procedure or service, or the rate charged other contractors for the service if the general public is not served.

"Vendor rate increase" means an inflation adjustment determined by the legislature, used to periodically increase reimbursement to vendors, including health care providers, that do business with the state.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-057, § 388-550-1050, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-043, § 388-550-1050, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-1050, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303 and .2652. 99-14-039, § 388-550-1050, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-1050, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1050, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1100 Hospital coverage. (1) The medical assistance administration (MAA) covers the admission of a medical assistance client to a hospital only when the client's attending physician orders admission and when the admission and treatment provided meet the requirements of this chapter. For nonemergency hospital admissions, "attending physician" means the client's primary care provider, or the primary provider of care to the client at the time of hospitalization. For emergent admissions, "attending physician" means the staff member who has hospital admitting privileges and evaluates the client's medical condition upon the client's arrival at the hospital.

(2) Medical record documentation of hospital services must meet the requirements in WAC 388-502-0020(1), Records and reports—Medical record system.

(3) In areas where the choice of hospitals is limited by managed care or selective contracting, the department is not responsible for payment under fee-for-service for hospital care and/or services:

(a) Provided to clients enrolled in an MAA managed care plan, unless the services are excluded from the health carrier's capitation contract with MAA and are covered under the medical assistance program; or

(b) Received by a Medicaid-eligible client from a non-participating hospital in a selective contracting area (SCA) unless exclusions in WAC 388-550-4600 and 388-550-4700 apply.

(4) The department provides chemical-dependent pregnant Medicaid-eligible clients up to twenty-six days of inpatient hospital care for hospital-based detoxification, medical stabilization, and drug treatment when:

(a) An alcoholism, drug addiction and treatment support act ADATSA assessment center verifies the need for the inpatient care; and

(b) The hospital chemical dependency treatment unit is certified by the division of alcohol and substance abuse.

See WAC 388-550-6250 for outpatient hospital services for chemical-dependent pregnant Medicaid clients.

(5) The department covers detoxification of acute alcohol or other drug intoxication only in a hospital having a detoxification provider agreement with MAA to perform these services.

(6) The department covers medically necessary services provided to eligible clients in a hospital setting for the care or treatment of teeth, jaws, or structures directly supporting the teeth:

(a) If the procedure requires hospitalization; and

(b) A physician or dentist provides or directly supervises such services.

(7) The department pays hospitals for services provided in special care units when the provisions in WAC 388-550-2900(13) are met.

(8) All services are subject to review and approval as stated in WAC 388-501-0050.

(9) For inpatient voluntary or involuntary psychiatric admissions, see WAC 388-550-2600 and chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-1100, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090. 01-02-075, § 388-550-1100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1200 Limitations on hospital coverage. Hospital coverage under the medical assistance fee for service program is limited for certain eligible clients. This coverage includes, but is not limited to the following:

(1) Medical care clients enrolled with the department's healthy options carriers are subject to the respective carrier's policies and procedures for coverage of hospital services;

(2) Medical care clients covered by primary care case management are subject to the clients' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for clients described in subsection (2) and (3) of this section, see WAC 388-538-100.

(4) Coverage for medically indigent (MI) clients is limited to emergent hospital services, subject to the conditions

and limitations of WAC 388-521-2140, 388-529-2950, and this chapter:

(a) Out-of-state care, hospital or other medical, is not covered for clients under the MI program; and

(b) Border areas are considered in-state.

(5) Out-of-state medical care is not covered for clients under the medical care services program.

(6) See WAC 388-550-1100(3) for chemical-dependent pregnant clients.

(7) Only Medicaid categorically needy and medically needy clients under twenty-one years of age, or sixty-five years of age or older may receive care in a state mental institution or approved psychiatric facility.

(8)(a) For clients eligible for both Medicare and Medicaid hospitalization, MAA pays deductibles and coinsurance, unless the client has exhausted his or her Medicare Part A benefits.

(i) MAA payment is limited in amount so that when added to the Medicare payment, the total amount is no more than what the department pays for the same service when provided to a Medicaid eligible, non-Medicare client.

(ii) Providers must accept the total Medicare/Medicaid amount as payment in full.

(iii) Beneficiaries are not liable for any additional charges billed by providers or by a managed care entity.

(iv) Providers or managed care entities that charge beneficiaries excess amounts are subject to sanctions.

(b) If such benefits are exhausted, the department pays for hospitalization for such clients subject to MAA rules.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-1200, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1300 Revenue code categories and subcategories. (1) Revenue code categories and subcategories listed in this chapter are published in the UB-92 National Uniform Billing Data Element Specifications Manual.

(2) The medical assistance administration (MAA) requires a hospital provider to report and bill all hospital services provided to medical assistance clients using the appropriate revenue codes published in the manual referenced in subsection (1) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-044, § 388-550-1300, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1350 Revenue code categories and subcategories—CPT and HCPCS reporting requirements for outpatient hospitals. (1) The medical assistance administration (MAA) requires an outpatient hospital provider to report the appropriate current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) codes in addition to the required revenue codes on an outpatient claim line with any of the following revenue code categories and subcategories:

(a) "IV therapy," only subcategory "infusion pump";

(b) "Medical/surgical supplies and devices," only subcategory "prosthetic/orthotic devices";

(c) "Laboratory";

(d) "Laboratory pathological";

(e) "Radiology - diagnostic";

(f) "Radiology - therapeutic";

(g) "Nuclear medicine";

(h) "CT scan";

(i) "Operating room services," only subcategories "general classification" and "minor surgery";

(j) "Blood and blood component administration, processing and storage," only subcategory "administration (e.g., transfusions)";

(k) "Other imaging services";

(l) "Respiratory services";

(m) "Physical therapy";

(n) "Occupational therapy";

(o) "Speech - language pathology";

(p) "Emergency room," only subcategories "general classification" and "urgent care";

(q) "Pulmonary function";

(r) "Audiology";

(s) "Cardiology";

(t) "Ambulatory surgical care";

(u) "Outpatient services";

(v) "Clinic," only subcategories "general classification," "dental clinic," and "other clinic";

(w) "Magnetic resonance technology (MRT)";

(x) "Medical/surgical supplies - extension";

(y) "Pharmacy - extension";

(z) "Labor room/delivery," only subcategories "delivery" and "birthing center";

(aa) "EKG/ECG (electrocardiogram)";

(bb) "EEG (electroencephalogram)";

(cc) "Gastro-intestinal services";

(dd) "Treatment/observation room";

(ee) "Lithotripsy";

(ff) "Acquisition of body components," only subcategories "living donor" and "cadaver donor";

(gg) "Hemodialysis - outpatient or home," only subcategory "general classification";

(hh) "Peritoneal dialysis - outpatient or home," only subcategory "general classification";

(ii) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home," only subcategory "general classification";

(jj) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home," only subcategory "general classification";

(kk) "Miscellaneous dialysis," only subcategories "general classification" and "ultrafiltration";

(ll) "Psychiatric/psychological treatments," only subcategory "electroshock therapy";

(mm) "Other diagnostic services";

(nn) "Other therapeutic services," only subcategory "other therapeutic service"; and

(oo) Other revenue code categories and subcategories identified and published by the department.

(2) For an outpatient claim line requiring a CPT or HCPCS code(s), the department denies payment if the required code is not reported on the line.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-044, § 388-550-1350, filed 9/10/03, effective 10/11/03.]

WAC 388-550-1400 Covered and noncovered revenue codes categories and subcategories for inpatient hospital services. Subject to the limitations and restrictions listed, this section identifies covered and noncovered revenue code categories and subcategories for inpatient hospital services.

(1) The department covers the following revenue code categories and subcategories for inpatient hospital services when the hospital provider accurately bills:

(a) "Room & board - private," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(b) "Room & board - semi-private two bed," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(c) "Room & board - semi-private - three and four beds," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(d) "Room & board - private (deluxe)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(e) "Nursery," only subcategories "general classification," "newborn - level I," "newborn - level II," "newborn - level III," and "newborn - level IV";

(f) "Intensive care," only subcategories "general classification," "surgical," "medical," "pediatric," "intermediate ICU," "burn care," and "trauma";

(g) "Coronary care," only subcategories "general classification," "myocardial infarction," "pulmonary care," and "intermediate CCU";

(h) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(i) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery" and "IV therapy/supplies";

(j) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant";

(k) "Oncology," only subcategory "general classification";

(l) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "nonroutine dialysis," "hematology," "bacteriology & microbiology," and "urology";

(m) "Laboratory pathological," only subcategories "general classification," "cytology," "histology," and "biopsy";

(n) "Radiology - diagnostic," only subcategories "general classification," "angiocardiology," "arthrography," "arteriography," and "chest X ray";

(o) "Radiology - therapeutic," only subcategories "general classification," "chemotherapy - injected," "chemotherapy - oral," "radiation therapy," and "chemotherapy - IV";

(p) "Nuclear medicine," only subcategories "general classification," "diagnostic," and "therapeutic";

(q) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(r) "Operating room services," only subcategories "general classification" and "minor surgery";

(s) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(t) "Blood and blood component administration, processing and storage," only subcategories "general classification" and "administration (e.g., transfusions)";

(u) "Other imaging services," only subcategories "general classification," "diagnostic mammography," "ultrasound," and "positron emission tomography";

(v) "Respiratory services," only subcategories "general classification," "inhalation services" and "hyper baric oxygen therapy";

(w) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(x) "Speech-language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(y) "Emergency room," only subcategories "general classification" and "urgent care";

(z) "Pulmonary function," only subcategory "general classification";

(aa) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(bb) "Ambulatory surgical care," only subcategory "general classification";

(cc) "Outpatient services," only subcategory "general classification";

(dd) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - brain (including brainstem)," "MRI - spinal cord (including spine)," "MRI - other," "MRA - head and neck," and "MRA - lower extremities";

(ee) "Medical/surgical supplies - extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(ff) "Pharmacy-extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(gg) "Cast room," only subcategory "general classification";

(hh) "Recovery room," only subcategory "general classification";

(ii) "Labor room/delivery," only subcategory "general classification," "labor," "delivery," and "birthing center";

(jj) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(kk) "EEG (Electroencephalogram)," only subcategory "general classification";

(ll) "Gastro-intestinal services," only subcategory "general classification";

(mm) "Treatment/observation room," only subcategories "general classification," "treatment room," and "observation room";

(nn) "Lithotripsy," only subcategory "general classification";

(oo) "Inpatient renal dialysis," only subcategories "general classification," "inpatient hemodialysis," "inpatient peritoneal (non-CAPD)," "inpatient continuous ambulatory peritoneal dialysis (CAPD)," and "inpatient continuous cycling peritoneal dialysis (CCPD)";

(pp) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(qq) "Miscellaneous dialysis," only subcategory "ultra filtration," and

(rr) "Other diagnostic services," only subcategories "peripheral vascularlab," "electromyogram," and "pregnancy test."

(2) The department covers the following revenue code subcategories for inpatient hospital services only when the hospital provider is approved by the department to provide the specific service(s):

(a) "All inclusive rate," only subcategory "all-inclusive room & board plus ancillary";

(b) "Room & board - private," only subcategory "psychiatric";

(c) "Room & board - semi-private two," only subcategories "psychiatric," "detoxification," "rehabilitation," and "other";

(d) "Room & board - semi-private three and four beds," only subcategories "psychiatric" and "detoxification";

(e) "Room & board - private (deluxe)," only subcategory "psychiatric";

(f) "Room & board - ward," only subcategories "general classification" and "detoxification";

(g) "Room & board - other," only subcategories "general classification" and "other";

(h) "Intensive care," only subcategory "psychiatric";

(i) "Coronary care," only subcategory "heart transplant";

(j) "Operating room services," only subcategories "organ transplant-other than kidney" and "kidney transplant";

(k) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate" and "evaluation or reevaluation";

(l) "Clinic," only subcategory "chronic pain clinic";

(m) "Ambulance," only subcategory "neonatal ambulance services";

(n) "Psychiatric/psychological treatments," only subcategory "electroshock treatment"; and

(o) "Psychiatric/psychological services," only subcategory "rehabilitation."

(3) The department covers revenue code category "occupational therapy," subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation" when:

(a) A client is in an acute PM&R facility;

(b) A client is age twenty or younger; or

(c) The diagnosis code is listed in the medical assistance administration's (MAA's) published billing instructions.

(4) The department does not cover the following revenue code categories and subcategories for inpatient hospital services:

(a) "All inclusive rate," subcategory "all-inclusive room and board";

(b) "Room & board - private" subcategories "hospice," "detoxification," "rehabilitation," and "other";

(c) "Room & board - semi-private two bed," subcategory "hospice";

(d) "Room & board - semi-private - three and four beds," subcategories "hospice," "rehabilitation," and "other";

(e) "Room & board - private (deluxe)," subcategories "hospice," "rehabilitation," and "other";

(f) "Room & board - ward," subcategories "medical/surgical/gyn," "OB," "pediatric" "hospice," "oncology," "rehabilitation," and "other";

(g) "Room & board - other," subcategories "sterile environment," and "self care";

(h) "Nursery," subcategory "other nursery";

(i) "Leave of absence";

(j) "Subacute care";

(k) "Intensive care," subcategory "other intensive care";

(l) "Coronary care," subcategory "other coronary care";

(m) "Special charges";

(n) "Incremental nursing charge rate";

(o) "All inclusive ancillary";

(p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";

(q) "IV therapy," subcategory "other IV therapy";

(r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotics devices," "oxygen - take home," and "other supplies/devices";

(s) "Oncology," subcategory "other oncology";

(t) "Durable medical equipment (other than renal)";

(u) "Laboratory," subcategories "renal patient (home)," and "other laboratory";

(v) "Laboratory pathological," subcategory "other laboratory - pathological";

(w) "Radiology - diagnostic," subcategory "other radiology - diagnostic";

(x) "Radiology - therapeutic," subcategory "other radiology - therapeutic";

(y) "Nuclear medicine," subcategory "other nuclear medicine";

(z) "CT scan," subcategory "other CT scan";

(aa) "Operating room services," subcategory "other operating room services";

(bb) "Anesthesia," subcategories "acupuncture," and "other anesthesia";

(cc) "Blood";

(dd) "Blood and blood component administration, processing and storage," subcategory "other processing and storage";

(ee) "Other imaging services," subcategories "screening mammography," and "other imaging services";

(ff) "Respiratory services," subcategory "other respiratory services";

(gg) "Physical therapy," subcategory "other physical therapy";

(hh) "Occupational therapy," subcategory "other occupational therapy";

(ii) "Speech-language pathology," subcategory "other speech-language pathology";

(jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening," and "other emergency room";

(kk) "Pulmonary function," subcategory "other pulmonary function";

(ll) "Audiology";

(mm) "Cardiology," subcategory "other cardiology";

(nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";

(oo) "Outpatient services," subcategory "other outpatient service";

(pp) "Clinic," subcategories "general classification," "dental clinic," "psychiatric clinic," "OB-gyn clinic," "pediatric clinic," "urgent care clinic," "family practice clinic," and "other clinic";

(qq) "Free-standing clinic";

(rr) "Osteopathic services";

(ss) "Ambulance," subcategories "general classification," "supplies," "medical transport," "heart mobile," "oxygen," "air ambulance," "pharmacy," "telephone transmission EKG," and "other ambulance";

(tt) "Skilled nursing";

(uu) "Medical social services";

(vv) "Home health - home health aide";

(ww) "Home health - other visits";

(xx) "Home health - units of service";

(yy) "Home health - oxygen";

(zz) "Magnetic resonance technology (MRT)," subcategories "MRA-other" and "other MRT";

(aaa) "Medical" "medical/surgical supplies - extension," subcategory "FDA investigational devices";

(bbb) "Home IV therapy services";

(ccc) "Hospice services";

(ddd) "Respite care";

(eee) "Outpatient residence charges";

(fff) "Trauma response";

(ggg) "Cast room," subcategory "other cast room";

(hhh) "Recovery room," subcategory "other recovery room";

(iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";

(jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";

(kkk) "EEG (Electroencephalogram)," subcategory "other EEG";

(lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";

(mmm) "Treatment/observation room," subcategory "other treatment/observation room";

(nnn) "Preventive care services";

(ooo) "Telemedicine";

(ppp) "Lithotripsy," subcategory "other lithotripsy";

(qqq) "Inpatient renal dialysis," subcategory "other inpatient dialysis";

(rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";

(sss) "Hemodialysis - outpatient or home";

(ttt) "Peritoneal dialysis - outpatient or home";

(uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home";

(vvv) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home";

(www) "Miscellaneous dialysis," subcategories "general classification," "home dialysis aid visit," and "other miscellaneous dialysis";

(xxx) "Psychiatric/psychological treatments," subcategories "general classification," "milieu therapy," "play therapy," "activity therapy," and "other psychiatric/psychological treatment";

(yyy) "Psychiatric/psychological services," subcategories "general classification," "partial hospitalization - less intensive," "partial hospitalization - intensive," "individual therapy," "group therapy," "family therapy," "bio feedback," "testing," and "other psychiatric/psychological service";

(zzz) "Other diagnostic services," subcategories "general classification," "pap smear," "allergy test," and "other diagnostic service";

(aaaa) "Medical rehabilitation day program";

(bbbb) "Other therapeutic services";

(cccc) "Professional fees";

(dddd) "Patient convenience items"; and

(eeee) Revenue code categories and subcategories that are not identified in this section.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-045, § 388-550-1400, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090. 01-02-075, § 388-550-1400, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1500 Covered and noncovered revenue code categories and subcategories for outpatient hospital services. (1) The department covers the following revenue code categories and subcategories for outpatient hospital services when the hospital provider accurately bills (see subsection (2) of this section for revenue code subcategories covered only when the department approves the hospital provider to provide the specific service(s)):

(a) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(b) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery," and "IV therapy/supplies";

(c) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant";

(d) "Oncology," only subcategory "general classification";

(e) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "renal patient (home)," "nonroutine dialysis," "hematology," "bacteriology and microbiology," and "urology";

(f) "Laboratory pathological," only subcategories "general classification," "cytology," "histology," and "biopsy";

(g) "Laboratory pathological," only subcategories "general classification," "cytology," "histology," and "biopsy";

(g) "Radiology - diagnostic," only subcategories "general classification," "angiocardiology," "arthrography," "arteriography," and "chest X ray";

(h) "Radiology - therapeutic," only subcategories "general classification," "chemotherapy - injected," "chemotherapy - oral," "radiation therapy," and "chemotherapy - IV";

(i) "Nuclear medicine," only subcategories "general classification," "diagnostic," and "therapeutic";

(j) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(k) "Operating room services," only subcategories "general classification" and "minor surgery";

(l) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(m) "Blood and blood component administration, processing and storage," only subcategories "general classification" and "administration (e.g., transfusions)";

(n) "Other imaging," only subcategories "general classification," "diagnostic mammography," "ultrasound," "screening mammography," and "positron emission tomography";

(o) "Respiratory services," only subcategories "general classification," "inhalation services," and "hyper baric oxygen therapy";

(p) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(q) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(r) "Speech-language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(s) "Emergency room," only subcategories "general classification" and "urgent care";

(t) "Pulmonary function," only subcategory "general classification";

(u) "Audiology," only subcategories "general classification," "diagnostic," and "treatment";

(v) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(w) "Ambulatory surgical care," only subcategory "general classification";

(x) "Outpatient services," only subcategory "general classification";

(y) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - brain (including brainstem)," "MRI - spinal cord (including spine)," "MRI - other," "MRA - head and neck," and "MRA - lower extremities";

(z) "Medical/surgical supplies - extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(aa) "Pharmacy - extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(bb) "Cast room," only subcategory "general classification";

(cc) "Recovery room," only subcategory "general classification";

(dd) "Labor room/delivery," only subcategories "general classification," "labor," "delivery," and "birthing center";

(ee) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(ff) "EEG (Electroencephalogram)," only subcategory "general classification";

(gg) "Gastro-intestinal services," only subcategory "general classification";

(hh) "Treatment/observation room," only subcategories "general classification," "treatment room," and "observation room";

(ii) "Lithotripsy," only subcategory "general classification";

(jj) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(kk) "Hemodialysis - outpatient or home," only subcategory "general classification";

(ll) "Peritoneal dialysis - outpatient or home," only subcategory "general classification";

(mm) "Continuous ambulatory peritoneal dialysis (CAPD - outpatient or home," only subcategory "general classification";

(nn) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home," only subcategory "general classification";

(oo) "Miscellaneous dialysis," only subcategories "general classification," and "ultra filtration";

(pp) "Psychiatric/psychological treatments," only subcategory "electroshock treatment"; and

(qq) "Other diagnostic services," only subcategories "peripheral vascular lab," "electromyelogram," "pap smear," "allergy test," and "pregnancy test."

(2) The department covers the following revenue code subcategories only when the outpatient hospital provider is approved by the department to provide the specific service(s):

(a) "Clinic," subcategories "general classification," "dental clinic," and "other clinic"; and

(b) "Other therapeutic services - extension," subcategories "education/training" and "other therapeutic service."

(3) The department does not cover the following revenue code categories and subcategories for outpatient hospital services:

(a) "All inclusive rate";

(b) "Room & board - private";

(c) "Room & board - semi-private two bed";

(d) "Room & board - semi-private three and four beds";

(e) "Room & board - private (deluxe)";

(f) "Room & board - ward";

(g) "Room & board - other";

(h) "Nursery";

(i) "Leave of absence";

(j) "Subacute care";

(k) "Intensive care";

(l) "Coronary care";

(m) "Special charges";

(n) "Incremental nursing charge rate";

- (o) "All inclusive ancillary";
- (p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";
- (q) "IV therapy," subcategory "other IV therapy";
- (r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotic devices," "oxygen - take home," and "other supplies/devices";
- (s) "Oncology," subcategory "other oncology";
- (t) "Durable medical equipment (other than renal);
- (u) "Laboratory," subcategory "other laboratory";
- (v) "Laboratory pathological," subcategory "other laboratory pathological";
- (w) "Radiology - diagnostic," subcategory "other radiology - diagnostic";
- (x) "Radiology - therapeutic," subcategory "other radiology - therapeutic";
- (y) "Nuclear medicine," subcategory "other nuclear medicine";
- (z) "CT scan," subcategory "other CT scan";
- (aa) "Operating room services," subcategories "organ transplant - other than kidney," "kidney transplant," and "other operating room services";
- (bb) "Anesthesia," subcategories "acupuncture" and "other anesthesia";
- (cc) "Blood";
- (dd) "Blood and blood component administration, processing and storage," subcategory "other processing and storage";
- (ee) "Other imaging," subcategory "other imaging service";
- (ff) "Respiratory services," subcategory "other respiratory services";
- (gg) "Physical therapy services," subcategory "other physical therapy";
- (hh) "Occupational therapy services," subcategory "other occupational therapy";
- (ii) "Speech-language pathology," subcategory "other speech-language pathology";
- (jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening" and "other emergency room";
- (kk) "Pulmonary function," subcategory "other pulmonary function";
- (ll) "Audiology," subcategory "other audiology";
- (mm) "Cardiology," subcategory "other cardiology";
- (nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";
- (oo) "Outpatient Services," subcategory "other outpatient service";
- (pp) "Clinic," subcategories "chronic pain center," "psychiatric clinic," "OB-GYN clinic," "pediatric clinic," "urgent care clinic," and "family practice clinic";
- (qq) "Free-standing clinic";
- (rr) "Osteopathic services";
- (ss) "Ambulance";
- (tt) "Skilled nursing";
- (uu) "Medical social services";
- (vv) "Home health - home health aide";
- (ww) "Home health - other visits";
- (xx) "Home health - units of service";
- (yy) "Home health - oxygen";

- (zz) "Magnetic resonance technology(MRT)," subcategories "MRA - other" and "other MRT";
- (aaa) "Medical/surgical supplies - extension," only subcategory "FDA investigational devices";
- (bbb) "Home IV therapy services";
- (ccc) "Hospice services";
- (ddd) "Respite care";
- (eee) "Outpatient special residence charges";
- (fff) "Trauma response";
- (ggg) "Cast room," subcategory "other cast room";
- (hhh) "Recovery room," subcategory "other recovery room";
- (iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";
- (jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";
- (kkk) "EEG (Electroencephalogram)," subcategory "other EEG";
- (lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";
- (mmm) "Treatment/observation room," subcategory "other treatment/observation room";
- (nnn) "Preventive care services";
- (ooo) "Telemedicine";
- (ppp) "Lithotripsy," subcategory "other lithotripsy";
- (qqq) "Inpatient renal dialysis";
- (rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";
- (sss) "Hemodialysis - outpatient or home," subcategories "hemodialysis/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent," "support services," and "other outpatient hemodialysis";
- (ttt) "Peritoneal dialysis - outpatient or home," subcategories "peritoneal/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent" "support services," and "other outpatient peritoneal dialysis";
- (uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home," subcategories "CAPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent" "support services," and "other outpatient CAPD";
- (vvv) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home," subcategories "CCPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent," "support services," and "other outpatient CCPD";
- (www) "Miscellaneous dialysis," subcategories "home dialysis aid visit" and "other miscellaneous dialysis";
- (xxx) "Psychiatric/psychological treatments," subcategories "general classification," "milieu therapy," "play therapy," "activity therapy," and "other psychiatric/psychological treatment";
- (yyy) "Psychiatric/psychological services";
- (zzz) "Other diagnostic services," subcategories "general classification" and "other diagnostic services";
- (aaaa) "Medical rehabilitation day program";
- (bbbb) "Other therapeutic services - extension," subcategories "general classification," "recreational therapy," "cardiac rehabilitation," "drug rehabilitation," "alcohol rehabilitation," "complex medical equipment - routine," "complex

medical equipment - ancillary," "athletic training," and "kinesiotherapy";

(cccc) "Professional fees";

(dddd) "Patient convenience items"; and

(eeee) Revenue code categories and subcategories that are not identified in this section.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, 03-19-046, § 388-550-1500, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1600 Specific items/services not covered. The department shall not cover certain hospital items/services for any hospital stay including, but not limited to, the following:

(1) Personal care items such as, but not limited to, slippers, toothbrush, comb, hair dryer, and make-up;

(2) Telephone/telegraph services or television/radio rentals;

(3) Medical photographic or audio/videotape records;

(4) Crisis counseling;

(5) Psychiatric day care;

(6) Ancillary services, such as respiratory and physical therapy, performed by regular nursing staff assigned to the floor or unit;

(7) Standby personnel and travel time;

(8) Routine hospital medical supplies and equipment such as bed scales;

(9) Handling fees and portable X-ray charges;

(10) Room and equipment charges ("rental charges") for use periods concurrent with another room or similar equipment for the same client;

(11) Cafeteria charges;

(12) Services and supplies provided to nonpatients, such as meals and "father packs"; and

(13) Standing orders. The department shall cover routine tests and procedures only if the department determines such services are medically necessary, according to the following criteria. The procedure or test:

(a) Is specifically ordered by the admitting physician or, in the absence of the admitting physician, the hospital staff having responsibility for the client (e.g., physician, advanced registered nurse practitioner, or physician assistant);

(b) Is for the diagnosis or treatment of the individual's condition; and

(c) Does not unnecessarily duplicate a test available or made known to the hospital which is performed on an outpatient basis prior to admission; or

(d) Is performed in connection with a recent admission.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1700 Authorization and utilization review of inpatient and outpatient hospital services. (1) This section applies to inpatient and outpatient hospital services provided to medical assistance clients receiving services through the fee-for-service program. For clients receiving services through other programs, see chapter 388-538 WAC (Managed care program), chapters 388-800 and 388-

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810 WAC (Alcohol and Drug Addiction Treatment and Support Act (ADATSA)), and chapter 388-865 WAC (Mental health treatment programs coordinated through the mental health division or its designee). See chapter 388-546 WAC for transportation services.

(2) The medical assistance administration (MAA) may perform one or more types of utilization reviews described in subsection (3)(b) of this section.

(3) MAA's utilization review:

(a) Is a concurrent, prospective and/or retrospective (including postpay and prepay) formal evaluation of a client's documented medical care to assure that the services provided are proper and necessary and of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the conditions(s) being treated; and

(b) Includes one or more of the following:

(i) "Concurrent utilization review" — an evaluation performed by MAA during a client's course of care;

(ii) "Prospective utilization review" — an evaluation performed by MAA prior to the provision of healthcare services; and

(iii) "Retrospective utilization review" — an evaluation performed by MAA following the provision of healthcare services that includes both a post-payment retrospective utilization review (performed by MAA after healthcare services are provided and reimbursed), and a prepayment retrospective utilization review (performed by MAA after healthcare services are provided but prior to reimbursement).

(4) Covered inpatient and outpatient hospital services must:

(a) Be medically necessary as defined in WAC 388-500-0005;

(b) Be provided at the appropriate level of care as defined in WAC 388-550-1050; and

(c) Meet all authorization and program requirements in WAC and MAA published issuances.

(5) Authorization for inpatient and outpatient hospital services is valid only if the client is eligible for covered services on the date of service. Authorization does not guarantee payment.

[Statutory Authority: RCW 74.08.090 and 74.09.500, 04-20-058, § 388-550-1700, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-1700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-1700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1800 Services—Contract facilities.

The department shall reimburse certain services without requiring prior authorization when such services are provided in medical assistance administration (MAA)-approved contract facilities. These services include, but are not limited to, the following:

(1) All transplant procedures specified in WAC 388-550-1900(2);

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400;

(3) Polysomnograms and multiple sleep latency tests for clients one year of age and older (allowed only in outpatient hospital settings), as described under WAC 388-550-6350;

(4) Diabetes education (allowed only in outpatient hospital setting), as described under WAC 388-550-6400; and

(5) Weight loss program (allowed only in outpatient hospital setting), as described under WAC 388-550-6450.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1900 Transplant coverage. (1) The department shall pay for transplant procedures only for eligible clients who:

(a) Meet the criteria in WAC 388-550-2000; and

(b) Are not otherwise subject to a managed care plan.

(2) The department shall cover the following transplant procedures:

(a) Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas;

(b) Bone marrow and peripheral stem cell (PSC);

(c) Skin grafts; and

(d) Corneal transplants.

(3) For procedures covered under subsections (2)(a) and (b) of this section, the department shall pay facility charges only to those medical centers that meet the standards and conditions:

(a) Established by the department; and

(b) Specified in WAC 388-550-2100 and 388-550-2200.

(4) The department shall pay facility charges for skin grafts and corneal transplants to any qualified medical facility, subject to the limitations in this chapter.

(5) The department shall deem organ procurement fees included in the reimbursement to the transplant facility. The department may make an exception to this policy and reimburse these fees separately to a transplant facility when an eligible medical care client is covered by a third-party payer which will pay for the organ transplant procedure itself but not for the organ procurement.

(6) The department shall, without requiring prior authorization, pay for up to fifteen matched donor searches per client approved for a bone marrow transplant. The department shall require prior authorization for matched donor searches in excess of fifteen per bone marrow transplant client.

(7) The department shall not pay for experimental transplant procedures. In addition, the department shall consider experimental those services including, but not limited to, the following:

(a) Transplants of three or more different organs during the same hospital stay;

(b) Solid organ and bone marrow transplants from animals to humans; and

(c) Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.

(8) The department shall pay for a solid organ transplant procedure only once per client's lifetime, except in cases of organ rejection by the client's immune system during the original hospital stay. The department shall cover bone mar-

row, PSC, skin grafts and corneal transplants whenever medically necessary.

(9) In reviewing coverage for transplant services, the department shall consider cost benefit analyses on a case-by-case basis.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2000 Medical criteria—Transplant services. (1) The department shall pay for transplant surgery in accordance with the provisions of this chapter for an eligible client who has:

(a) End-stage organ disease, except end-stage renal disease and diseases treatable with bone marrow or peripheral stem cell (PSC) transplants;

(b) A critical medical need for a transplant and a poor prognosis for survival without one, except for kidney, skin graft, or corneal transplants;

(c) Tried all other appropriate medical and surgical therapies that customarily yield both short and long-term survival comparable to that of a transplant;

(d) Been identified by the transplant facility as a candidate for whom the transplant, as a therapy, has a high probability of a successful clinical outcome, defined as a better than sixty percent survival rate after one year; and

(e) Agreed to long-term adherence to a disciplined medical regimen.

(2) Medical care clients enrolled with the department's managed care carriers shall be subject to their respective carriers' criteria and policies.

(3) The department shall not cover transplant procedures for clients with the following medical conditions:

(a) An irreversible terminal state in which the client has had multiorgan system failure, is moribund, or on life support, defined as mechanical systems such as ventilators or heart-lung respirators which are used to supplement or supplant the normal autonomic functions of a person;

(b) Current active and incurable or metastatic malignancy within other organ systems;

(c) An active infection that will interfere with the client's recovery;

(d) Irreversible renal or hepatic disease that substantially affects longevity. MAA shall exempt from this criterion clients requesting a kidney, liver, bone marrow, PSC, skin graft or corneal transplant;

(e) Significant atherosclerotic vascular disease or atherosclerotic coronary disease that substantially affects longevity. MAA shall not apply this criterion to clients requesting a heart, bone marrow, PSC, skin graft or corneal transplant;

(f) Any other major irreversible disease likely to substantially limit life expectancy to three years or less;

(g) Inability to follow a drug regimen or maintain necessary therapies and/or other prescribed health care regimens;

(h) Ventilator dependence, except when used in short-term, acute situations. The department shall not consider ventilator dependence for transplants involving bone marrow, PSC, skin or cornea;

(i) Current use or history within the past year of alcohol or substance abuse and/or smoking, or failure to have

abstained for long enough to indicate low likelihood of recidivism; and

(j) A history of behavior pattern or psychiatric illness that has not been assessed, treated or considered stable, that would likely lead to nonconformance or interference with a disciplined medical regimen.

(4) The department may deny coverage for corneal transplants for clients with an associated disease severe enough to prevent visual improvement, such as macular degeneration or diabetic retinopathy.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2100 Requirements—Transplant facilities. (1) The department shall require a transplant facility to meet the following requirements in order to be reimbursed for transplant services provided to medical care clients. The facility shall have:

(a) An approved certificate of need (CON) from the state department of health (DOH) for the type(s) of transplant procedure(s) to be performed, except that MAA shall not require CON approval for peripheral stem cell (PSC), skin graft and corneal transplant facilities;

(b) Approval from the United Network of Organ Sharing (UNOS) to perform transplants, except that MAA shall not require UNOS approval for PSC, skin graft and corneal transplant facilities; and

(c) Been approved by the department as a center of excellence transplant center for the specific organ(s) or procedure(s) the facility proposes to perform. An out-of-state transplant center shall be a Medicare-certified facility participating in that state's Medicaid program.

(2) The department shall consider a facility for approval as a transplant center of excellence when the facility submits to the department a copy of its DOH-approved CON for transplant services, or documentation that it has, at a minimum:

(a) Organ-specific transplant physicians for each organ or transplant team. The transplant surgeon and other responsible team members shall be experienced and board-certified or board-eligible practitioners in their respective disciplines, including, but not limited to, the fields of cardiology, cardiovascular surgery, anesthesiology, hemodynamics and pulmonary function, hepatology, hematology, immunology, oncology, and infectious diseases. The department shall consider this requirement met when the facility submits to the department a copy of its DOH-approved CON for transplant services;

(b) Component teams which are integrated into a comprehensive transplant team with clearly defined leadership and responsibility. Transplant teams shall include, but not be limited to:

(i) A team-specific transplant coordinator for each type of organ;

(ii) An anesthesia team available at all times;

(iii) A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients;

(iv) Pathology resources for studying and reporting the pathological responses of transplantation;

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(v) Infectious disease services with both the professional skills and the laboratory resources needed to discover, identify, and manage a whole range of organisms; and

(vi) Social services resources.

(c) An organ procurement coordinator;

(d) A method ensuring that transplant team members are familiar with transplantation laws and regulations;

(e) An interdisciplinary body and procedures in place to evaluate and select candidates for transplantation;

(f) An interdisciplinary body and procedures in place to ensure distribution of donated organs in a fair and equitable manner conducive to an optimal or successful patient outcome;

(g) Extensive blood bank support;

(h) Patient management plans and protocols;

(i) Written policies safeguarding the rights and privacy of patients; and

(j) Satisfied the annual volume and survival rates criteria for the particular transplant procedures performed at the facility, as specified in WAC 388-550-2200(2).

(3) In addition to the requirements of subsection (2) of this section, a facility being considered for approval as a transplant center of excellence shall submit a copy of its approval from the United Network for Organ Sharing (UNOS), or documentation showing that the facility:

(a) Participates in the national donor procurement program and network; and

(b) Systematically collects and shares data on its transplant program(s) with the network.

(4) The department shall apply the following specific requirements to PSC transplant facilities:

(a) A PSC transplant facility may receive approval from the department to do PSC:

(i) Harvesting, if it has its own apheresis equipment which meets federal or American Association of Blood Banks (AABB) requirements;

(ii) Processing, if it meets AABB quality of care requirements for human tissue/tissue banking; and/or

(iii) Reinfusion, if it meets the criteria established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

(b) A hospital may purchase PSC processing and harvesting services from other department-approved processing providers.

(c) The department shall not reimburse a PSC transplant facility for AABB inspection and certification fees related to PSC transplant services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2200 Transplant requirements—COE. (1) The department shall measure the effectiveness of transplant centers of excellence (COE) using the performance criteria in this section. Unless otherwise waived by the department, the department shall apply these criteria to a facility during both initial and periodic evaluations for designation as a transplant COE. The COE performance criteria shall include, but not be limited to:

(a) Meeting annual volume requirements for the specific transplant procedures for which approved;

(b) Patient survival rates; and

(c) Relative cost per case.

(2) A transplant COE shall meet or exceed annually the following applicable volume criteria for the particular transplant procedures performed at the facility, except for cornea transplants which do not have established minimum volume requirements. Annual volume requirements for transplant centers of excellence include:

(a) Twelve or more heart transplants;

(b) Ten or more lung transplants;

(c) Ten or more heart-lung transplants;

(d) Twelve or more liver transplants;

(e) Twenty-five or more kidney transplants;

(f) Eighteen or more pancreas transplants;

(g) Eighteen or more kidney-pancreas transplants;

(h) Ten or more bone marrow transplants; and

(i) Ten or more peripheral stem cell (PSC) transplants.

Dual-organ procedures may be counted once under each organ and the combined procedure.

(3) A transplant facility within the state that fails to meet the volume requirements in subsection (1) of this section may submit a written request to the department for conditional approval as a transplant center of excellence. The department shall consider the minimum volume requirement met when the requestor submits an approved certificate of need for transplant services from the state department of health.

(4) An in-state facility granted conditional approval by the department as a transplant center of excellence shall meet the department's criteria, as established in this chapter, within one year of the conditional approval. The department shall automatically revoke such conditional approval for any facility which fails to meet the department's published criteria within the allotted one year period, unless:

(a) The facility submits a written request for extension of the conditional approval thirty calendar days prior to the expiration date; and

(b) Such request is granted by the department.

(5) A transplant center of excellence shall meet Medicare's survival rate requirements for the transplant procedure(s) performed at the facility.

(6) A transplant center of excellence shall submit to the department annually, at the same time the hospital submits a copy of its Medicare Cost Report (HCFA 2552 report) documentation showing:

(a) The numbers of transplants performed at the facility during its preceding fiscal year, by type of procedure; and

(b) Survival rates data for procedures performed over the preceding three years as reported on the United Network of Organ Sharing report form.

(7)(a) Transplant facilities shall submit to the department, within sixty days of the date of the facility's approval as a center of excellence, a complete set of the comprehensive patient selection criteria and treatment protocols used by the facility for each transplant procedure it has been approved to perform.

(b) The facility shall submit to the department updates to said documents annually thereafter, or whenever the facility makes a change to the criteria and/or protocols.

(c) If no changes occurred during a reporting period the facility shall so notify the department to this effect.

(8) The department shall evaluate compliance with the provisions of WAC 388-550-2100 (2)(d) and (e) based on the protocols and criteria submitted to the department by transplant centers of excellence in accordance with subsection (7) of this section. The department shall terminate a facility's designation as a transplant center of excellence if a review or audit finds that facility in noncompliance with:

(a) Its protocols and criteria in evaluating and selecting candidates for transplantation; and

(b) Distributing donated organs in a fair and equitable manner that promotes an optimal or successful patient outcome.

(9)(a) The department shall provide transplant centers of excellence it finds in noncompliance with subsection (8) of this section sixty days within which such centers may submit a plan to correct a breach of compliance;

(b) The department shall not allow the sixty-day option as stated in (a) of this subsection for a breach that constitutes a danger to the health and safety of clients as stated in WAC 388-502-0030;

(c) Within six months of submitting a plan to correct a breach of compliance, a center shall report to the department showing:

(i) The breach of compliance has been corrected; or

(ii) Measurable and significant improvement toward correcting such breach of compliance.

(10) The department shall periodically review the list of approved transplant centers of excellence. The department may limit the number of facilities it designates as transplant centers of excellence or contracts with to provide services to medical care clients if, in the department's opinion, doing so would promote better client outcomes and cost efficiencies.

(11) The department shall reimburse department-approved centers of excellence for covered transplant procedures using any of the methods identified in chapter 388-550 WAC.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-2200, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2301 Hospital and medical criteria requirements for bariatric surgery. (1) The medical assistance administration (MAA) pays a hospital for bariatric surgery and bariatric surgery-related services only when:

(a) The client qualifies for bariatric surgery by successfully completing all requirements under WAC 388-531-1600;

(b) The client continues to meet the criteria to qualify for bariatric surgery under WAC 388-531-1600 up to the actual surgery date; and

(c) The hospital providing the bariatric surgery and bariatric surgery-related services meets the requirements in this section and other applicable WAC.

(2) A hospital must meet the following requirements in order to be reimbursed for bariatric surgery and bariatric surgery-related services provided to an eligible medical assistance client. The hospital must:

(a) Be located in Washington state or approved bordering cities (see WAC 388-501-0175) and have a current core provider agreement with MAA.

(b) Have an established bariatric surgery program in operation under which at least one hundred bariatric surgery procedures have been performed. The program must have been in operation for at least five years and be under the direction of an experienced board-certified surgeon. In addition, MAA requires the bariatric surgery program to:

- (i) Have a mortality rate of two percent or less;
- (ii) Have a morbidity rate of fifteen percent or less;
- (iii) Document patient follow-up for at least five years postsurgery;
- (iv) Have an average loss of at least fifty percent of excess body weight achieved by patients at five years post-surgery; and
- (v) Have a reoperation or revision rate of five percent or less.

(c) Submit documents to MAA's Division of Medical Management that verify the performance requirements listed in this section. The hospital must receive approval from MAA prior to performing a bariatric surgery for a medical assistance client.

(3) MAA waives the program requirements listed in subsection (2)(b) of this section if the hospital participates in a statewide bariatric surgery quality assurance program such as the Clinical Outcomes Assessment Program (COAP).

(4) See WAC 388-531-1600(13) for requirements for surgeons who perform bariatric surgery.

(5) Authorization does not guarantee payment. Authorization for bariatric surgery and bariatric surgery-related services is valid only if:

- (a) The client is eligible on the date of service; and
- (b) The provider meets the criteria in this section and other applicable WAC to perform bariatric surgery and/or to provide bariatric surgery-related services.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-12-022, § 388-550-2301, filed 5/20/05, effective 6/20/05.]

WAC 388-550-2400 Chronic pain management program. (1)(a) The department shall cover inpatient chronic pain management training to assist eligible clients to manage chronic pain.

(b) The department shall pay for only one inpatient hospital stay, up to a maximum of twenty-one days, for chronic pain management training per eligible client's lifetime.

(c) Refer to WAC 388-550-1700 (2)(i) and 388-550-1800 for prior authorization.

(2) The department shall reimburse approved chronic pain management facilities an all-inclusive per diem facility fee under the revenue code published in the department's chronic pain management fee schedule. MAA shall reimburse professional fees for chronic pain management services to performing providers in accordance with the department's fee schedule.

(3) The department shall not reimburse a contract facility for unrelated services provided during the client's inpatient stay for chronic pain management, unless the facility requested and received prior approval from the department for those services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2400, filed 12/18/97, effective 1/18/98.]

(2007 Ed.)

WAC 388-550-2431 Hospice services—Inpatient payments. See chapter 388-551 WAC, Alternatives to hospital services, subchapter I—Hospice services.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-2431, filed 2/26/99, effective 3/29/99.]

WAC 388-550-2500 Inpatient hospice services. (1) The department shall reimburse hospice agencies participating in the medical assistance program for general inpatient and inpatient respite services provided to clients in hospice care, when:

(a) The hospice agency coordinates the provision of such inpatient services; and

(b) Such services are related to the medical condition for which the client sought hospice care.

(2) Hospice agencies shall bill the department for their services using revenue codes. The department shall reimburse hospice providers a set per diem fee according to the type of care provided to the client on a daily basis.

(3) The department shall reimburse hospital providers directly pursuant to this chapter for inpatient care provided to clients in the hospice program for medical conditions not related to their terminal illness.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2501 Acute physical medicine and rehabilitation (acute PM&R) program—General. **Acute physical medicine and rehabilitation (acute PM&R)** is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation. The medical assistance administration (MAA) requires prior authorization for acute PM&R services. (See WAC 388-550-2561 for prior authorization requirements.)

(1) An interdisciplinary team coordinates individualized acute PM&R services at an MAA-approved rehabilitation facility to achieve the following for a client:

- (a) Improved health and welfare; and
- (b) Maximum physical, social, psychological and educational or vocational potential.

(2) MAA determines and authorizes a length of stay based on:

- (a) The client's acute PM&R needs; and
- (b) Community standards of care for acute PM&R services.

(3) When MAA's authorized acute period of rehabilitation ends, the provider transfers the client to a more appropriate level of care. Therapies may continue to help the client achieve maximum potential through other MAA programs such as:

- (a) Home health services;
- (b) Nursing facilities;
- (c) Outpatient physical, occupational, and speech therapies; or
- (d) Neurodevelopmental centers.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56, 03-06-047, § 388-550-2501, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520, 99-17-111, § 388-550-2501, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2511 Acute PM&R definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to the acute PM&R program. If conflicts occur, this section prevails for this subchapter.

"Accredit" (or "Accreditation") means a term used by nationally recognized health organizations, such as CARF, to state a facility meets community standards of medical care.

"Acute" means an intense medical episode, not longer than three months.

"Acute physical medicine and rehabilitation (acute PM&R)" means a comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for specific medical conditions for which the client shows significant potential for functional improvement.

"Administrative day" means a day of a hospital stay in which an acute inpatient level of care is no longer necessary, and noninpatient hospital placement is appropriate.

"Administrative day rate" means the statewide Medicaid average daily nursing facility rate as determined by the department.

"CARF" is the official name for The Rehabilitation Accreditation Commission' of Tucson, Arizona. CARF is a national private agency that develops and maintains current, "field-driven" (community) standards through surveys and accreditations of rehabilitation facilities.

"Rehabilitation Accreditation Commission, The" - See "CARF."

"Survey" or "review" means an inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with acute PM&R program requirements.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2511, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2511, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2521 Client eligibility requirements for acute PM&R services. (1) Only a client who is eligible for one of the following programs may receive acute PM&R services, subject to the restrictions and limitations in this section and WAC 388-550-2501, 388-550-2511, 388-550-2531, 388-550-2541, 388-550-2551, 388-550-2561, 388-550-3381, and other published rules:

- (a) Categorically needy program (CNP);
- (b) CNP - Children's health insurance program (CNP-CHIP);
- (c) Limited casualty program - Medically needy program (LCP-MNP);
- (d) CNP - Emergency medical only;
- (e) LCP-MNP - Emergency medical only;
- (f) General assistance unemployable (GA-U - No out-of-state care);
- (g) Alcoholism and drug addiction treatment and support act (ADATSA); and
- (h) Medically indigent program (MIP) - Emergency hospital-based and emergency transportation services only when:

(i) The client is transferred directly from an acute hospital stay; and

(ii) The client's acute PM&R needs are directly related to the emergency medical condition that qualified the client for MIP.

(2) If a client is enrolled in an MAA Healthy Options managed care plan at the time of acute care admission, that plan pays for and coordinates acute PM&R services as appropriate.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2521, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2521, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2531 Requirements for becoming an acute PM&R provider. (1) Only an in-state or border area hospital may apply to become a medical assistance administration (MAA)-approved acute PM&R facility. To apply, MAA requires the hospital provider to submit a letter of request to:

Acute PM&R Program Manager
Division of Medical Management - Medical Operations
Medical Assistance Administration
P.O. Box 45506
Olympia, WA 98504-5506

(2) A hospital that applies to become an MAA-approved acute PM&R facility must provide MAA with documentation that confirms the facility is all of the following:

- (a) A Medicare-certified hospital;
- (b) Accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO);
- (c) Licensed by the department of health (DOH) as an acute care hospital as defined under WAC 246-310-010;
- (d) CARF accredited as a comprehensive integrated inpatient rehabilitation program or as a pediatric family centered rehabilitation program, unless subsection (3) of this section applies;
- (e) Contracted under MAA's selective contracting program, if in a selective contracting area, unless exempted from the requirements by MAA; and
- (f) Operating per the standards set by DOH (excluding the certified rehabilitation registered nurse (CRRN) requirement) in either:

(i) WAC 246-976-830, Level I trauma rehabilitation designation; or

(ii) WAC 246-976-840, Level II trauma rehabilitation designation.

(3) A hospital not yet accredited by CARF:

(a) May apply for or be awarded a twelve-month conditional written approval by MAA if the facility:

(i) Provides MAA with documentation that it has started the process of obtaining full CARF accreditation; and

(ii) Is actively operating under CARF standards.

(b) Is required to obtain full CARF accreditation within twelve months of MAA's conditional approval date. If this requirement is not met, MAA sends a letter of notification to revoke the conditional approval.

(4) A hospital qualifies as an MAA-approved acute PM&R facility when:

(a) The facility meets all the applicable requirements in this section;

(b) MAA's clinical staff has conducted a facility site visit; and

(c) MAA provides written notification that the facility qualifies to be reimbursed for providing acute PM&R services to eligible medical assistance clients.

(5) MAA-approved acute PM&R facilities must meet the general requirements in chapter 388-502 WAC, Administration of medical programs—Providers.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56, 03-06-047, § 388-550-2531, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520, 99-17-111, § 388-550-2531, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2541 Quality of care. (1) To ensure quality of care, the medical assistance administration (MAA) may conduct reviews (e.g., post-pay, on-site) of any MAA-approved acute PM&R facility.

(2) A provider of acute PM&R services must act on any report of substandard care or violation of the facility's medical staff bylaws and CARF standards. The provider must have and follow written procedures that:

(a) Provide a resolution to either a complaint or grievance or both; and

(b) Comply with applicable CARF standards for adults or pediatrics as appropriate.

(3) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(a) The department of health (DOH);

(b) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO);

(c) CARF;

(d) MAA; or

(e) Other agencies with review authority for MAA programs.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56, 03-06-047, § 388-550-2541, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520, 99-17-111, § 388-550-2541, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2551 How a client qualifies for acute PM&R services. (1) To qualify for acute PM&R services, a client must meet one of the conditions in subsection (2) of this section and have:

(a) Extensive or complex medical needs, nursing needs, and therapy needs; and

(b) A recent or new onset of a condition that causes an impairment in two or more of the following areas:

(i) Mobility and strength;

(ii) Self-care/ADLs (activities of daily living);

(iii) Communication; or

(iv) Cognitive/perceptual functioning.

(2) To qualify for acute PM&R services, a client must meet the conditions in subsection (1) of this section and have a new or recent onset of one of the following conditions:

(a) Brain injury caused by trauma or disease.

(b) Spinal cord injury resulting in:

(i) Quadriplegia; or

(ii) Paraplegia.

(c) Extensive burns.

(d) Bilateral limb loss.

(e) Stroke or aneurysm with resulting hemiplegia or cognitive deficits, including speech and swallowing deficits.

(f) Multiple trauma (after the client is cleared to bear weight) with complicated orthopedic conditions and neurological deficits.

(g) Severe pressure ulcers after skin flap surgery for a client who:

(i) Requires close observation by a surgeon; and

(ii) Is ready to mobilize or be upright in a chair.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56, 03-06-047, § 388-550-2551, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520, 99-17-111, § 388-550-2551, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2561 MAA's prior authorization requirements for acute PM&R services. (1) The medical assistance administration (MAA) requires prior authorization for acute PM&R services. The acute PM&R provider of services must obtain prior authorization:

(a) Before admitting a client to the rehabilitation unit; and

(b) For an extension of stay before the client's current authorized period of stay expires.

(2) For an initial admit:

(a) A client must:

(i) Be eligible under one of the programs listed in WAC 388-550-2521, subject to the restrictions and limitations listed in that section;

(ii) Require acute PM&R services as determined in WAC 388-550-2551;

(iii) Be medically stable and show evidence of physical and cognitive readiness to participate in the rehabilitation program; and

(iv) Be willing and capable to participate at least three hours per day, seven days per week, in acute PM&R activities.

(b) The acute PM&R provider of services must:

(i) Submit a request for prior authorization to the MAA clinical consultation team by fax, electronic mail, or telephone as published in MAA's acute PM&R billing instructions; and

(ii) Include sufficient medical information to justify that:

(A) Acute PM&R treatment would effectively enable the client to obtain a greater degree of self-care and/or independence;

(B) The client's medical condition requires that intensive twenty-four-hour inpatient comprehensive acute PM&R services be provided in an MAA-approved acute PM&R facility; and

(C) The client suffers from severe disabilities including, but not limited to, neurological and/or cognitive deficits.

(3) For an extension of stay:

(a) A client must meet the conditions listed in subsection (2)(a) of this section and have observable and significant improvement; and

(b) The acute PM&R provider of services must:

(i) Submit a request for the extension of stay to the MAA clinical consultation team by fax, electronic mail, or tele-

phone as published in MAA's acute PM&R billing instructions; and

(ii) Include sufficient medical information to justify the extension and include documentation that the client's condition has observably and significantly improved.

(4) If MAA denies the request for an extension of stay, the client must be transferred to an appropriate lower level of care as described in WAC 388-550-2501(3).

(5) The MAA clinical consultation team approves or denies authorization for acute PM&R services for initial stays or extensions of stay based on individual circumstances and the medical information received. MAA notifies the client and the acute PM&R provider of a decision.

(a) If MAA approves the request for authorization, the notification letter includes:

- (i) The number of days requested;
- (ii) The allowed dates of service;
- (iii) An MAA-assigned authorization number;
- (iv) Applicable limitations to the authorized services;

and

- (v) MAA's process to request additional services.

(b) If MAA denies the request for authorization, the notification letter includes:

- (i) The number of days requested;
- (ii) The reason for the denial;
- (iii) Alternative services available for the client; and
- (iv) The client's right to request a fair hearing. (See subsection (7) of this section.)

(6) A facility intending to transfer a client to an MAA-approved acute PM&R facility, and/or an acute PM&R facility requesting an extension of stay for a client, must:

(a) Discuss MAA's authorization decision with the client and/or the client's legal representative; and

(b) Document in the client's medical record that MAA's decision was discussed with the client and/or the client's legal representative.

(7) A client who does not agree with a decision regarding acute PM&R services has a right to a fair hearing under chapter 388-02 WAC. After receiving a request for a fair hearing, MAA may request additional information from the client and the facility, or both. After MAA reviews the available information, the result may be:

- (a) A reversal of the initial MAA decision;
- (b) Resolution of the client's issue(s); or
- (c) A fair hearing conducted per chapter 388-02 WAC.

(8) MAA may authorize administrative day(s) for a client who:

(a) Does not meet requirements described in subsection (3) of this section;

(b) Stays in the facility longer than the "community standards length of stay"; or

(c) Is waiting for a discharge destination or a discharge plan.

(9) MAA does not authorize acute PM&R services for a client who:

(a) Is deconditioned by a medical illness or by surgery; or

(b) Has loss of function primarily as a result of a psychiatric condition(s); or

(c) Has had a recent surgery and has no complicating neurological deficits. Examples of surgeries that do not qual-

ify a client for inpatient acute PM&R services without extenuating circumstances are:

- (i) Single amputation;
- (ii) Single extremity surgery; and
- (iii) Spine surgery.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56. 03-06-047, § 388-550-2561, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520. 99-17-111, § 388-550-2561, filed 8/18/99, effective 9/18/99.]

WAC 388-550-2565 The long-term acute care (LTAC) program—General. The long-term acute care (LTAC) program is a twenty-four-hour inpatient comprehensive program of integrated medical and rehabilitative services provided in a medical assistance administration (MAA)-approved LTAC facility during the acute phase of a client's care. MAA requires prior authorization for LTAC stays. See WAC 388-550-2590 for prior authorization requirements.

(1) A facility's multidisciplinary team coordinates individualized LTAC services at an MAA-approved LTAC facility.

(2) MAA determines the authorized length of stay for LTAC services based on the client's need as documented in the client's medical records and the criteria described in WAC 388-550-2590.

(3) When the MAA-authorized length of stay ends, the provider transfers the client to a more appropriate level of care or, if appropriate, discharges the client to the client's residence.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2565, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2570 LTAC program definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to the LTAC program.

"Level 1 services" means long-term acute care (LTAC) services provided to clients who require more than eight hours of direct skilled nursing care per day. Level 1 services include one or both of the following:

(1) Active ventilator weaning care and any specialized therapy services, such as physical, occupational, and speech therapies; or

(2) Complex medical care that may include: Care for complex draining wounds, care for central lines, multiple medications, frequent assessments and close monitoring, third degree burns that may involve grafts and/or frequent transfusions, and specialized therapy services, such as physical, occupational, and speech therapies.

"Level 2 services" means long-term acute care (LTAC) services provided to clients who require four to eight hours of direct skilled nursing care per day. Level 2 services include at least two of the following:

(1) Ventilator care for clients who are stable, dependent on a ventilator, and have complex medical needs;

(2) Care for clients who have tracheostomies, complex airway management and medical needs, and the potential for decannulation; and

(3) Specialized therapy services, such as physical, occupational, and speech therapies.

"Long-term acute care" means inpatient intensive long-term care services provided in MAA-approved LTAC facilities to eligible medical assistance clients who require Level 1 or Level 2 services.

"Survey" or "review" means an inspection conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with LTAC program requirements.

"Transportation company" means either an MAA-approved transportation broker or a transportation company doing business with MAA.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2570, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2575 Client eligibility requirements for LTAC services. Only a client who is eligible for one of the following programs may receive LTAC services, subject to the restrictions and limitations in WAC 388-550-2565, 388-550-2570, 388-550-2580, 388-550-2585, 388-550-2590, 388-550-2595, 388-550-2596, and other published rules:

- (1) Categorically needy program (CNP);
- (2) CNP - Children's health insurance program (CNP-CHIP);
- (3) Limited casualty program - medically needy program (LCP-MNP);
- (4) CNP - Emergency medical only; or
- (5) LCP-MNP - Emergency medical only.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2575, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2580 Requirements for becoming an LTAC facility. (1) To apply to become an MAA-approved LTAC facility, MAA requires a hospital provider to:

- (a) Submit a letter of request to:
LTAC Program Manager
Division of Medical Management
Medical Assistance Administration
P.O. Box 45506
Olympia WA 98504-5506; and
- (b) Include documentation that confirms the facility is:
 - (i) Medicare certified for LTAC;
 - (ii) Accredited by the joint commission on accreditation of hospital organizations (JCAHO);
 - (iii) Licensed by the department of health (DOH) as an acute care hospital as defined under WAC 246-310-010; and
 - (iv) Contracted under MAA's selective contracting program, if in a selective contracting area, unless exempted from the requirements by MAA.

(2) The hospital facility qualifies as an MAA-approved LTAC facility when:

- (a) The facility meets all the requirements in this section;
- (b) MAA's clinical staff has conducted a facility site visit; and
- (c) MAA provides written notification that the facility qualifies to be reimbursed for providing LTAC services to eligible medical assistance clients.

(3) MAA-approved LTAC facilities must meet the general requirements in chapter 388-502 WAC, Administration of medical programs providers.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2580, filed 7/3/02, effective 8/3/02.]

(2007 Ed.)

WAC 388-550-2585 LTAC facilities—Quality of care. (1) To ensure quality of care, MAA may conduct post-pay or on-site reviews of any MAA-approved LTAC facility. See WAC 388-502-0240, Audits and the audit appeal process for contractors/providers, for additional information on audits conducted by department staff.

(2) A provider of LTAC services must act on any reports of substandard care or violations of the facility's medical staff bylaws. The provider must have and follow written procedures that provide a resolution to either a complaint or grievance or both.

(3) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

- (a) The department of health (DOH);
- (b) The Joint Commission on Accreditation of Hospital Organizations (JCAHO);
- (c) MAA; or
- (d) Other agencies with review authority for MAA programs.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2585, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2590 MAA's prior authorization requirements for Level 1 and Level 2 services. (1) MAA requires prior authorization for Level 1 and Level 2 LTAC inpatient stays. The prior authorization process includes all of the following:

- (a) For an initial thirty-day stay:
 - (i) The client must:
 - (A) Be eligible under one of the programs listed in WAC 388-550-2575;
 - (B) Meet the high cost outlier status at the transferring hospital as described in WAC 388-550-3700; and
 - (C) Require Level 1 or Level 2 services as defined in WAC 388-550-2570.
 - (ii) The LTAC provider of services must:
 - (A) Before admitting the client to the LTAC facility, submit a request for prior authorization to the MAA clinical consultation team by fax, electronic mail, or telephone, as published in MAA's LTAC billing instructions; and
 - (B) Include sufficient medical information to justify the requested initial stay.
- (b) For extensions of stay:
 - (i) The client must:
 - (A) Be eligible under one of the programs listed in WAC 388-550-2575; and
 - (B) Require Level 1 or Level 2 services as defined in WAC 388-550-2570.
 - (ii) The LTAC provider of services must:
 - (A) Before the client's current authorized period of stay expires, submit a request for the extension of stay to the MAA clinical consultation team by fax, electronic mail, or telephone; and
 - (B) Include sufficient medical information to justify the requested extension of stay.

(2) The MAA clinical consultation team authorizes, in writing, Level 1 or Level 2 services for initial stays or extensions of stay based on the client's circumstances and the medical justification received. A client who does not agree with a decision regarding a length of stay has a right to a fair hearing

under chapter 388-02 WAC. After receiving a request for a fair hearing, MAA may request additional information from the client and the facility, or both. After MAA reviews the available information, the result may be:

- (a) A reversal of the initial MAA decision;
- (b) Resolution of the client's issue(s); or
- (c) A fair hearing conducted per chapter 388-02 WAC.

(3) MAA may authorize administrative day rate reimbursement for a client who:

- (a) Does not meet the requirements described in this section;
- (b) Is waiting for placement in another facility; or
- (c) If appropriate, is waiting to be discharged to the client's residence.

[Statutory Authority: RCW 74.08.090. 02-14-162, § 388-550-2590, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2595 Identification of and payment methodology for services and equipment included in the LTAC fixed per diem rate. (1) In addition to room and board, the LTAC fixed per diem rate includes, but is not limited to, the following (see MAA's LTAC billing instructions for applicable revenue codes):

- (a) Room and board - Rehabilitation;
- (b) Room and board - Intensive care;
- (c) Pharmacy - Up to and including two hundred dollars per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy;
- (d) Medical/surgical supplies and devices;
- (e) Laboratory - General;
- (f) Laboratory - Chemistry;
- (g) Laboratory - Immunology;
- (h) Laboratory - Hematology;
- (i) Laboratory - Bacteriology and microbiology;
- (j) Laboratory - Urology;
- (k) Laboratory - Other laboratory services;
- (l) Respiratory services;
- (m) Physical therapy;
- (n) Occupational therapy; and
- (o) Speech-language therapy.

(2) MAA pays the LTAC facility the LTAC fixed per diem rate in effect at the time the LTAC services are provided, minus the sum of:

- (a) Client liability, whether or not collected by the provider; and
- (b) Any amount of coverage from third parties, whether or not collected by the provider, including, but not limited to, coverage from:
 - (i) Insurers and indemnitors;
 - (ii) Other federal or state medical care programs;
 - (iii) Payments made to the provider on behalf of the client by individuals or organizations not liable for the client's financial obligations; and
 - (iv) Any other contractual or legal entitlement of the client, including, but not limited to:
 - (A) Crime victims' compensation;
 - (B) Workers' compensation;
 - (C) Individual or group insurance;
 - (D) Court-ordered dependent support arrangements; and

(E) The tort liability of any third party.

(3) MAA may make annual rate increases to the LTAC fixed per diem rate by using the same inflation factor and date of rate increase that MAA uses for acute care hospital diagnostic-related group (DRG) rates. This DRG rate adjustment method is described in WAC 388-550-3450(5).

[Statutory Authority: RCW 74.08.090. 03-02-056, § 388-550-2595, filed 12/26/02, effective 1/26/03; 02-14-162, § 388-550-2595, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2596 Services and equipment covered by the department but not included in the LTAC fixed per diem rate. (1) The department uses the ratio of costs-to-charges (RCC) payment method to reimburse an LTAC facility for the following that are not included in the LTAC fixed per diem rate:

(a) Pharmacy - After the first two hundred dollars per day in total allowed charges for any combination of pharmacy services that includes prescription drugs, total parenteral nutrition (TPN) therapy, IV infusion therapy, and/or epogen/neupogen therapy;

- (b) Radiology services;
- (c) Nuclear medicine services;
- (d) Computerized tomographic (CT) scan;
- (e) Operating room services;
- (f) Anesthesia services;
- (g) Blood storage and processing;
- (h) Blood administration;
- (i) Other imaging services - Ultrasound;
- (j) Pulmonary function services;
- (k) Cardiology services;
- (l) Recovery room services;
- (m) EKG/ECG services;
- (n) Gastro-intestinal services;
- (o) Inpatient hemodialysis; and
- (p) Peripheral vascular laboratory services.

(2) The department uses the appropriate inpatient or outpatient payment method described in other published WAC to reimburse providers other than LTAC facilities for services and equipment that are covered by the department but not included in the LTAC fixed per diem rate. The provider must bill the department directly and the department reimburses the provider directly.

(3) Transportation services that are related to transporting a client to and from another facility for the provision of outpatient medical services while the client is still an inpatient at the LTAC facility, or related to transporting a client to another facility after discharge from the LTAC facility:

- (a) Are not covered or reimbursed through the LTAC fixed per diem rate;
- (b) Are not reimbursable directly to the LTAC facility;
- (c) Are subject to the provisions in chapter 388-546 WAC; and

(d) Must be billed directly to the:

- (i) Department by the transportation company to be reimbursed if the client required ambulance transportation; or
- (ii) Department's contracted transportation broker, subject to the prior authorization requirements and provisions described in chapter 388-546 WAC, if the client:

- (A) Required nonemergent transportation; or

(B) Did not have a medical condition that required transportation in a prone or supine position.

(4) The department evaluates requests for covered transportation services that are subject to limitations or other restrictions, and approves such services beyond those limitations or restrictions under the provisions of WAC 388-501-0165 and 388-501-0169.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-550-2596, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 03-02-056, § 388-550-2596, filed 12/26/02, effective 1/26/03; 02-14-162, § 388-550-2596, filed 7/3/02, effective 8/3/02.]

WAC 388-550-2598 Critical access hospitals (CAHs).

(1) The department reimburses eligible critical access hospitals (CAHs) for inpatient and outpatient hospital services provided to fee-for-service medical assistance clients on a cost basis, using departmental weighted costs-to-charges (DWCC) ratios and a retrospective cost settlement process.

(2) For inpatient and outpatient hospital services provided to clients enrolled in a managed care plan, DWCC rates for each CAH are incorporated into the calculations for the managed care capitated premiums. The department considers managed care DWCC rates to be cost. Cost settlements are not performed for managed care claims.

(3) The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to this section:

- (a) "CAH," see "critical access hospital."
- (b) "CAH HFY" see "CAH hospital fiscal year."
- (c) "CAH hospital fiscal year" means each individual hospital's fiscal year.
- (d) "Cost settlement" means a reconciliation of the fee-for-service interim CAH payments with a CAH's actual costs determined after the end of the CAH's HFY.
- (e) "Critical access hospital (CAH)" means a hospital that is approved by the department of health (DOH) for inclusion in DOH's critical access hospital program.
- (f) "Departmental weighted costs-to-charges (DWCC) rate" means a rate the department uses to determine a CAH payment. See subsection (8) for how the department calculates a DWCC rate.
- (g) "DWCC rate" see "departmental weighted costs-to-charges (DWCC) rate."
- (h) "Interim CAH payment" means the actual payment the department makes for claims submitted by a CAH for services provided during its current hospital fiscal year, using the appropriate DWCC rate, as determined by the department.

(4) To be reimbursed as a CAH by the department, a hospital must be approved by the department of health (DOH) for inclusion in DOH's critical access hospital program. The hospital must provide proof of CAH status to the department upon request. CAHs reimbursed under the CAH program must meet the general applicable requirements in chapter 388-502 WAC. For information on audits and the audit appeal process, see WAC 388-502-0240.

(5) A CAH must have and follow written procedures that provide a resolution to complaints and grievances.

(6) To ensure quality of care:

(a) A CAH is responsible to investigate any reports of substandard care or violations of the facility's medical staff bylaws; and

(b) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

- (i) Department of health (DOH); or
- (ii) Other agencies with review authority for department programs.

(7) The department may conduct a postpay or on-site review of any CAH.

(8) The department prospectively calculates fee-for-service and managed care inpatient and outpatient DWCC rates separately for each CAH. To calculate prospective interim inpatient and outpatient DWCC rates for each hospital currently in the CAH program, the department:

(a) Obtains from each CAH its estimated aggregate charge master change for its next HFY;

(b) Obtains from the Medicare HCFA-2552 cost report the CAH initially submits for cost settlement of its most recently completed HFY:

- (i) The costs-to-charges ratio of each respective service cost center; and
- (ii) Total costs, charges, and number of patient days of each respective accommodation cost center.

(c) Obtains from the Medicaid management information system (MMIS) the following fee-for-service summary claims data submitted by each CAH for services provided during the same HFY identified in (b) of this subsection:

- (i) Medical assistance program codes;
- (ii) Inpatient and outpatient claim types;
- (iii) Procedure codes, revenue codes, or diagnosis-related group (DRG) codes;
- (iv) Allowed charges and third party liability/client and department paid amounts; and
- (v) Units of service.

(d) Obtains from the managed care encounter data the following data submitted by each CAH for services provided during the same HFY identified in (b) of this section:

- (i) Medical assistance program codes;
- (ii) Inpatient and outpatient claim types;
- (iii) Procedure codes, revenue codes, or diagnosis-related group (DRG) codes; and
- (iv) Allowed charges.

(e) Separates the inpatient claims data and outpatient claims data;

(f) Obtains the cost center allowed charges by classifying inpatient and outpatient allowed charges from (c) and (d) of this subsection billed by a CAH (using any one of, or a combination of, procedure codes, revenue codes, or DRG codes) into the related cost center in the CAH's Medicare HCFA-2552 cost report the CAH initially submits to the department;

(g) Determines the departmental-weighted costs for each cost center by multiplying the cost center's allowed charges from (c) of this subsection for the appropriate inpatient or outpatient claim type by the related service cost center ratio;

(h) Sums all allowed charges from (e) of this subsection;

(i) Sums all departmental-weighted costs for inpatient and outpatient claims from (g) of this subsection;

(j) Multiplies each hospital's total departmental-weighted costs from (h) of this subsection by the Medicare

market basket inflation rate. The Medicare market basket inflation rate is published and updated periodically by the centers for Medicare and Medicaid services (CMS);

(k) Multiplies each hospital's total allowed charges from (h) of this subsection by the CAH estimated charge master change from (a) of this subsection. If the charge master change factor is not available from the hospital, the department will apply a reasonable alternative factor; and

(l) Determines the DWCC inpatient and outpatient rates by dividing the total appropriate departmental-weighted costs from (9)(i) of this subsection by the total appropriate allowed charges from (h) of this subsection.

(9) For a currently enrolled hospital provider that is new to the CAH program, the basis for calculating DWCC rates for inpatient and outpatient hospital claims for:

(a) Fee-for-service clients is:

(i) The hospital's most recently submitted Medicare cost report; and

(ii) The appropriate MMIS summary claims data for that hospital fiscal year (HFY).

(b) Managed care clients is:

(i) The hospital's most recently submitted Medicare cost report; and

(ii) The appropriate managed care encounter data for that HFY.

(10) For a newly licensed hospital that is also a CAH, the department uses the current statewide average DWCC rates for the initial prospective DWCC rates.

(11) For a CAH that comes under new ownership, the department uses the prior owner's DWCC rates.

(12) In addition to the prospective managed care inpatient and outpatient DWCC rates, the department:

(a) Incorporates the DWCC rates into the calculations for the managed care capitated premiums that will be paid to the managed care plans; and

(b) Requires all managed care plans having contract relationships with CAHs to pay the inpatient and outpatient DWCC rates applicable to managed care claims. For purposes of this section, the department considers the DWCC rates used to reimburse CAHs for care given to clients enrolled in a managed care plan to be cost. Cost settlements are not performed for managed care claims.

(13) For fee-for-service claims only, the department performs an interim retrospective cost settlement for each CAH after the end of the CAH's HFY, using Medicare cost report data and claims data from the MMIS related to fee-for-service claims. Specifically, the department:

(a) Compares actual department total interim CAH payments to the departmental-weighted CAH fee-for-service costs for the period being cost settled; and

(b) Pays the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to exceed the total interim CAH payments for that period. The department recoups from the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to be less than total interim CAH payments.

(14) The department performs finalized cost settlements using the same methodology as outlined in subsection (13) of this section, except that the department uses the hospital's settled Medicare cost report instead of the initial cost report.

Whenever a CAH's Medicare cost report is settled by the Medicare fiscal intermediary, the CAH must send the settled cost report to the department to be used in a final cost settlement.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.5225, 06-04-089, § 388-550-2598, filed 1/31/06, effective 3/2/06; 05-01-026, § 388-550-2598, filed 12/3/04, effective 1/3/05. Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.5225, and HB 1162, 2001 2nd sp.s. c 2. 02-13-099, § 388-550-2598, filed 6/18/02, effective 7/19/02.]

WAC 388-550-2600 Inpatient psychiatric services.

For psychiatric hospitalizations, including involuntary admissions, see chapter 246-318 [246-320] WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2750 Hospital discharge planning services. For discharge planning service requirements, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2750, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2800 Inpatient payment methods and limits. (1) The department reimburses hospitals for Medicaid inpatient hospital services using the rate setting methods identified in the department's approved state plan that includes:

Method	Used for
Diagnoses related group (DRG) negotiated conversion factor	Hospitals participating in the Medicaid hospital selective contracting program under waiver from the federal government
DRG cost-based conversion factor	Hospitals not participating in or exempt from the Medicaid hospital selective contracting program
Ratio of costs-to-charges (RCC)	Hospitals or services exempt from DRG payment methods
Single case rate	Bariatric surgery
Fixed per diem rate	Acute physical medicine and rehabilitation (Acute PM&R)
	Level B facilities and long-term acute care (LTAC) hospitals
Cost settlement	MAA-approved critical access hospitals (CAHS)

(2) The department's annual aggregate Medicaid payments to each hospital for inpatient hospital services provided to Medicaid clients will not exceed the hospital's usual and customary charges to the general public for the services (42 CFR § 447.271). The department recoups annual aggregate Medicaid payments that are in excess of the usual and customary charges.

(3) The department's annual aggregate payments for inpatient hospital services, including state-operated hospitals, will not exceed the estimated amounts that the department would have paid using Medicare payment principles.

(4) When hospital ownership changes, the department's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(5) Hospitals participating in the medical assistance program must annually submit to the medical assistance administration:

(a) A copy of the hospital's HCFA 2552 Medicare Cost Report; and

(b) A disproportionate share hospital application.

(6) Reports referred to in subsection (5) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by MAA.

(7) The department requires hospitals to follow generally accepted accounting principles unless federally or state regulated.

(8) Participating hospitals must permit the department to conduct periodic audits of their financial and statistical records.

(9) The department reimburses hospitals for claims involving clients with third-party liability insurance:

(a) At the lesser of either the DRG:

(i) Billed amount minus the third-party payment amount;

or

(ii) Allowed amount minus the third-party payment amount; or

(b) The RCC allowed payment minus the third-party payment amount.

[Statutory Authority: RCW 74.08.090, 74.09.500, 05-12-022, § 388-550-2800, filed 5/20/05, effective 6/20/05. Statutory Authority: RCW 74.08.090 and 74.09.500, 04-19-113, § 388-550-2800, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 02-21-019, § 388-550-2800, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652, 01-16-142, § 388-550-2800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652, 99-14-027, § 388-550-2800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652, 99-06-046, § 388-550-2800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2900 Payment limits—Inpatient hospital services. (1) To receive reimbursement for covered inpatient hospital services, a hospital must:

(a) Have a core-provider agreement with the department; and

(b) Be an in-state border city hospital that meets the definition in RCW 70.41.020 and is certified under Title XVIII of the federal Social Security Act; or

(c) Be an out-of-state hospital that meets the conditions in WAC 388-550-6700.

(2) The department does not pay:

(a) A hospital for inpatient care and/or services when a managed care plan is contracted to cover those services.

(b) A hospital for care or services provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(2007 Ed.)

(c) Hospitals for ancillary services in addition to the diagnosis-related group (DRG) payment.

(d) For additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established at the seventy-fifth percentile as published in the *"Length of Stay by Diagnosis and Operations, Western Region"*; and

(ii) The hospital has not requested and/or received approval for an extended length of stay (LOS) from the department as specified in WAC 388-550-4300(3).

(e) For elective or nonemergent inpatient services provided in a nonparticipating hospital. A nonparticipating hospital is defined in WAC 388-550-1050. See also WAC 388-550-4600.

(f) For inpatient hospital services when the department determines that the medical record fails to support the medical necessity and inpatient level of care for the inpatient admission.

(3) The department limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by C.F.R. §447.271.

[Statutory Authority: RCW 74.08.090 and 74.09.500, 04-20-058, § 388-550-2900, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652, 01-16-142, § 388-550-2900, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652, 99-14-027, § 388-550-2900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652, 99-06-046, § 388-550-2900, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-2900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3000 Payment method—DRG. (1) The medical assistance administration (MAA) uses the diagnosis-related group (DRG) payment method to reimburse covered inpatient hospital services, except as specified in WAC 388-550-4300 and 388-550-4400.

(2) MAA uses the all-patient grouper (AP-DRG) to assign a DRG to each inpatient hospital stay. MAA periodically evaluates which version of the AP-DRG to use.

(3) A DRG payment includes, but is not limited to:

(a) All covered hospital services provided to a client during the client's inpatient hospital stay.

(b) Outpatient hospital services, including preadmission, emergency room, and observation services related to an inpatient hospital admission and provided within one calendar day of a client's inpatient hospital admission. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c))

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or pro-

vider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(4) MAA's DRG payment is determined by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, by the hospital's conversion factor. See WAC 388-550-3450 and 388-550-4600(4).

(5) MAA's DRG payments to hospitals may be adjusted when one or more of the following occur:

(a) A claim qualifies as a DRG high-cost or low-cost outlier (see WAC 388-550-3700);

(b) A client transfers from one acute care hospital or distinct unit to another acute care hospital or distinct unit (see WAC 388-550-3600);

(c) A client is not eligible for a medical assistance program on one or more of the days of the hospital stay;

(d) A client is eligible for Part B Medicare and Medicare has made a payment for the Part B hospital charges; or

(e) A client is discharged from an inpatient hospital stay and is readmitted as an inpatient within seven days. MAA or its designee performs a retrospective utilization review (see WAC 388-550-1700 (3)(b)(iii)) on the initial admission and the readmission(s) to determine which inpatient hospital stay(s) qualify for DRG payment.

[Statutory Authority: RCW 74.04.050, 74.08.090, 05-11-077, § 388-550-3000, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3100 Calculating DRG relative weights. (1) This section describes how the medical assistance administration (MAA) calculates Washington diagnostic-related group (DRG) relative weights, MAA:

(a) Classifies the Washington hospital admissions data using the all-patient grouper (AP-DRG).

(b) Statistically tests each DRG for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.

(c) Establishes a single set of Medicaid-specific relative weights from Washington hospital admissions data. These relative weights may be stable or unstable.

(d) Tests the stability of the relative weights from subsection (1)(c) of this section using a reasonable statistical test to determine if the weights are stable. MAA accepts as stable and adopts those relative weights that pass the reasonable statistical test.

(e) May compare the Medicaid-specific relative weights to non-Medicaid relative weights. MAA:

(i) May combine the Medicaid-specific relative weights with the non-Medicaid relative weights if the non-Medicaid relative weights are statistically comparable to the Medicaid-specific weights; or

(ii) Uses only the Medicaid-specific relative weights if the non-Medicaid relative weights are not statistically comparable to the Medicaid-specific relative weights.

(f) Uses the ratio of costs-to-charges (RCC) method to pay for hospital stays that have unstable DRG relative weights.

(2) When using ratios with a DRG relative weight as base, MAA adjusts all stable relative weights so that the average weight of the case mix population equals 1.0.

[Statutory Authority: RCW 74.08.090, 74.04.050, 04-13-048, § 388-550-3100, filed 6/10/04, effective 7/11/04. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3100, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3150 Base period costs and claims data. (1) The department shall set a hospital's cost-based conversion factor using base period cost data from its Medicare cost report (Form HCFA 2552) for its fiscal year corresponding with the base period.

(2) The department shall use in rate-setting only base period cost data that have been desk reviewed and/or field audited by the Medicare intermediary.

(3) The department shall, to the extent feasible, factor out of a hospital's base period cost data nonallowable hospital charges associated with the items/services listed in WAC 388-550-1600(1) before calculating the hospital's conversion factor.

(4) The department shall use the figures for total costs, capital costs, and direct medical education costs from a hospital's HCFA 2552 report in calculating that hospital's allowable costs for each of the thirty-eight categories of cost/revenue centers, listed in subsections (5) and (6) below, used to categorize Medicaid claims.

(5) The department shall use nine categories to assign a hospital's accommodation costs and days of care. These accommodation categories are:

- (a) Routine;
- (b) Intensive care;
- (c) Intensive care-psychiatric;
- (d) Coronary care;
- (e) Nursery;
- (f) Neonatal intensive care unit;
- (g) Alcohol/substance abuse;
- (h) Psychiatric; and
- (i) Oncology.

(6) The department shall use twenty-nine categories to assign ancillary costs and charges. These ancillary categories are:

- (a) Operating room;
- (b) Recovery room;
- (c) Delivery/labor room;
- (d) Anesthesiology;
- (e) Radiology-diagnostic;
- (f) Radiology-therapeutic;
- (g) Radioisotope;
- (h) Laboratory;
- (i) Blood storage;
- (j) Intravenous therapy;
- (k) Respiratory therapy;
- (l) Physical therapy;
- (m) Occupational therapy;
- (n) Speech pathology;

- (o) Electrocardiography;
 - (p) Electroencephalography;
 - (q) Medical supplies;
 - (r) Drugs;
 - (s) Renal dialysis;
 - (t) Ancillary oncology;
 - (u) Cardiology;
 - (v) Ambulatory surgery;
 - (w) Computerized tomography scan/magnetic resonance imaging;
 - (x) Clinic;
 - (y) Emergency;
 - (z) Ultrasound;
 - (aa) Neonatal intensive care unit transportation;
 - (bb) Gastrointestinal laboratory; and
 - (cc) Miscellaneous.
- (7) The department shall:
- (a) Extract from the Medicaid Management Information System all Medicaid paid claims data for each hospital's base year;
 - (b) Assign line item charges from the paid hospital claims to the appropriate accommodation and ancillary cost center categories; and
 - (c) Use the cost center categories to apportion Medicaid costs.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3200 Medicaid cost proxies. (1) For cases in which a hospital has Medicaid charges (claims) for certain accommodation or ancillary cost centers which are not separately reported on its Medicare cost report, the department shall establish cost proxies to estimate such costs in order to ensure recognition of Medicaid related costs.

(2) The department shall develop per diem proxies for accommodation cost centers using the median value of the hospital's per diem cost data within the affected hospital peer group.

(3) The department shall develop ratio of cost-to-charge (RCC) proxies for ancillary cost centers using the median value of the hospital's RCC data within the affected hospital peer group.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3250 Indirect medical education costs. (1) For a hospital with a graduate medical education program, the department shall remove indirect medical education-related costs from the aggregate operating and capital costs of each hospital in the peer group before calculating a peer group's cost cap.

(2) To arrive at indirect medical education costs for each component, the department shall:

- (a) Multiply Medicare's indirect cost factor of 0.579 by the ratio of the number of interns and residents in the hospital's approved teaching programs to the number of hospital beds; and

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(b) Multiply the product obtained in subsection (2)(a) of this section by the hospital's operating and capital components.

(3) After the peer group's cost cap has been calculated, the department shall add back to the hospital's aggregate costs its indirect medical education costs. See WAC 388-550-3450(6).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3300 Hospital peer groups and cost caps. (1) For rate-setting purposes the department groups hospitals into peer groups and establishes cost caps for each peer group. The department sets hospital reimbursement rates at levels that recognize the costs of reasonable, efficient, and effective providers.

(2) The six hospital peer groups are:

- (a) Group A, rural hospitals;
- (b) Group B, urban hospitals without medical education programs;
- (c) Group C, urban hospitals with medical education program;
- (d) Group D, specialty hospitals or other hospitals not easily assignable to the other five groups;
- (e) Group E, public hospitals participating in the "full cost" public hospital certified public expenditure (CPE) program; and
- (f) Group F, critical access hospitals.

(3) The department uses a cost cap at the seventieth percentile for hospitals in peer groups B and C. All other peer groups are exempt from the cost caps for the following reasons:

- (a) Peer group A hospitals because they are paid under the ratio of costs-to-charges (RCC) methodology for Medicaid claims.

- (b) Peer group D hospitals because they are specialty hospitals without a common peer group on which to base comparisons.

- (c) Peer group E hospitals because they are paid under the RCC methodology for inpatient claims.

- (d) Peer group F hospitals because they are paid under the departmental weighted costs-to-charges (DWCC) methodology for Medicaid claims.

(4) The department calculates cost caps for peer groups B and C based on the hospitals' base period costs after subtracting:

- (a) Indirect medical education costs, in accordance with WAC 388-550-3250(2), from the aggregate operating and capital costs of each hospital in the peer group; and

- (b) The cost of outlier cases from the aggregate costs in accordance with WAC 388-550-3350(1).

(5) The department uses the lesser of each individual hospital's calculated aggregate cost or the peer group's seventieth percentile cost cap as the base amount in calculating the individual hospital's adjusted cost-based conversion factor. After the peer group cost cap is calculated, the department adds back to the individual hospital's base amount its indirect medical education costs and appropriate outlier costs, as determined in WAC 388-550-3350(2).

(6) In cases where corrections or changes in an individual hospital's base-year cost or peer group assignment occur after peer group cost caps are calculated, the department updates the peer group cost caps involved only if the change in the individual hospital's base-year costs or peer group assignment will result in a five percent or greater change in the seventieth percentile of costs calculated for either its previous peer group category, its new peer group category, or both.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-3300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-3300, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652, 01-16-142, § 388-550-3300, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-3300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3350 Outlier costs. (1)(a) The department shall remove the cost of low- and high-cost outlier cases from individual hospitals' aggregate costs before calculating the peer group cost cap.

(b) After this initial step, all subsequent calculations involving outliers in subsections (2) through (5) of this section pertain only to high-cost outliers.

(c) For a definition of outliers see WAC 388-550-1050, Definitions.

(2) After an individual hospital's base period costs and its peer group cost cap are determined, the department shall add the individual hospital's indirect medical education costs and an outlier cost adjustment back to:

(a) The lesser of the hospital's calculated aggregate cost; or

(b) The peer group's seventieth percentile cost cap.

(3) The outlier cost adjustment is determined as follows to reduce the original high-cost outlier amount in proportion to the reduction in the hospital's base period costs as a result of the capping process:

(a) If the individual hospital's aggregate operating, capital, and direct medical education costs for the base period are less than the seventieth percentile costs for the peer group, the entire high-cost outlier amount is added back.

(b) A reduced high-cost outlier amount is added back if:

(i) The individual hospital's aggregate base period costs are higher than the seventieth percentile for the peer group; and

(ii) The hospital is capped at the seventieth percentile.

(iii) The amount of the outlier added back is determined by multiplying the original high-cost outlier amount by the percentage obtained when the hospital's final cost cap, which is the peer group's seventieth percentile cost, is divided by its uncapped base period costs, as determined in WAC 388-550-3300(4).

(4) The department shall pay high-cost outlier claims from the outlier set-aside pool. The department shall calculate an individual hospital's high-cost outlier set-aside as follows:

(a) For each hospital, the department extracts utilization and paid claims data from the Medicaid Management Information System (MMIS) for the most recent twelve-month period for which the department estimates the MMIS has complete payment information.

(b) Using the data in (a) of this subsection, the department determines the projected annual amount above the high-cost DRG outlier threshold that the department paid to each hospital.

(c) The department's projected high-cost outlier payment to the hospital determined in (b) of this subsection is divided by the department's total projected annual DRG payments to the hospital to arrive at a hospital-specific high-cost outlier percentage. This percentage becomes the hospital's outlier set-aside factor.

(5) The department shall use the individual hospital's outlier set-aside factor to reduce the hospital's CBCF by an amount that goes into a set-aside pool to pay for all high-cost outlier cases during the year. The department shall fund the outlier set-aside pool on hospitals' prior high-cost outlier experience. No cost settlements shall be made to hospitals for outlier cases.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-3350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3381 Payment methodology for acute PM&R services and administrative day services. The medical assistance administration's (MAA's) payment methodology for acute PM&R services provided by hospital-based acute PM&R facilities is described in this section.

(1) MAA pays a rehabilitation facility according to the individual hospital's current ratio of costs-to-charges as described in WAC 388-550-4500, Payment method—RCC.

(2) Acute PM&R room and board includes, but is not limited to:

(a) Facility use;

(b) Medical social services;

(c) Bed and standard room furnishings; and

(d) Dietary and nursing services.

(3) When MAA authorizes administrative day(s) for a client as described in WAC 388-550-2561(8), MAA reimburses the facility:

(a) The administrative day rate; and

(b) For pharmaceuticals prescribed in the client's use during the administrative portion of the client's stay.

(4) The department pays for transportation services provided to a client receiving acute PM&R services in a hospital-based facility according to chapter 388-546 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.520 and 42 C.F.R. 482.56, 03-06-047, § 388-550-3381, filed 2/28/03, effective 3/31/03. Statutory Authority: RCW 74.08.090 and 74.09.520, 99-17-111, § 388-550-3381, filed 8/18/99, effective 9/18/99.]

WAC 388-550-3400 Case-mix index. (1)(a) The department shall adjust hospital costs for case mix under the diagnosis-related group (DRG) payment systems.

(b) The department shall calculate a case-mix index (CMI) for each individual hospital to measure the relative cost for treating Medicaid cases in a given hospital.

(2) The department shall calculate the CMI for each hospital using Medicaid admissions data from the individual hospital's base period cost report, as described in WAC 388-550-3150. The hospital-specific CMI is calculated as follows:

(a) The department shall multiply the number of Medicaid admissions to the hospital for a specific DRG by the relative weight for that DRG. The department shall repeat this process for each DRG billed by the hospital.

(b) The department shall add together the products in (a) of this subsection for all of the Medicaid admissions to the hospital in the base year.

(c) The department shall divide the sum obtained in (b) of this subsection by the corresponding number of Medicaid hospital admissions.

(d) Example: If the average case mix index for a group of hospitals is 1.0, a CMI of 1.0 or greater for a hospital in that group means that the hospital has treated a mix of patients in the more costly DRGs. A CMI of less than 1.0 indicates a mix of patients in the less costly DRGs.

(3) The department shall recalculate each hospital's case mix index periodically, but no less frequently than each time rebasing is done.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3450 Payment method for calculating CBCF rates. (1) For Medicaid accommodation costs, MAA:

(a) Uses each hospital's base period cost data to calculate the hospital's total operating, capital, and direct medical education costs for each of the nine accommodation categories described in WAC 388-550-3150(5); then

(b) Divides those costs per category by total hospital days per category to arrive at a per day accommodation cost; then

(c) Multiplies the per day accommodation cost for each category by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

(2) For ancillary costs MAA:

(a) Uses the base period cost data to calculate total operating, capital, and direct medical education costs for each of the hospital's twenty-nine ancillary categories; then

(b) Divides these costs by total charges per category to arrive at a ratio of costs-to-charges (RCC) per ancillary category; then

(c) Multiplies these RCCs by Medicaid charges per category, as tracked by the Medicaid Management Information System (MMIS), to arrive at total Medicaid ancillary costs per category for the three components (operating, capital, and medical education).

(3) MAA:

(a) Combines Medicaid accommodation and ancillary costs to derive the hospital's total costs for operating, capital, and direct medical education components for the base year; then

(b) Divides the hospital's combined total cost by the number of Medicaid cases during the base year to arrive at an average Medicaid cost per DRG admission; then

(c) Adjusts, for hospitals with a fiscal year ending different than the common fiscal year end, the Medicaid average cost by a factor determined by MAA to standardize hospital costs to the common fiscal year end. MAA adjust the hospital's Medicaid average cost by the hospital's specific case mix index.

(2007 Ed.)

(4) MAA caps the Medicaid average cost per case for peer groups B and C at seventy percent of the peer group average. In calculation of the peer group cap, MAA removes the indirect medical education and outlier costs from the Medicaid average cost per admission.

(a) For hospitals in MAA peer groups B or C, MAA determines aggregate costs for the operating, capital, and direct medical education components at the lesser of hospital-specific aggregate cost or the peer group cost cap; then

(b) To whichever is less, the hospital-specific aggregate cost or the peer group cost cap determined in subsection (4) of this section, MAA adds:

(i) The individual hospital's indirect medical education costs, as determined in WAC 388-550-3250(2); and

(ii) An outlier cost adjustment in accordance with WAC 388-550-3350(2).

(5) For an inflation adjustment MAA may:

(a) Multiply the sum obtained in subsection (4) of this section by an inflation factor as determined by the legislature for the period January 1 of the year after the base year through October 31 of the rebase year; then

(b) Reduce the product obtained in (a) of this subsection by the outlier set-aside percentage determined in accordance with WAC 388-550-3350(3) to arrive at the hospital's adjusted CBCF; then

(c) Multiply the hospital's adjusted CBCF by the applicable DRG relative weight to calculate the DRG payment for each admission.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3450, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3450, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3500 Hospital inflation adjustment determinations. Effective on November 1 of each year, MAA may adjust all cost-based conversion factors (CBCF) by an inflation factor, as determined by the legislature and as addressed in subsequent budget notes. MAA does not automatically give an inflation increase to negotiated conversion factors for contracted hospitals participating in the hospital selective contracting program.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3500, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-3500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. The department applies the following payment rules when a client transfers from one acute care hospital or distinct unit to another acute care hospital or distinct unit:

(1) The department does not reimburse a hospital for a nonemergent case when the hospital transfers the client to another hospital.

(2) The department pays a hospital that transfers emergent cases to another hospital, the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment; or

(b) A per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital. The department determines the per diem rate by dividing the hospital's DRG payment amount for the appropriate DRG by that DRG's average length of stay.

(3) The department uses:

(a) The hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer; and

(b) MAA's length of stay data to determine the number of medically necessary days for a client's hospital stay.

(4) The department:

(a) Pays the hospital that ultimately discharges the client to any residence other than a hospital (e.g., home, nursing facility, etc.) the full DRG payment; and

(b) Applies the outlier payment methodology if a transfer case qualifies as a high- or low-cost outlier.

(5) The department does not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital (intervening hospital) which subsequently sends the client back.

(a) The department's maximum payment to the discharging hospital is the full DRG payment.

(b) The department pays the intervening hospital(s) a per diem payment based on the method described in subsection (2) of this section.

[Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3600, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3700 DRG high-cost and low-cost outliers. This section applies to inpatient hospital claims paid under the diagnosis-related group (DRG) payment methodology.

(1) A Medicaid or state-administered claim qualifies as a DRG high-cost outlier when:

(a) The client's admission date on the claim is before January 1, 2001, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of twenty-eight thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(b) The client's admission date on the claim is January 1, 2001, or after, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of thirty-three thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(2) If the claim qualifies as a DRG high-cost outlier, the high-cost outlier threshold, for payment purposes, is the amount in subsection (1)(a)(i) or (ii), whichever is greater, for an admission date before January 1, 2001; or subsection (1)(b)(i) or (ii), whichever is greater, for an admission date January 1, 2001 or after.

(3) The department determines payment for Medicaid claims that qualify as DRG high-cost outliers as follows:

(a) All qualifying claims, except for claims in psychiatric DRGs 424-432 and in-state children's hospitals, are paid seventy-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(b) In-state children's hospitals are paid eighty-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(c) Psychiatric DRG high-cost outliers for DRGs 424-432 are paid one hundred percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

Examples for DRG high-cost outlier claim qualification and payment calculation (admission dates are January 1, 2001, or after).

Allowed Charges	Applicable DRG Payment	Three times App. DRG Payment	Allowed Charges > \$33,000?	Allowed Charges > Three times App. DRG Payment?	DRG High-Cost Outlier Payment	Hospital's Individual RCC Rate
\$17,000	\$5,000	\$15,000	No	Yes	N/A	64%
*\$33,500	5,000	15,000	Yes	Yes	**\$5,240	64%
10,740	35,377	106,131	No	No	N/A	64%

Medicaid Payment calculation example for allowed charges of:	Nonpsych DRGs/Nonin-state children's hospital (RCC is 64%)
*\$33,500	Allowed charges
- \$33,000	The greater amount of 3 x app. DRG pymt (\$15,000) or \$33,000
\$ 500	
x 48%	75% of allowed charges x hospital RCC rate (nonpsych DRGs/nonin-state children's) (75% x 64% = 48%)

Medicaid Payment calculation example for allowed charges of:	Nonpsych DRGs/Nonin-state children's hospital (RCC is 64%)
\$ 240	Outlier portion
+ \$ 5,000	Applicable DRG payment
**\$ 5,240	Outlier payment

(4) DRG high-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(5) A Medicaid or state-administered claim qualifies as a DRG low-cost outlier if:

(a) The client's admission date on the claim is before January 1, 2001, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred dollars.

(b) The client's admission date on the claim is January 1, 2001, or after, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred fifty dollars.

(6) If the claim qualifies as a DRG low-cost outlier:

(a) For an admission date before January 1, 2001, the low-cost outlier amount is the amount in subsection (5)(a)(i) or (ii), whichever is greater; or

(b) For an admission date on January 1, 2001, or after, the low-cost outlier amount is the amount in subsection (5)(b)(i) or (ii), whichever is greater.

(7) The department determines payment for a Medicaid claim that qualifies as a DRG low-cost outlier by multiplying the allowed charges for each claim by the hospital's RCC rate.

(8) DRG low-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(9) The department makes day outlier payments to hospitals in accordance with section 1923 (a)(2)(C) of the Social Security Act, for clients who have exceptionally long stays that do not reach DRG high-cost outlier status. A hospital is eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share hospital (DSH) and the client served is under age six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The allowed charges for the hospitalization are less than the DRG high-cost outlier threshold as defined in subsection (2) of this section; and

(d) The client's length of stay exceeds the day outlier threshold for the applicable DRG payment amount. The day outlier threshold is defined as the number of days in an average length of stay for a discharge (for an applicable DRG payment), plus twenty days.

(10) The department bases the day outlier payment on the number of days that exceed the day outlier threshold, multiplied by the administrative day rate.

(11) The department's total payment for day outlier claims is the applicable DRG payment plus the day outlier or administrative days payment.

(12) A client's outlier claim is either a day outlier or a high-cost outlier, but not both.

[Statutory Authority: RCW 74.08.090, 74.09.500, 03-13-053, § 388-550-3700, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3700, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303 and 447.2652. 99-06-046, § 388-550-3700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200,

(2007 Ed.)

[74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3800 Rebasing and recalibration. (1)

The medical assistance administration (MAA) rebases the Medicaid payment system periodically using each hospital's cost report for its fiscal year that ends during the calendar year designated by MAA to be used for each update.

(2) MAA recalibrates diagnosis-related group (DRG) relative weights periodically, as described in WAC 388-550-3100, but no less frequently than each time rebasing is conducted. The department makes recalibrated relative weights effective on the rate implementation date, which can change with each rebasing.

(3) When recalibrating DRG relative weights without rebasing, MAA may apply a budget neutrality factor (BNF) to hospitals' cost based conversion factors to ensure that total DRG payments to hospitals do not exceed total DRG payments that would have been made to hospitals if the relative weights had not been recalibrated. For the purposes of this section, BNF equals the percentage change from total reimbursement calculated under a new payment system to total reimbursement calculated under the prior payment system.

[Statutory Authority: RCW 74.08.090, 74.09.500, 05-06-044, § 388-550-3800, filed 2/25/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3900 Payment method—Border area hospitals. (1) Under the diagnosis-related group (DRG) payment method:

(a) MAA calculates the cost-based conversion factor (CBCF) of a border area hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(b) For a border area hospital with no HCFA 2552 for the rebasing year, MAA assigns the MAA peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.

(2) MAA calculates:

(a) The ratio of costs-to-charges (RCC) in accordance with WAC 388-550-4500.

(b) For a border area hospital with no HCFA 2552 Medicare cost report, its RCC on the Washington in-state average RCC ratios.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-3900, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4000 Out-of-state hospitals payment method. The department shall pay out-of-state hospitals the lesser of billed charges or the amount calculated using the weighted average of ratio of cost-to-charge ratios for in-state Washington hospitals multiplied by the allowed charges for medically necessary services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4100 Payment method—New hospitals. (1) For rate-setting purposes, MAA considers as new:

(a) A hospital which began services after the most recent rebased cost-based conversion factors (CBCFs), or

(b) A hospital that has not been in operation for a complete fiscal year.

(2) MAA determines a new hospital's CBCF as the average of the CBCF of all hospitals within the same MAA peer group.

(3) MAA determines a new hospital's ratio of costs-to-charges (RCC) by calculating and using the average RCC rate for all current Washington in-state hospitals.

(4) MAA considers that a change in hospital ownership does not constitute a new hospital.

[Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271, 11303 and 2652. 99-14-027, § 388-550-4100, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4200 Change in hospital ownership.

(1) For purposes of this section, a change in hospital ownership may involve one or more, but is not limited to, the following events:

(a) A change in the composition of the partnership;

(b) A sale of an unincorporated sole proprietorship;

(c) The statutory merger or consolidation of two or more corporations;

(d) The leasing of all or part of a provider's facility if the leasing affects utilization, licensure, or certification of the provider entity;

(e) The transfer of a government-owned institution to a governmental entity or to a governmental corporation;

(f) Donation of all or part of a provider's facility to another entity if the donation affects licensure or certification of the provider entity;

(g) Disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity; or

(h) A change in the provider's federal identification tax number.

(2) A hospital shall notify the department in writing ninety days prior to the date of an expected change in the hospital's ownership, but in no case later than thirty days after the change in ownership takes place.

(3) When a change in a hospital's ownership occurs, the department shall set the new provider's cost-based conversion factor (CBCF) at the same level as the prior owner's, except as provided in subsection (4) below.

(4) The department shall set for a hospital formed as a result of a merger:

(a) A blended CBCF based on the old hospitals' rates, proportionately weighted by admissions for the old hospitals; and

(b) An RCC rate determined by combining the old hospitals' cost reports and following the process described in WAC 388-550-4500.

(5) The department shall recapture depreciation and acquisition costs as required by section 1861 (V)(1)(O) of the Social Security Act.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4300 Hospitals and units exempt from the DRG payment method.

(1) Except when otherwise specified, inpatient services provided by hospitals and units that are exempt from the diagnosis-related group (DRG) payment method are reimbursed under the ratio of costs-to-charges (RCC) payment method described in WAC 388-550-4500.

(2) Subject to the restrictions and limitations listed in this section, the department exempts the following hospitals and units from the DRG payment method for inpatient services provided to Medicaid-eligible clients:

(a) Peer group A hospitals, as described in WAC 388-550-3300(2). Exception: Inpatient services provided to clients eligible under the following programs are reimbursed through the DRG payment method:

(i) General assistance programs; and

(ii) Other state-only administered programs.

(b) Peer group E hospitals, as described in WAC 388-550-3300(2). See WAC 388-550-4650 for how the department calculates payment to Peer group E hospitals.

(c) Peer group F hospitals (critical access hospitals).

(d) Rehabilitation units when the services are provided in department-approved acute physical medicine and rehabilitation (acute PM&R) hospitals and designated distinct rehabilitation units in acute care hospitals.

The department uses the same criteria as the Medicare program to identify exempt rehabilitation hospitals and designated distinct rehabilitation units. Exception: Inpatient rehabilitation services provided to clients eligible under the following programs are covered and reimbursed through the DRG payment method:

(i) General assistance programs; and

(ii) Other state-only administered programs.

(e) Out-of-state hospitals excluding hospitals located in designated bordering cities as described in WAC 388-501-0175. Inpatient services provided in out-of-state hospitals to clients eligible under the following programs are not covered or reimbursed by the department:

(i) General assistance programs; and

(ii) Other state-only administered programs.

(f) Military hospitals when no other specific arrangements have been made with the department. Military hospitals may individually elect or arrange for one of the following payment methods in lieu of the RCC payment method:

(i) A negotiated per diem rate; or

(ii) DRG.

(g) Nonstate-owned specifically identified psychiatric hospitals and designated hospitals with Medicare certified distinct psychiatric units. The department uses the same criteria as the Medicare program to identify exempt psychiatric hospitals and distinct psychiatric units of hospitals.

(i) Inpatient psychiatric services provided to clients eligible under the following programs are reimbursed through the DRG payment method:

(A) General assistance programs; and

(B) Other state-only administered programs.

(ii) Regional support networks (RSNs) that arrange to reimburse nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals directly, may use the department's payment methods or contract with the hospitals to reimburse using different methods. Claims not paid directly through an RSN are paid through the department's payment system.

(3) The department limits inpatient hospital stays that are exempt from the DRG payment method and identified in subsection (2) of this section to the number of days established at the seventy-fifth percentile in the current edition of the publication, *Length of Stay by Diagnosis and Operation, Western Region*, unless the stay is:

(a) Approved for a specific number of days by the department, or for psychiatric inpatient stays, by the regional support network (RSN);

(b) For chemical dependency treatment which is subject to WAC 388-550-1100; or

(c) For detoxification of acute alcohol or other drug intoxication.

(4) If subsection (3)(c) of this section applies to an eligible client, the department will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) Extend the three- and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:

(i) Petition for commitment to chemical dependency treatment; or

(ii) Temporary order for chemical dependency treatment.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-4300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-4300, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652, 01-16-142, § 388-550-4300, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-4300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4400 Services—Exempt from DRG payment. (1) Except when otherwise specified, inpatient services exempt from the diagnosis-related group (DRG) payment method are reimbursed by the RCC payment method described in WAC 388-550-4500.

(2) Subject to the restrictions and limitations in this section, the department exempts the following services for Medicaid clients from the DRG payment method:

(a) Neonatal services for DRGs 602-619, 621-628, 630, 635, and 637-641.

(b) Acquired immunodeficiency syndrome (AIDS)-related inpatient services for those cases with a reported diagnosis of AIDS-related complex and other human immunodeficiency virus infections. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state-only administered program.

(c) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agree-

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ment with the department to perform these services. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state-only administered program.

(d) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically dependent pregnant women (CUP program) by a certified hospital. These are Medicaid program services and are not funded by the department through the general assistance programs or any other state-only administered program.

(e) Acute physical medicine and rehabilitation services provided in MAA-approved rehabilitation hospitals and hospital distinct units, and services for physical medicine and rehabilitation patients. Rehabilitation services provided to clients under the general assistance programs and any other state-only administered program are also reimbursed through the RCC payment method.

(f) Psychiatric services provided in nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals.

(g) Chronic pain management treatment provided in department-approved pain treatment facilities.

(h) Administrative day services. The department reimburses administrative days based on the statewide average Medicaid nursing facility per diem rate, which is adjusted annually each November 1. The department applies this rate to patient days identified as administrative days on the hospital's notice of rates. Hospitals must request an administrative day designation on a case-by-case basis.

(i) Inpatient services recorded on a claim that is grouped by MAA to a DRG for which MAA has not published an all patient DRG relative weight, except that claims grouped to DRGs 469 and 470 will be denied payment. This policy also applies to covered services paid through the general assistance programs and any other state-only administered program.

(j) Organ transplants that involve the heart, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, or simultaneous kidney/pancreas. These services are also exempt from the DRG payment method when funded by MAA through the general assistance programs and any other state-only administered program.

(k) Bariatric surgery performed in hospitals that meet the criteria in WAC 388-550-2301. MAA pays hospitals for bariatric surgery on a single case rate basis.

(3) Inpatient services provided through a managed care plan contract are reimbursed by the managed care plan.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-12-022, § 388-550-4400, filed 5/20/05, effective 6/20/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652, 01-16-142, § 388-550-4400, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-4400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4500 Payment method—Inpatient RCC and administrative day rate and outpatient rate. (1) The inpatient ratio of costs-to-charges (RCC) payment is the hospital's allowable charges on a claim multiplied by the hospital's inpatient RCC rate. The department limits this RCC

payment to the hospital's allowable usual and customary charges.

(a) The medical assistance administration (MAA) calculates a hospital's RCC by dividing allowable operating costs by patient revenues associated with these allowable costs.

(b) MAA bases these figures on the annual Medicare cost report data provided by the hospital.

(c) MAA updates a hospital's inpatient RCC rate annually with the submittal of new CMS 2552 Medicare cost report data. Prior to computing the ratio, MAA excludes increases in operating costs or total rate-setting revenue attributable to a change in ownership.

(2) The department limits a hospital's RCC payment to one hundred percent of its allowable charges.

(3) The department establishes the basic inpatient hospital RCC payment by multiplying the hospital's assigned RCC rate by the allowed charges for medically necessary services. MAA deducts client responsibility (spend-down) and third-party liability (TPL) from the basic payment to determine the actual payment due.

(4) The department uses the RCC payment method to reimburse:

(a) DRG-exempt hospitals as provided in WAC 388-550-4300; and

(b) Any hospital for DRG-exempt services described in WAC 388-550-4400.

(5) In-state and border area hospitals that lack sufficient CMS 2552 Medicare cost report data to establish a hospital specific RCC are reimbursed using the weighted average in-state:

(a) RCC rate for inpatient services as provided in WAC 388-550-4300 and 388-550-4400; and

(b) Outpatient rate as provided in WAC 388-550-6000.

(6) Out-of-state hospitals are also reimbursed for the respective services using the weighted average in-state:

(a) RCC rate for inpatient services as provided in WAC 388-550-4300 and 388-550-4400; and

(b) Outpatient rate for outpatient hospital services as provided in WAC 388-550-6000.

(7) MAA identifies all in-state hospitals that have hospital specific RCC rates, and calculates the weighted average in-state RCC rate annually by dividing the total allowable operating costs of these hospitals by the total respective patient revenues.

(8) The department pays hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client no longer needs an acute inpatient level of care, but is not discharged because an appropriate placement outside the hospital is not available.

(a) MAA sets payment for administrative days at the statewide average Medicaid nursing facility per diem rate. The administrative day rate is adjusted annually.

(b) Ancillary services provided during administrative days are not reimbursed.

(c) The department identifies administrative days for a DRG exempt case during the length of stay review process after the client's discharge from the hospital.

(d) The department pays the hospital at the administrative day rate starting the date of hospital admission if the admission is solely for a stay until an appropriate sub-acute placement can be made.

(9) MAA calculates the weighted average in-state outpatient rate annually by multiplying the weighted average in-state RCC rate by the outpatient adjustment factor.

(10) For hospitals that have their own hospital specific inpatient RCC rate, MAA calculates the hospital's specific outpatient rate by multiplying the hospital's inpatient RCC rate by the outpatient adjustment factor.

(11) The outpatient adjustment factor:

(a) Must not exceed 1.0; and

(b) Is updated annually. This update causes an additional update of the outpatient rate for each hospital.

(12) MAA establishes the basic hospital outpatient payment as provided in WAC 388-550-6000. MAA deducts client responsibility (spend-down) and third-party liability (TPL) from the basic payment to determine the actual payment due.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-4500, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-4500, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 42 USC 1395x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4500, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4600 Hospital selective contracting program. (1) The department designates selective contracting areas (SCA) in which hospitals participate in competitive bidding to provide hospital services to Medicaid clients. Selective contracting areas are based on historical patterns of hospital use by Medicaid clients.

(2) The department requires Medicaid clients in a selective contracting area obtain their elective (nonemergent) inpatient hospital services from participating or exempt hospitals in the SCA. Elective (nonemergent) inpatient hospital services provided by nonparticipating hospitals in an SCA shall not be reimbursed by the department, except as provided in WAC 388-550-4700.

(3) The department exempts from the selective contracting program those hospitals that are:

(a) In an SCA but designated by the department as remote. The department designates hospitals as remote when they meet the following criteria:

(i) Located more than ten miles from the nearest hospital in the SCA;

(ii) Having fewer than seventy-five beds; and

(iii) Having fewer than five hundred Medicaid admissions in a two-year period.

(b) Owned by health maintenance organizations (HMOs) and providing inpatient services to HMO enrollees only;

(c) Children's hospitals;

(d) State psychiatric hospitals or separate (freestanding) psychiatric facilities;

(e) Out-of-state hospitals located in nonbordering cities, and out-of-state hospitals in bordering cities not designated as selective contracting areas;

(f) Peer group E hospitals; and

(g) Peer group F hospitals (critical access hospitals).

(4) The department:

(a) Negotiates with selectively contracted hospitals a negotiated conversion factor (NCF) for inpatient hospital services provided to Medicaid clients.

(b) Calculates its maximum financial obligation for a Medicaid client under the hospital selective contract in the same manner as DRG payments using cost-based conversion factors (CBCFs).

(c) Applies NCFs to Medicaid clients only. (The department uses CBCFs in calculating payments for medical care services clients.)

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-4600, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-4600, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-4600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4650 "Full cost" public hospital certified public expenditure (CPE) payment program. (1) The department's "full cost" public hospital certified public expenditure (CPE) payment program provides payments to participating hospitals based on the "full cost" of covered medically necessary services and requires the expenditure of local funds in lieu of state funds to qualify for federal matching funds. The department's payments to participating hospitals equal the federal matching amount for allowable costs. The department uses the ratio of costs-to-charges method described in WAC 388-550-4500 to determine "full cost."

(2) Only the following facilities are reimbursed through the "full cost" public hospital CPE payment program:

(a) Public hospitals located in the state of Washington that are:

(i) Owned by public hospital districts; and

(ii) Not certified by the department of health (DOH) as a critical access hospital;

(b) Harborview Medical Center; and

(c) University of Washington Medical Center.

(3) Payments made under the CPE payment program are limited to medically necessary services provided to medical assistance clients eligible for inpatient hospital services.

(4) Each hospital described in subsection (2) of this section is responsible to provide certified public expenditures as the required state match for claiming federal Medicaid funds.

(5) The department determines the actual payment for inpatient hospital services under the CPE payment program by:

(a) Multiplying the hospital's Medicaid RCC rate by the covered charges (to determine allowable costs), then;

(b) Subtracting the client's responsibility and any third party liability (TPL) from the amount derived in (a) of this subsection, then;

(c) Multiplying the state's federal matching assistance percentage (FMAP) by the amount derived in (b) of this subsection.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-4650, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-4650, filed 6/1/05, effective 7/1/05.]

WAC 388-550-4670 CPE payment program—"Hold harmless" provision. (1) To meet legislative requirements, the department includes a "hold harmless" provision for hospital providers eligible for the certified public expenditure

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(CPE) payment program. Under the "hold harmless" provision, hospitals eligible for payments under the CPE payment program will receive no less in combined state and federal payments than they would have received under the methodologies in effect during state fiscal year (SFY) 2005.

(2) As part of the "hold harmless" payment calculation, the department repurchases inpatient hospital claims paid during the service year, beginning with service year SFY 2006, to determine how these claims would have been paid under the payment methodologies in effect during SFY 2005.

(3) The department makes the final "hold harmless" calculation after the department receives the hospital's final audited Medicare cost report and audited financial statements for the service year. The department calculates the federally required prospective cost settlement at the same time. Any adjustments to state grants payments due to the cost settlement calculations will be made as payment adjustments to the next year's state grants.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518 § 209(9), 06-11-100, § 388-550-4670, filed 5/17/06, effective 6/17/06.]

WAC 388-550-4690 Authorization requirements and utilization review for hospitals eligible for CPE payments.

(1) Certified public expenditure (CPE) inpatient hospital claims submitted to the department must meet all authorization and program requirements in WAC and current department-published issuances.

(2) The department performs utilization reviews of inpatient hospital:

(a) Admissions in accordance with the requirements of 42 CFR 456, subparts A through C; and

(b) Claims for compliance with medical necessity and length of stay (LOS) standards.

(3) CPE inpatient hospital claims that would have been paid by the diagnosis related group (DRG) payment method prior to July 1, 2005:

(a) Are not targeted for retrospective utilization review based on the department's Professional Activity Study (PAS) Length of Stay (LOS) criteria;

(b) Are subject to the department's medical necessity retrospective utilization review process (see WAC 388-550-1700); and

(c) That involve a client's seven-day readmission (see WAC 388-550-1050) are subject to a department retrospective utilization review described in WAC 388-550-3000(5)(e).

(4) CPE inpatient hospital claims that would have been paid by the ratio of costs-to-charges (RCC) payment method prior to July 1, 2005 and exceed the Professional Activity Study (PAS) average LOS, will continue to be targeted for retrospective utilization review based on the department's PAS LOS criteria. See WAC 388-550-4300(3).

(5) For claims identified in subsection (4) of this section, the department may request a copy of the client's hospital medical records and itemized billing statements. The department sends written notification to the hospital detailing the department's findings. Any day of a client's hospital stay that exceeds the PAS LOS:

(a) Is paid under the RCC payment method if the department determines it to be medically necessary for the client at the acute level of care;

(b) Is paid as an administrative day (see WAC 388-550-1050 and 388-550-4500(8)) if the department determines it to be medically necessary for the client at the subacute level of care; and

(c) Is not eligible for payment if the department determines it was not medically necessary.

(6) Inpatient hospital claims that would not have been paid under a prior payment methodology are not eligible for payment under the CPE payment program.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518 § 209(9). 06-11-100, § 388-550-4690, filed 5/17/06, effective 6/17/06.]

WAC 388-550-4700 Payment—Non-SCA participating hospitals. (1) In a selective contracting area (SCA), MAA pays any qualified hospital for inpatient hospital services provided to an eligible medical care client for treatment of an emergency medical condition.

(2) MAA pays any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the department to reside an excessive travel distance from a contracting hospital.

(a) The client is deemed to have an excessive travel burden if the travel distance from a client's residence to the nearest contracting hospital exceeds the client's county travel distance standard, as follows:

<u>County</u>	<u>Community Travel Distance Standard</u>
Adams	25 miles
Asotin	15 miles
Benton	15 miles
Chelan	15 miles
Clallam	20 miles
Clark	15 miles
Columbia	19 miles
Cowlitz	15 miles
Douglas	20 miles
Ferry	27 miles
Franklin	15 miles
Garfield	30 miles
Grant	24 miles
Grays Harbor	23 miles
Island	15 miles
Jefferson	15 miles
King	15 miles
Kitsap	15 miles
Kittitas	18 miles
Klickitat	15 miles
Lewis	15 miles
Lincoln	31 miles
Mason	15 miles
Okanogan	29 miles
Pacific	21 miles
Pend Oreille	25 miles
Pierce	15 miles
San Juan	34 miles
Skagit	15 miles
Skamania	40 miles
Snohomish	15 miles
Spokane	15 miles
Stevens	22 miles

<u>County</u>	<u>Community Travel Distance Standard</u>
Thurston	15 miles
Wahkiakum	32 miles
Walla Walla	15 miles
Whatcom	15 miles
Whitman	20 miles
Yakima	15 miles

(b) If a client must travel outside his/her SCA to obtain inpatient services not available within the community, such as treatment from a tertiary hospital, the client may obtain such services from a contracting hospital appropriate to the client's condition.

(3) MAA requires prior authorization for all nonemergency admissions to nonparticipating hospitals in an SCA. See WAC 388-550-1700 (2)(a).

(4) MAA pays a licensed hospital all applicable Medicare deductible and coinsurance amounts for inpatient services provided to Medicaid clients who are also beneficiaries of Medicare Part A subject to the Medicaid maximum allowable as established in WAC 388-550-1200 (8)(a).

(5) The department pays any licensed hospital DRG-exempt services as listed in WAC 388-550-4400.

[Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-4700, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4800 Hospital payment methods—State administered programs. (1) Except as provided in subsection (2) of this section, the medical assistance administration (MAA) uses the ratio of costs-to-charges (RCC) and diagnosis-related group (DRG) payment methods described in this section to reimburse hospitals at reduced rates for covered services provided to a client not eligible under any Medicaid program and:

(a) Who qualifies for the general assistance unemployable (GAU) program; or

(b) Is involuntarily detained under the Involuntary Treatment Act (ITA).

(2) MAA exempts the following services from the state-administered programs' payment methods and/or reduced rates:

(a) Detoxification services when the services are provided under an MAA-assigned provider number starting with "thirty-six." (MAA reimburses these services using the Title XIX Medicaid RCC payment method.)

(b) Program services provided by MAA-approved critical access hospitals (CAHs) to clients eligible under state-administered programs. (MAA reimburses these services through cost settlement as described in WAC 388-550-2598.)

(c) Program services provided by Peer group E hospitals to clients eligible under the GAU program. (MAA reimburses these services through the "full cost" public hospital certified public expenditure (CPE) program (see WAC 388-550-4650)).

(3) MAA determines:

(a) A state-administered program RCC payment by reducing a hospital's Title XIX Medicaid RCC rate using the hospital's ratable.

(b) A state-administered program DRG payment by reducing a hospital's Title XIX Medicaid DRG cost based conversion factor (CBCF) using the hospital's ratable and equivalency factor (EF).

(4) MAA determines:

(a) The RCC rate for the state-administered programs mathematically as follows:

State-administered programs' RCC rate = current Title XIX Medicaid RCC rate x (one minus the current hospital ratable)

(b) The DRG conversion factor (CF) for the state-administered programs mathematically as follows:

State-administered programs' DRG CF = current Title XIX Medicaid DRG CBCF x (one minus the current hospital ratable) x EF

(5) MAA determines payments to hospitals for covered services provided to clients eligible under the state-administered programs mathematically as follows:

(a) Under the RCC payment method:

State-administered programs' RCC payment = state-administered programs' RCC Rate x allowed charges

(b) Under the DRG payment method:

State-administered programs' DRG payment = state-administered programs' DRG CF x all patient DRG relative

weight (See subsection (6) of this section for how MAA determines payment for state-administered program claims that qualify as DRG high-cost outliers.)

(6) For state-administered program claims that qualify as DRG high-cost outliers, MAA determines:

(a) In-state children's hospital payments for state-administered program claims that qualify as DRG high-cost outliers mathematically as follows:

Eighty-five percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the DRG allowed amount

(b) Psychiatric DRG high-cost outlier payments for DRGs 424 through 432 mathematically as follows:

One hundred percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

(c) Payments for all other claims that qualify as DRG high-cost outliers as follows:

Sixty percent x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

High-cost Outlier Calculations for Qualifying Claims State-administered Programs (for admission dates January 1, 2001 and after)														
In-state Children's Hospitals Allowed charges	(-)	> of \$33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Rat-able	(x)	85%	(=)	Outlier Add-on Amount	(+)	*DRG Allowed Amount
Psychiatric DRGs 424-432 Allowed charges	(-)	> of \$33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Rat-able	(x)	100%	(=)	Outlier Add-on Amount	(+)	* DRG Allowed Amount
All other qualifying claims Allowed charges	(-)	> of \$33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Rat-able	(x)	60%	(=)	Outlier Add-on Amount	(+)	* DRG Allowed Amount
*Basic DRG allowed amount calculation: DRG relative weight x conversion factor = DRG allowed amount														

*Basic DRG allowed amount calculation: DRG relative weight x conversion factor = DRG allowed amount

(7) See WAC 388-550-3700(5) for how claims qualify as low-cost outliers.

(8) MAA determines payments for claims that qualify as DRG low-cost outliers mathematically as follows:

Allowed charges for the claim x the specific hospital's RCC rate x (one minus the current hospital ratable)

(9) To calculate a hospital's ratable that is applied to both the Title XIX Medicaid RCC rate and the Title XIX Medicaid DRG CBCF used to determine the respective state-administered program's reduced rates, MAA:

(a) Adds the hospital's Medicaid revenue (Medicaid revenue as reported by department of health (DOH) includes all Medicaid revenue and all other medical assistance revenue) and Medicare revenue to the value of the hospital's charity care and bad debts, all of which is taken from the most recent complete calendar year data available from DOH at the time of the ratable calculation; then

(b) Deducts the hospital's low-income disproportionate share hospital (LIDSH) revenue from the amount derived in (a) of this subsection to arrive at the hospital's community care dollars; then

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(c) Subtracts the hospital-based physicians revenue that is reported in the hospital's most recent HCFA-2552 Medicare cost report received by MAA at the time of the ratable calculation, from the total hospital revenue reported by DOH from the same source as discussed in (a) of this subsection, to arrive at the net hospital revenue; then

(d) Divides the amount derived in (b) of this subsection by the amount derived in (c) of this subsection to obtain the ratio of community care dollars to net hospital revenue (also called the preliminary ratable factor); then

(e) Subtracts the amount derived in (d) of this subsection from 1.0 to obtain the hospital's preliminary ratable; then

(f) Determines a neutrality factor by:

(i) Multiplying hospital-specific Medicaid revenue that is reported by DOH from the same source as discussed in (a) of this subsection by the preliminary ratable factor; then

(ii) Multiplying that same hospital-specific Medicaid revenue by the prior year's final ratable factor; then

(iii) Summing all hospital Medicaid revenue from the hospital-specific calculations that used the preliminary ratable factor discussed in (f)(i) of this subsection; then

(iv) Summing all hospital revenue from the hospital-specific calculations that used the prior year's final ratable factor discussed in (f)(ii) of this subsection; then

(v) Comparing the two totals; and

(vi) Setting the neutrality factor at 1.0 if the total using the preliminary ratable factor is less than the total using the prior year's final ratable factor; or

(vii) Establishing a neutrality factor that is less than 1.0 that will reduce the total using the preliminary ratable factor to the level of the total using the prior year's final ratable factor, if the total using the preliminary ratable factor is greater than the total using the prior year's ratable factor; then

(g) Multiplies, for each specific hospital, the preliminary ratable by the neutrality factor to establish hospital-specific final ratables for the year; then

(h) Subtracts each hospital-specific final ratable from 1.0 to determine hospital-specific final ratable factors for the year; then

(i) Calculates an instate-average ratable and an instate-average ratable factor used for new hospitals with no prior year history.

(10) MAA updates each hospital's ratable annually on August 1.

(11) MAA:

(a) Uses the equivalency factor (EF) to hold the hospital specific state-administered programs' DRG CF at the same level prior to rebasing, adjusted for inflation; and

(b) Calculates a hospital's EF as follows:

EF = State-administered programs' prior DRG CF divided by current Title XIX Medicaid DRG CBCF x (one minus the prior ratable)

[Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-4800, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 74.09.500, 04-19-113, § 388-550-4800, filed 9/21/04, effective 10/22/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 02-21-019, § 388-550-4800, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652, 01-16-142, § 388-550-4800, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.09.080, 74.09.730, 42 U.S.C. 1395x(v) and 1396r-4, 42 C.F.R. 447.271 and 2652, 99-14-026, § 388-550-4800, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652, 99-06-046, § 388-550-4800, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-4800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4900 Disproportionate share payments. As required by section 1902 (a)(13)(A) of the Social Security Act, the department gives consideration to hospitals that serve a disproportionate number of low-income clients with special needs by making a payment adjustment to eligible hospitals in accordance with legislative direction and established prospective payment methods. The department considers this adjustment a disproportionate share hospital (DSH) payment.

(1) To qualify for a DSH payment for each state fiscal year (SFY), an instate or bordering city hospital provider must submit to the department, the hospital's completed and final DSH application by the due date specified in that year's application letter.

(2) A hospital is a disproportionate share hospital eligible for the low-income disproportionate share hospital

(LIDSH) program for a specific SFY if the hospital submits a DSH application for that specific year in compliance with subsection (1) and if both the following apply:

(a) The hospital's Medicaid inpatient utilization rate (MIPUR) is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or the hospital's low-income utilization rate (LIUR) exceeds twenty-five percent; and

(b) At least two obstetricians who have staff privileges at the hospital have agreed to provide obstetric services to eligible individuals at the hospital. For the purpose of establishing DSH eligibility, "obstetric services" is defined as routine nonemergency delivery of babies. This requirement for two obstetricians with staff privileges does not apply to a hospital:

(i) That provides inpatient services predominantly to individuals under eighteen years of age; or

(ii) That did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(3) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(4) The department may consider a hospital a disproportionate share hospital for programs other than the LIDSH program if the hospital submits a DSH application for the specific year and meets the following criteria for the year specified in the application:

(a) The hospital has a MIPUR of not less than one percent; and

(b) The hospital meets the requirement of subsection (2)(b) of this section.

(5) To determine a hospital's eligibility for any DSH program, the department uses the criteria in this section and the information derived from the DSH application submitted by the hospital, subject to the following:

(a) Charity care. If the hospital's DSH application and audited financial statement for the relevant fiscal year do not agree on the amount for charity care, the department uses the lower amount claimed.

(b) Bad debt. If the hospital's DSH application does not allocate bad debt between insured and uninsured patients, the department assigns the entire amount of bad debt to insured patients.

(c) Total inpatient hospital days. If the hospital's DSH application lists a total number of inpatient hospital days that is lower than the total number in the hospital's Medicare cost report, the department uses the higher number to determine the hospital's MIPUR. The department may use the lower number to determine the hospital's MIPUR if, within ten business days of the department's written notification to the hospital of the discrepancy, the hospital submits documentation that supports the lower number of inpatient hospital days listed on the DSH application. Acceptable documentation includes, but is not limited to, a revised cost report submitted to Medicare that shows the correct data.

(6) Hospitals must submit annually to the department a copy of the hospital's charity and bad debt policy as part of the individual hospital's DSH application.

(7) The department administers the low-income disproportionate share hospital (LIDSH) program and may administer any of the following DSH programs:

(a) General assistance-unemployable disproportionate share hospital (GAUDSH);

(b) Small rural hospital assistance program disproportionate share hospital (SRHAPDSH);

(c) Small rural hospital indigent assistance program disproportionate share hospital (SRHIAPDSH);

(d) Nonrural hospital indigent assistance program disproportionate share hospital (NRHIAPDSH);

(e) Public hospital disproportionate share hospital (PHDSH); and

(f) Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).

(8) The department allows a hospital to receive any one or all of the DSH payment adjustments discussed in subsection (7) of this section when the hospital:

(a) Meets the requirements in subsection (4) of this section; and

(b) Meets the eligibility requirements for the particular DSH payment program, as discussed in WAC 388-550-5000 through 388-550-5400.

(9) The department ensures each hospital's total DSH payments do not exceed the individual hospital's DSH limit, defined as:

(a) The cost to the hospital of providing services to Medicaid clients, including clients served under Medicaid managed care programs;

(b) Less the amount paid by the state under the non-DSH payment provision of the state plan;

(c) Plus the cost to the hospital of providing services to uninsured patients;

(d) Less any cash payments made by uninsured clients; and

(e) Plus any adjustments required and/or authorized by federal regulation.

(10) The department's total annual DSH payments cannot exceed the state's DSH allotment for the federal fiscal year.

If the department's statewide allotment is exceeded, the department may adjust future DSH payments to each hospital to compensate for the amount overpaid. Adjustments will be made in the following program order:

(a) PHDSH;

(b) SRHAPDSH;

(c) NRHIAPDSH;

(d) SRHIAPDSH;

(e) GAUDSH;

(f) PIIDSH; and

(g) LIDSH.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-4900, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-4900, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25, 04-12-044, § 388-550-4900, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 03-13-055, § 388-550-4900, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4, 99-14-040, § 388-550-4900, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

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WAC 388-550-5000 Payment method—LIDSH. (1)

A hospital that is not a peer group E hospital but serves the department's clients is eligible for a low-income disproportionate share hospital (LIDSH) payment adjustment if the hospital meets the requirements of WAC 388-550-4900 (1) through (3).

(2) Hospitals considered eligible under the criteria in subsection (1) of this section receive LIDSH payments. The total LIDSH payment amounts equal the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(3) The department distributes LIDSH payments to each LIDSH eligible hospital using a prospective payment method. The department determines the standardized Medicaid inpatient utilization rate (MIPUR) by:

(a) Dividing the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals; then

(b) Multiplying the hospital's standardized MIPUR by the hospital's most recent DRG payment method rebased case mix index, and then by the hospital's most recent fiscal year Title XIX admissions; then

(c) Multiplying the product by an initial random base amount; and then

(d) Comparing the sum of all annual LIDSH payments to the appropriated amount. If the amounts differ, the department progressively selects a new base amount by successive approximation until the sum of the LIDSH payments to hospitals equals the legislatively appropriated amount.

(4) After each applicable state fiscal year, the department will not make changes to the LIDSH payment distribution that has resulted from calculations identified in subsection (3) of this section. However, hospitals may still submit corrected DSH application data to the department after June 15 and prior to July 1 of the applicable state fiscal year to correct calculation of the MIPUR or low income utilization rate (LIUR) for historical record keeping. See WAC 388-550-5550 for rules regarding public notice for changes in Medicaid payment rates for hospital services.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-5000, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 03-13-055, § 388-550-5000, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4, 99-14-040, § 388-550-5000, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5125 Payment method—PIIDSH. (1)

Effective July 1, 2003, a hospital is eligible for the psychiatric indigent inpatient disproportionate share hospital (PIIDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(b) through (4)(a);

(b) Is an in-state or bordering city hospital;

(c) Provides services to clients eligible under the psychiatric indigent inpatient (PII) program. See WAC 388-865-0217 for more information regarding the PII program; and

(d) Qualifies under Section 1923(d) of the Social Security Act.

(2) The department determines the PIIDSH payment for each eligible hospital using a prospective payment method, in accordance with WAC 388-550-4800.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-5125, filed 3/30/06, effective 4/30/06.]

WAC 388-550-5150 Payment method—GAUDSH.

(1) A hospital is eligible for the general assistance-unemployment disproportionate share hospital (GAUDSH) payment if the hospital:

- (a) Meets the criteria in WAC 388-550-4900 (2)(b) through (4)(a);
- (b) Is an in-state or bordering city hospital;
- (c) Provides services to clients under the medical care services program; and
- (d) Has a low-income utilization rate (LIUR) of one percent or more.

(2) The department determines the GAUDSH payment for each eligible hospital, using a prospective payment method, in accordance with WAC 388-550-4800, except that the payment is not reduced by the additional three percent specified in WAC 388-550-4800(4).

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-5150, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 03-13-055, § 388-550-5150, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5150, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5200 Payment method—SRHAPDSH.

(1) The department makes small rural hospital assistance program disproportionate share hospital (SRHAPDSH) payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for a SRHAPDSH payment, a hospital must:

- (a) Not be a peer group E hospital;
- (b) Meet the criteria in WAC 388-550-4900 (2)(b) through (4)(a);
- (c) Be an in-state hospital;
- (d) Be a small rural hospital with fewer than seventy-five acute licensed beds; and
- (e) For the SRHAPDSH program year to be implemented for state fiscal year (SFY) beginning July 1, 2002, the city or town must have a nonstudent population of fifteen thousand five hundred or less.

For each subsequent SFY, the nonstudent population requirement is increased cumulatively by two percent.

(3) The department pays hospitals qualifying for SRHAPDSH payments from a legislatively appropriated pool. The department determines each hospital's individual SRHAPDSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

- (a) At the time the SRHAPDSH payment is to be made, the department calculates each hospital's profitability margin based on the most recent, completed year-end data using audited financial statements from the hospital.
- (b) The department determines the average profitability margin for the qualifying hospitals.
- (c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin

for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies the individual hospital's most recent, completed SFY Medicaid reimbursement amounts. These amounts are based on historical data considered to be complete; then

(ii) Multiplies the Medicaid reimbursement amount by the individual hospital's assigned profit factor (1.1 or 1.0) to identify a revised Medicaid reimbursement amount; then

(iii) Divides the revised Medicaid reimbursement amount by the sum of the revised Medicaid reimbursement amounts for all qualifying hospitals during the same period.

(4) The department's SRHAPDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid clients and uninsured indigent patients for that hospital unless an exception is identified by federal regulation. The department reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-5200, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25, 04-12-044, § 388-550-5200, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 03-13-055, § 388-550-5200, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5200, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5210 Payment method—SRHIAPDSH.

(1) The department makes small rural hospital indigent assistance program disproportionate share hospital (SRHIAPDSH) payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an SRHIAPDSH payment, a hospital must:

- (a) Not be a peer group E hospital;
- (b) Meet the criteria in WAC 388-550-4900 (2)(b) through (4)(a);
- (c) Be an in-state hospital that provided charity services to clients during the most recent, completed fiscal year;
- (d) Be a small rural hospital with fewer than seventy-five acute licensed beds; and
- (e) For state fiscal year (SFY) beginning July 1, 2003, be located in a city or town that has a nonstudent population of fifteen thousand eight hundred ten or less. For each subsequent SFY, the nonstudent population requirement is increased cumulatively by two percent.

(3) The department pays hospitals qualifying for SRHIAPDSH payments from a legislatively appropriated pool. The department determines each hospital's individual SRHIAPDSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

- (a) At the time the SRHIAPDSH payment is to be made, the department calculates each hospital's profitability margin based on the most recent, completed year-end data using audited financial statements from the hospital.
- (b) The department determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of revised costs by dividing its revised cost amount by the sum of the revised charity cost amounts for all qualifying hospitals during the same period.

(4) The department's SRHIAPDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid clients and uninsured indigent patients for that hospital unless an exception is identified by federal regulation. The department reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-5210, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-5210, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-5210, filed 5/28/04, effective 7/1/04.]

WAC 388-550-5220 Payment method—NRHIAPDSH. (1) The department makes nonrural hospital indigent assistance program disproportionate share hospital (NRHIAPDSH) payments to qualifying nonrural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an NRHIAPDSH payment, a hospital must:

(a) Not be a peer group E hospital;

(b) Meet the criteria in WAC 388-550-4900 (2)(b) through (4)(a);

(c) Be an in-state or bordering city hospital that provided charity services to clients during the most recent, completed fiscal year; and

(d) Be a hospital that does not qualify as a small rural hospital as defined in WAC 388-550-5210.

(3) The department pays hospitals qualifying for NRHIAPDSH payments from a legislatively appropriated pool. The department determines each hospital's individual NRHIAPDSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the NRHIAPDSH payment is to be made, the department calculates each hospital's profitability margin based on the most recent, completed year-end data using audited financial statements from the hospital.

(b) The department determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

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(d) The department:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of the NRHIAPDSH revised costs by dividing the hospital's revised cost amount by the total charity costs for all qualifying hospitals during the same period.

(4) The department's NRHIAPDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid clients and uninsured indigent patients for the hospital unless an exception is identified by federal regulation. The department reallocates dollars as defined in the state plan.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-5220, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-5220, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. 04-12-044, § 388-550-5220, filed 5/28/04, effective 7/1/04.]

WAC 388-550-5400 Payment method—PHDSH. (1)

The department's public hospital disproportionate share hospital (PHDSH) program is a public hospital program for:

(a) Public hospitals located in the state of Washington that are:

(i) Owned by public hospital districts; and

(ii) Not certified by the department of health (DOH) as a critical access hospital;

(b) Harborview Medical Center; and

(c) University of Washington Medical Center.

(2) The department pays hospitals eligible under this program a payment equal to the hospital's individual disproportionate share hospital (DSH) payment limit calculated according to WAC 388-550-4900. The resulting amount is multiplied by the federal matching assistance percentage in effect for Washington State at the time of the payment. This amount is sent to the hospital.

(3) Hospitals receiving payment under this DSH program must certify that funds have been spent on uncompensated care at the hospital equal to or in excess of the payment amount before applying the federal matching assistance percentage.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-5400, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090, 05-12-132, § 388-550-5400, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290, 03-13-055, § 388-550-5400, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730, chapter 74.46 RCW and 42 U.S.C. 1396r-4, 99-14-025, § 388-550-5400, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020, 98-01-124, § 388-550-5400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5425 Upper payment limit (UPL) payments for inpatient hospital services. (1) Each state fiscal year, in accordance with legislative direction and established prospective payment methods, the department creates an

upper payment limit (UPL) payment pool that provides supplemental payments for inpatient hospital services to a hospital provider of Title XIX Medicaid services that is classified as either a:

(a) Washington state-owned or state-operated hospital; or

(b) Nonstate government-owned hospital.

(2) UPL payments for inpatient hospital services are subject to:

(a) Federal approval for federal matching funds; and

(b) A department analysis of the Medicare UPL for hospital payment.

(3) The department determines each payment year's UPL payment for inpatient hospital services by:

(a) Using the charge and payment data from the department's payment system for inpatient hospital services for the base year; and

(b) Calculating the cumulative difference between Medicare payments and Title XIX payments, including third party liability payment for all eligible hospitals during the most recent state fiscal year.

(4) UPL payments for inpatient hospital services:

(a) Are determined for participating eligible hospitals during each federal fiscal year;

(b) Are paid by the department on a periodic basis to one or more of the participating eligible hospitals; and

(c) Must be used by the receiving hospital(s) to improve health care services to low income patients.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-5425, filed 3/30/06, effective 4/30/06.]

WAC 388-550-5450 Supplemental distributions to approved trauma service centers. (1) The department's trauma care fund (TCF) is an amount legislatively appropriated to DSHS each biennium for the purpose of supplementing the department's payments to eligible trauma service centers for providing qualified trauma services to eligible Medicaid fee-for-service clients. Claims for trauma care provided to clients enrolled in the department's managed care programs are not eligible for supplemental distributions from the TCF.

(2) Beginning with trauma services provided after June 30, 2003, the department makes supplemental distributions from the TCF to qualified hospitals, subject to the provisions in this section.

(3) To qualify for supplemental distributions from the TCF, a hospital must:

(a) Be designated or recognized by the department of health (DOH) as an approved Level 1, Level 2, or Level 3 adult or pediatric trauma service center;

(b) Meet the provider requirements in this section and other applicable WAC;

(c) Meet the billing requirements in this section and other applicable WAC;

(d) Submit all information the department requires to ensure services are being provided; and

(e) Comply with DOH's Trauma Registry reporting requirements.

(4) Supplemental distributions from the TCF are:

(a) For qualified hospitals, determined as a percentage of a fixed amount per quarter. Each eligible hospital's share per

quarter is based on the amount paid by the department to that hospital for inpatient and outpatient trauma care the hospital provides to Medicaid clients during that quarter, expressed as a percentage of the following total:

(i) The department's payments to Level 1, Level 2, and Level 3 trauma service centers for qualified Medicaid trauma cases in that quarter. The department determines the countable payment per quarter for trauma care provided to Medicaid clients based on date of service, not date of payment;

(ii) The department's payments to Level 1, Level 2, and Level 3 hospitals for trauma cases transferred in during that quarter. A Level 1, Level 2, or Level 3 hospital that receives a transferred trauma case from any lower level hospital is eligible for the enhanced payment, regardless of the client's Injury Severity Score (ISS). An ISS is a summary rating system for traumatic anatomic injuries; and

(iii) The department's payments to Level 2 and Level 3 hospitals for qualified trauma cases (those that meet or exceed the ISS criteria in subsection (4)(b) of this section) that are transferred to a higher level designated trauma service center during that quarter.

(b) Paid only for a Medicaid trauma case that meets:

(i) The ISS of thirteen or greater for an adult trauma patient (a client age fifteen or older);

(ii) The ISS of nine or greater for a pediatric trauma patient (a client younger than age fifteen); or

(iii) The conditions of subsection (4)(c).

(c) Made to hospitals, as follows, for a trauma case that is transferred:

(i) A hospital that receives the transferred trauma case qualifies for payment regardless of the ISS if the hospital is designated or recognized by DOH as an approved Level 1, Level 2, or Level 3 adult or pediatric trauma service center;

(ii) A hospital that transfers the trauma case qualifies for payment only if:

(A) It is designated or recognized by DOH as an approved Level 2 or Level 3 adult or pediatric trauma service center; and

(B) The ISS requirements in (b)(i) or (b)(ii) of this subsection are met.

(iii) A hospital that DOH designates or recognizes as an approved Level 4 or Level 5 trauma service center does not qualify for supplemental distributions for transferred trauma cases, even when the transferred cases meet the ISS criteria in subsection (4)(b) of this section.

(d) Not funded by disproportionate share hospital (DSH) funds; and

(e) Not distributed by the department to:

(i) Trauma service centers designated or recognized as Level 4 or Level 5;

(ii) Critical access hospitals (CAHs); or

(iii) Any hospital for follow-up surgical services related to the qualifying trauma incident but provided to the client after the client has been discharged for the initial qualifying injury.

(5) Distributions for an SFY are divided into five "quarters" and paid as follows:

(a) Each quarterly distribution paid by the department from the TCF totals twenty percent of the amount designated by the department for that SFY;

(b) The first quarterly supplemental distribution from the TCF is made six months after the SFY begins;

(c) Subsequent quarterly payments are made approximately every four months after the first quarterly payment is made, except as described in subsection (d);

(d) The "fifth quarter" final distribution from the TCF for the same SFY is:

(i) Made one year after the end of the SFY;

(ii) Based on the SFY that the TCF designated amount relates to; and

(iii) Distributed based on each eligible hospital's percentage of the total payments made by the department to all designated trauma service centers for qualified trauma cases during the relevant fiscal year.

(6) For purposes of the supplemental distributions from the TCF, all of the following apply:

(a) The department may consider a request for a claim adjustment submitted by a provider only if the request is received by the department within one year from the date of the initial trauma service;

(b) The department does not allow any carryover of liabilities for a supplemental distribution from the TCF after a date specified by the department as the last date to make adjustments to a trauma claim for an SFY. WAC 388-502-0150(7) does not apply to TCF claims;

(c) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(d) The total amount of supplemental distributions from the TCF disbursed to eligible hospitals by the department in any biennium cannot exceed the amount appropriated by the legislature for that biennium. The department has the authority to take whatever actions necessary to ensure the department stays within the TCF appropriation.

[Statutory Authority: RCW 74.08.090, 74.09.500, 06-08-046, § 388-550-5450, filed 3/30/06, effective 4/30/06; 04-19-113, § 388-550-5450, filed 9/21/04, effective 10/22/04.]

WAC 388-550-5500 Payment—Hospital-based RHCs. (1) The department shall reimburse hospital-based rural health clinics under the prospective payment methods effective July 1, 1994. Under the prospective payment method, the department shall not make reconciliation payments to a hospital-based rural health clinic to cover its costs for a preceding period.

(2) The department shall pay an amount equal to the hospital-based rural health clinic's charge multiplied by the hospital's specific ratio of costs to charges (RCC), not to exceed one hundred percent of the charges.

(3) The department shall determine the hospital-based rural health clinic's RCC from the hospital's annual Medicare cost report, pursuant to WAC 388-550-4500(1).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5550 Public notice for changes in Medicaid payment rates for hospital services. (1) The purpose and intent of this section is to describe the manner in which the department, pertaining to Medicaid hospital rates, will comply with section 4711(a) of the federal Balanced

Budget Act of 1997, Public Law 105-33, as codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For purposes of this section, the term:

(a) "Stakeholders" means providers, beneficiaries, representatives of beneficiaries, and other concerned state residents.

(b) "Rate" means the Medicaid payment amount to a provider for a particular hospital service, except for disproportionate share payments not mandated by federal law.

(c) "Methodology" underlying the establishment of a Medicaid hospital rate means (unless otherwise noted) the principles, procedures, limitations, and formulas detailed in WAC 388-550-2800 through 388-550-5500.

(d) "Justification" means an explanation of why the department is proposing or implementing a Medicaid rate change based on a change in Medicaid rate-setting methodology.

(e) "Reasonable opportunity to review and provide written comments" means a period of fourteen calendar days in which stakeholders may provide written comments to the department.

(f) "Hospital services" means those services that are performed in a hospital facility for an inpatient client and which are payable only to the hospital entity, not to individual performing providers.

(g) "Web site" means the department's internet home page on the worldwide web: <http://www.wa.gov/dshs/maa> is the internet address.

(3) The department will notify stakeholders of proposed and final changes in individual Medicaid hospital rates for hospital services, as follows:

(a) Publish the proposed Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates;

(b) Give stakeholders a reasonable opportunity to review and provide written comments on the proposed Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates; and

(c) Publish the final Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates.

(4)(a) Except as otherwise provided in this section, the department will determine the manner of publication of proposed or final Medicaid hospital rates.

(b) Publication of proposed Medicaid hospital rates will occur as follows:

(i) The department will mail each provider's proposed rate to the affected provider via first-class mail at least fifteen calendar days before the proposed date for implementing the rates; and

(ii) For other stakeholders, the department will post proposed rates on the department's web site.

(c) Publication of final Medicaid hospital rates will occur as follows:

(i) The department will mail each provider's final rate to the affected provider via first-class mail at least one calendar day before implementing the rate; and

(ii) For other stakeholders, the department will post final rates on the department's web site.

(d) The publications required by subsections (4)(b) and (c) of this section will refer to the appropriate sections of

chapter 388-550 WAC for information on the methodologies underlying the proposed and final rates.

(5) The department, whenever it proposes amendments to the methodologies underlying the establishment of Medicaid hospital rates as described in WAC 388-550-2800 through 388-550-5500, will adhere to the notice and comment provisions of the Administrative Procedure Act (chapter 34.05 RCW).

(6) Stakeholders who wish to receive notice of either proposed and final Medicaid hospital rates or proposed and final amendments to WAC 388-550-2800 through 388-550-5500 must notify the department in writing. The department will send notice of all such actions to such stakeholders post-agre prepaid by regular mail.

(7)(a) The notice and publication provisions of section 4711(a) of the Balanced Budget Act of 1997 do not apply when a rate change is:

(i) Necessary to conform to Medicare rules, methods, or levels of reimbursement for clients who are eligible for both Medicare and Medicaid;

(ii) Required by Congress, the legislature, or court order, and no further rulemaking is necessary to implement the change; or

(iii) Part of a non-Medicaid program.

(b) Although notice and publication are not required for Medicaid rate changes described in subsection (7)(a) of this section, the department will attempt to timely notify stakeholders of these rate changes.

(8) The following rules apply when the department and an individual hospital negotiate or contractually agree to Medicaid rates for hospital services:

(a) Receipt by the hospital of the contract or contract amendment form for signature constitutes notice to the hospital of proposed Medicaid rates.

(b) Receipt by the hospital of the contract or contract amendment form signed by both parties constitutes notice to the hospital of final Medicaid rates.

(c) Notwithstanding subsection (4)(c) of this section, final Medicaid contract rates are effective on the date contractually agreed to by the department and the individual hospital.

(d) Prior to the execution of the contract, the department will not publish negotiated contract prices that are agreed to between the department and an individual provider to anyone other than the individual provider. Within fifteen calendar days after the execution of any such contract, the department will publish the negotiated contract prices on its web site.

(9) The following rules apply when a hospital provider or other stakeholder wishes to challenge the adequacy of the public notification process followed by the department in proposing or implementing a change to Medicaid hospital rates, the methodologies underlying the establishment of such rates, or the justification for such rates:

(a) If any such challenge is limited solely to the adequacy of the public notification process, then the challenge will:

(i) Not be pursued in any administrative appeal or dispute resolution procedure established in rule by the department; and

(ii) Be pursued only in a court of proper jurisdiction as may be provided by law.

(b) If a hospital provider brings any such challenge in conjunction with an appeal of its Medicaid rate, then the hospital provider may pursue the challenge in an administrative appeal or dispute resolution procedure established in rule by the department under which hospital providers may appeal their Medicaid rates.

[Statutory Authority: RCW 74.09.500 and 42 USC 1396a (a)(13)(A). 98-23-036, § 388-550-5550, filed 11/10/98, effective 12/11/98.]

WAC 388-550-5600 Dispute resolution process for hospital rate reimbursement. The dispute resolution process for hospital rate reimbursement follows the procedures as stated in WAC 388-502-0220.

[Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-5600, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090 and 74.09.730. 99-16-070, § 388-550-5600, filed 8/2/99, effective 9/2/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5700 Hospital reports and audits. (1) In-state and border area hospitals shall complete and submit a copy of their annual Medicare cost reports (HCFA 2552) to the department. These hospital providers shall:

(a) Maintain adequate records for audit and review purposes, and assure the accuracy of their cost reports;

(b) Complete their annual Medicare HCFA 2552 cost report according to the applicable Medicare statutes, regulations, and instructions; and

(c) Submit a copy to the department:

(i) Within one hundred fifty days from the end of the hospital's fiscal year; or

(ii) If the hospital provider's contract is terminated, within one hundred fifty days of effective termination date; or

(d) Request up to a thirty day extension of the time for submitting the cost report in writing at least ten days prior to the due date of the report. Hospital providers shall include in the extension request the completion date of the report, and the circumstances prohibiting compliance with the report due date;

(2) If a hospital provider improperly completes a cost report or the cost report is received after the due date or approved extension date, the department may withhold all or part of the payments due the hospital until the department receives the properly completed or late report.

(3) Hospitals shall submit other financial information required by the department to establish rates.

(4) The department shall periodically audit:

(a) Cost report data used for rate setting;

(b) Hospital billings; and

(c) Other financial and statistical records.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5800 Outpatient and emergency hospital services. The department shall cover outpatient services, emergent outpatient surgical care, and other emergency care performed on an outpatient basis in a hospital for categorically needy or limited casualty program-medically

needy clients. The department shall limit clients eligible for the medically indigent program to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6000 Outpatient hospital services—Conditions of payment and reimbursement. (1) The medical assistance administration (MAA) pays hospitals for covered outpatient hospital services provided to eligible clients when the services meet the provisions in WAC 388-550-1700. All professional medical services must be billed according to chapter 388-531 WAC.

(2) To be paid for covered outpatient hospital services, a hospital provider must:

- (a) Have a current core provider agreement with MAA;
 - (b) Bill MAA according to the conditions of payment under WAC 388-502-0100;
 - (c) Bill MAA according to the time limits under WAC 388-502-0150; and
 - (d) Meet program requirements in other applicable WAC and MAA published issuances.
- (3) MAA does not pay separately for any services:
- (a) Included in a hospital's room charges;
 - (b) Included as covered under MAA's definition of room and board (e.g., nursing services). See WAC 388-550-1050; or
 - (c) Related to an inpatient hospital admission and provided within one calendar day of a client's inpatient admission.

(4) MAA does not pay:

(a) A hospital for outpatient hospital services when a managed care plan is contracted with MAA to cover these services;

(b) More than the "acquisition cost" ("A.C.") for HCPCS (Healthcare Common Procedure Coding System) codes noted in the outpatient fee schedule as paid "A.C."; or

(c) For cast room, emergency room, labor room, observation room, treatment room, and other room charges in combination when billing periods for these charges overlap.

(5) MAA uses the outpatient departmental weighted costs-to-charges (ODWCC) rate to pay for covered outpatient services provided in a critical access hospital (CAH). See WAC 388-550-2598.

(6) MAA uses the maximum allowable fee schedule to pay non-OPPS hospitals and non-CAH hospitals for the following types of covered outpatient hospital services listed in MAA's current published outpatient hospital fee schedule and billing instructions:

- (a) Laboratory services;
- (b) Imaging services;
- (c) EKG/ECG/EEG and other diagnostics;
- (d) Physical therapy;
- (e) Speech/language therapy;
- (f) Synagis;
- (g) Sleep studies; and
- (h) Other hospital services identified and published by the department.

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(7) MAA uses the hospital outpatient rate as described in WAC 388-550-4500 to pay for covered outpatient hospital services when:

(a) A hospital provider is a non-OPPS or a non-CAH provider; and

(b) The services are not included in subsection (6) of this section.

(8) Hospitals must provide documentation as required and/or requested by MAA.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-060, § 388-550-6000, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-044, § 388-550-6000, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 02-21-019, § 388-550-6000, filed 10/8/02, effective 11/8/02. Statutory Authority: RCW 74.09.090, 42 U.S.C. 1395x(v), 42 C.F.R. 447.271 and 42 C.F.R. 11303. 99-14-028, § 388-550-6000, filed 6/28/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 USC 1395 x(v), 42 CFR 447.271, 447.11303, and 447.2652. 99-06-046, § 388-550-6000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6100 Outpatient hospital physical therapy. (1) The department pays for physical therapy provided to eligible clients as an outpatient hospital service according to WAC 388-545-500 and 388-550-6000.

(2) A hospital must bill outpatient hospital physical therapy services using appropriate billing codes listed in the department's current published billing instructions. The department does not pay outpatient hospitals a facility fee for such services.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-043, § 388-550-6100, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6150 Outpatient hospital occupational therapy. (1) The department pays for occupational therapy provided as an outpatient hospital service to eligible clients according to WAC 388-545-300 and 388-550-6000.

(2) The hospital must bill outpatient hospital occupational therapy services using appropriate billing codes listed in the department's current published billing instructions. The department does not pay outpatient hospitals a facility fee for such services.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-043, § 388-550-6150, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6200 Outpatient hospital speech therapy services. (1) The department pays for speech therapy services provided to eligible clients as an outpatient hospital service according to this section and WAC 388-545-700 and 388-550-6000.

(2) The department requires swallowing (dysphagia) evaluations to be performed by a speech/language pathologist who holds a master's degree in speech pathology and who has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

(3) The department requires a swallowing evaluation to include:

- (a) An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;
- (b) Dietary recommendations for oral food and liquid intake therapeutic or management techniques;
- (c) Therapeutic or management techniques; and
- (d) Videofluoroscopy, when necessary, for further evaluation of swallowing status and aspiration risks.

(4) A hospital must bill outpatient hospital speech therapy services using appropriate billing codes listed in the department's current published billing instructions. The department does not pay the outpatient hospital a facility fee for these services.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, 03-19-043, § 388-550-6200, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6250 Pregnancy—Enhanced outpatient benefits. The department shall provide outpatient chemical dependency treatment in programs qualified under chapter 440-25 WAC and certified under chapter 440-22 WAC or its successor.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6300 Outpatient nutritional counseling. (1) The department shall cover nutritional counseling services only for eligible Medicaid clients twenty years of age and under referred during an early and periodic screening, diagnosis and treatment screening to a certified dietitian.

(2) Except for children under the children's medical program, the department shall not cover nutritional counseling for clients under the medically indigent and other state-only funded programs.

(3) The department shall pay for nutritional counseling for the following conditions:

- (a) Inadequate or excessive growth such as failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile, and obesity;
- (b) Inadequate dietary intake, such as formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite;
- (c) Infant feeding problems, such as poor suck/swallow reflex, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited caregiver knowledge and/or skills;
- (d) Chronic disease requiring nutritional intervention, such as congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, and gastrointestinal disease;
- (e) Medical conditions requiring nutritional intervention, such as iron-deficiency anemia, familial hyperlipidemia, and pregnancy;
- (f) Developmental disability, such as increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings; or

(g) Psycho-social factors, such as behavior suggesting eating disorders.

(4) The department shall pay for maximum of twenty sessions, in any combination, of assessment/evaluation and/or nutritional counseling in a calendar year.

(5) The department shall require each assessment/evaluation or nutritional counseling session be for a period of twenty-five to thirty minutes of direct interaction with a client and/or the client's caregiver.

(6) The department shall pay the provider for a maximum of two sessions per day per client.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6350 Outpatient sleep apnea/sleep study programs. (1) The department shall pay for polysomnograms or multiple sleep latency tests only for clients one year of age or older with obstructive sleep apnea or narcolepsy.

(2) The department shall pay for polysomnograms or multiple sleep latency tests only when performed in outpatient hospitals approved by the medical assistance administration (MAA) as centers of excellence for sleep apnea/sleep study programs.

(3) The department shall not require prior authorization for sleep studies as outlined in WAC 388-550-1800.

(4) Hospitals shall bill the department for sleep studies using current procedural terminology codes. The department shall not reimburse hospitals for these services when billed under revenue codes.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6400 Outpatient hospital diabetes education. (1) The department pays for outpatient hospital-based diabetes education for an eligible client when:

(a) The facility where the services are provided is approved by the department of health (DOH) as a diabetes education center, and

(b) The client is referred by a licensed health care provider.

(2) The department requires the diabetes education teaching curriculum to have measurable, behaviorally stated educational objectives. The diabetes education teaching curriculum must include all the following core modules:

- (a) An overview of diabetes;
- (b) Nutrition, including individualized meal plan instruction that is not part of the women, infants, and children program;
- (c) Exercise, including an individualized physical activity plan;
- (d) Prevention of acute complications, such as hypoglycemia, hyperglycemia, and sick day management;
- (e) Prevention of other chronic complications, such as retinopathy, nephropathy, neuropathy, cardiovascular disease, foot and skin problems;
- (f) Monitoring, including immediate and long-term diabetes control through monitoring of glucose, ketones, and glycosylated hemoglobin; and

(g) Medication management, including administration of oral agents and insulin, and insulin startup.

(3) The department pays for a maximum of six hours of individual core survival skills outpatient diabetes education per calendar year per client.

(4) The department requires DOH-approved centers to bill the department for diabetes education services on the UB92 billing form using the specific revenue code(s) designated and published by the department.

(5) The department reimburses for outpatient hospital-based diabetes education based on the individual hospital's current specific ratio of costs-to-charges, or the hospital's customary charge for diabetes education, whichever is less.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191, 03-19-043, § 388-550-6400, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6450 Outpatient hospital weight loss program. The department may pay for an outpatient weight loss program only when provided through an outpatient weight loss facility approved by the medical assistance administration. The department shall deny payment for services provided by nonapproved providers.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6450, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6500 Blood and blood products. (1) The department shall limit Medicaid reimbursement to a hospital for blood derivatives to blood bank service charges for processing the blood and blood products.

(2) Other than payment of blood bank service charges, the department shall not pay for blood and blood derivatives.

(3) The department shall not separately reimburse blood bank service charges for handling and processing blood and blood derivatives provided to an individual who is hospitalized when the hospital is reimbursed under the diagnosis-related group (DRG) system. The department shall bundle these service charges into the total DRG payment.

(4) The department shall reimburse a hospital, which is paid under the cost to charge method, separately for processing blood and blood products.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6600 Hospital-based physician services. See chapter 388-531 WAC regarding rules for inpatient and outpatient physician services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6700 Hospital services provided out-of-state. (1) The department shall reimburse only emergency care for an eligible Medicaid client who goes to another state, except specified border cities, specifically for the purpose of obtaining medical care that is available in the state of Washington. See WAC 388-501-0175 for a list of border cities.

(2007 Ed.)

(2) The department shall authorize and provide comparable medical care services to a Medicaid client who is temporarily outside the state to the same extent that such medical care services are furnished to an eligible Medicaid client in the state, subject to the exceptions and limitations in this section.

(3) The department shall not authorize payment for out-of-state medical care furnished to state-funded clients (medically indigent/medical care services), but may authorize medical services in designated bordering cities.

(4) The department shall cover hospital care provided to Medicaid clients in areas of Canada as described in WAC 388-501-0180.

(5) The department shall review all cases involving out-of-state medical care to determine whether the services are within the scope of the medical assistance program.

(6)(a) If the client can claim deductible or coinsurance portions of Medicare, the provider shall submit the claim to the intermediary or carrier in the provider's own state on the appropriate Medicare billing form.

(b) If the state of Washington is checked on the form as the party responsible for medical bills, the intermediary or carrier may bill on behalf of the provider or may return the claim to the provider for submission to the state of Washington.

(7) For reimbursement for out-of-state inpatient hospital services, see WAC 388-550-4000.

(8) The department shall reimburse out-of-state outpatient hospital services billed under the physician's current procedural terminology codes at an amount that is the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX Medicaid program.

(9) Out-of-state providers shall present final charges to MAA within three hundred sixty-five days of the date of service. In no case shall the state of Washington be liable for payment of charges received beyond one year from the date services were rendered.

[Statutory Authority: RCW 74.08.090, 01-02-075, § 388-550-6700, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.-730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.-020. 98-01-124, § 388-550-6700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-7000 Outpatient prospective payment system (OPPS)—General. (1) The medical assistance administration's (MAA's) outpatient prospective payment system (OPPS) uses an ambulatory payment classification (APC) based reimbursement methodology as its primary reimbursement method. MAA is basing its OPPS on the centers for Medicare and Medicaid services (CMS) prospective payment system for hospital outpatient department services.

(2) For a complete description of the CMS outpatient hospital prospective payment system, including the assignment of status indicators (SIs), see 42 CFR, Chapter IV, Part 419. The Code of Federal Regulations (CFR) is available from the CFR web site and the Government Printing Office, Seattle office. The document is also available for public inspection at the Washington state library (a copy of the document may be obtained upon request, subject to any pertinent charge).

[Title 388 WAC—p. 1147]

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-061, § 388-550-7000, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7050 OPPS—Definitions. The following definitions and abbreviations and those found in WAC 388-550-1050 apply to the medical assistance administration's (MAA's) outpatient prospective payment system (OPPS):

"Alternative outpatient payment" means a payment calculated using a method other than the ambulatory payment classification (APC) method, such as the outpatient hospital rate or the fee schedule.

"Ambulatory payment classification (APC)" means a grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

"Ambulatory payment classification (APC) weight" means the relative value assigned to each APC.

"Ambulatory payment classification (APC) conversion factor" means a dollar amount that is one of the components of the APC payment calculation.

"Budget target" means the amount of money appropriated by the legislature or through MAA's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjustor" means the MAA specific multiplier applied to all payable ambulatory payment classifications (APCs) to allow MAA to reach and not exceed the established budget target.

"Discount factor" means the percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

"Medical visit" means diagnostic, therapeutic, or consultative services provided to a client by a healthcare professional in an outpatient setting.

"Modifier" means a two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"Observation services" means services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Outpatient code editor (OCE)" means a software program published by 3M Health Information Systems that MAA uses for classifying and editing claims in ambulatory payment classification (APC) based OPPS.

"Outpatient prospective payment system (OPPS)" means the payment system used by MAA to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Pass-throughs" means certain drugs, devices, and biologicals, as identified by Centers for Medicare and Medicaid Services (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC).

"Significant procedure" means a procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the healthcare professional.

"Status indicator (SI)" means a one-digit identifier assigned to each service by the outpatient code editor (OCE) software.

"SI" see "status indicator."

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-061, § 388-550-7050, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7100 OPPS—Exempt hospitals. The medical assistance administration (MAA) exempts the following hospitals from the initial implementation of MAA's outpatient prospective payment system (OPPS). (Refer to other sections in chapter 388-550 WAC for outpatient payment methods MAA uses to pay hospital providers that are exempt from MAA's OPPS.)

- (1) Cancer hospitals;
- (2) Critical access hospitals;
- (3) Free-standing psychiatric hospitals;
- (4) Out-of-state hospitals (Bordering-city hospitals are considered in-state hospitals. See WAC 388-550-1050.);
- (5) Pediatric hospitals;
- (6) Peer group A hospitals;
- (7) Rehabilitation hospitals; and
- (8) Veterans' and military hospitals.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-061, § 388-550-7100, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7200 OPPS—Payment method. (1) This section describes the payment methods the medical assistance administration (MAA) uses to pay for covered outpatient hospital services provided by hospitals not exempted from the outpatient prospective payment system (OPPS).

AMBULATORY PAYMENT CLASSIFICATION (APC) METHOD

(2) MAA uses the APC method when the Centers for Medicare and Medicaid Services (CMS) has established either an APC weight or a national payment rate to pay for covered:

- (a) Medical visits;
- (b) Significant procedures that are not subject to multiple procedure discounting;
- (c) Significant procedures that are subject to multiple procedure discounting;
- (d) Nonpass-through drugs or devices;
- (e) Observation services; and
- (f) Ancillary services.

OPPS MAXIMUM ALLOWABLE FEE SCHEDULE

(3) MAA uses the OPPS fee schedule published in the OPPS section of MAA's billing instructions to pay for covered:

- (a) Services that are exempted from the APC payment methodology or services for which there are no established weight(s);
- (b) Procedures that are on the CMS inpatient only list;

- (c) Items, codes, and services that are not covered by Medicare;
- (d) Corneal tissue acquisition;
- (e) Drugs or biologicals that are pass-throughs; and
- (f) Devices that are pass-throughs.

HOSPITAL OUTPATIENT RATE

(4) MAA uses the hospital outpatient rate described in WAC 388-550-4500 to pay for the services listed in subsection (3) of this section for which MAA has not established a maximum allowable fee.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-061, § 388-550-7200, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7300 OPPS—Payment limitations. (1)

The medical assistance administration (MAA) limits payment for covered outpatient hospital services to the current published maximum allowable units of services listed in the outpatient prospective payment system (OPPS) fee schedule and published in the OPPS section of MAA's hospital billing instructions, subject to the following:

(a) When a unit limit for services is not stated in the OPPS fee schedule, MAA pays for services according to the program's unit limits stated in applicable WAC and published issuances.

(b) Because multiple units for services may be factored into the ambulatory payment classification (APC) weight, MAA pays for services according to the unit limit stated in the OPPS fee schedule when the limit is not the same as the program's unit limit stated in applicable WAC and published issuances.

(2) MAA does not pay separately for covered services that are packaged into the APC rates. These services are paid through the APC rates.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-061, § 388-550-7300, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7400 OPPS APC relative weights. The medical assistance administration (MAA) uses the ambulatory payment classification (APC) relative weights established by the Centers for Medicare and Medicaid Services (CMS). MAA updates the APC relative weights at least quarterly in conjunction with the outpatient code editor (OCE) updates.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-061, § 388-550-7400, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7500 OPPS APC conversion factor.

The medical assistance administration (MAA) uses the ambulatory payment classification (APC) conversion factors established by the Centers for Medicare and Medicaid Services (CMS) and in effect on November 1, 2004, as MAA's initial APC conversion factors. MAA updates its APC conversion factors at least biannually.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-061, § 388-550-7500, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7600 OPPS payment calculation. (1)

The medical assistance administration (MAA) follows the discounting and modifier policies of the Centers for Medicare and Medicaid Services (CMS). MAA calculates the ambulatory payment classification (APC) payment as follows:

(2007 Ed.)

APC payment =
 APC relative weight x APC conversion factor x
 Discount factor (if applicable) x Units of service (if applicable) x
 Budget target adjustor

(2) The total OPPS claim payment is the sum of the APC payments plus the sum of the lesser of the billed charge or allowed charge for each non-APC service.

[Statutory Authority: RCW 74.08.090 and 74.09.500. 04-20-061, § 388-550-7600, filed 10/1/04, effective 11/1/04.]

Chapter 388-551 WAC

ALTERNATIVES TO HOSPITAL SERVICES

WAC

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388-551-3000	Private duty nursing services for clients seventeen years of age and younger.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-551-1315	Example of how hospice client certifications (election periods) work. [Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1315, filed 4/9/99, effective 5/10/99.] Repealed by 05-18-033, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.08.090, 74.09.520.
388-551-1410	Hospice providers must notify institutional providers. [Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1410, filed 4/9/99, effective 5/10/99.] Repealed by 05-18-033, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.08.090, 74.09.520.

SUBCHAPTER I—HOSPICE SERVICES

Hospice—General

WAC 388-551-1000 Hospice program—General. (1)

The department's hospice program is a twenty-four hour a day program that allows a terminally ill client to choose physical, pastoral/spiritual, and psychosocial comfort care rather than cure. A hospice interdisciplinary team communicates with the client's nonhospice care providers to ensure the client's needs are met through the hospice plan of care. Hospitalization is used only for acute symptom management.

(2) A client, a physician, or an authorized representative under RCW 7.70.065 may initiate hospice care. The client's physician must certify the client as terminally ill and appropriate for hospice care.

(3) Hospice care is provided in a client's temporary or permanent place of residence.

(4) Hospice care ends when:

(a) The client or an authorized representative under RCW 7.70.065 revokes the hospice care;

(b) The hospice agency discharges the client;

(c) The client's physician determines hospice care is no longer appropriate; or

(d) The client dies.

(5) Hospice care includes the provision of emotional and spiritual comfort and bereavement support to the client's family member(s).

(6) Department-approved hospice agencies must meet the general requirements in chapter 388-502 WAC, Administration of medical programs—Providers.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1000, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1000, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1010 Hospice program—Definitions.

The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions, apply to this subchapter.

"**Authorized representative**" means an individual who has been authorized to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated. See RCW 7.70.065.

"**Biologicals**" means medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products.

"**Brief period**" means six days or less within a thirty consecutive-day period.

"**Community services office (CSO)**" means an office of the department that administers social and health services at the community level.

"**Discharge**" means an agency ends hospice care for a client.

"**Election period**" means the time, ninety or sixty days, that the client is certified as eligible for and chooses to receive hospice care.

"**Family**" means an individual or individuals who are important to, and designated in writing by, the client and need not be relatives, or who are legally authorized to represent the client.

"**Home and community services (HCS) office**" means an aging and disability services administration (ADSA) office that manages the state's comprehensive long-term care system which provides in-home, residential, and nursing home services to clients with functional disabilities.

"**Home health aide**" means an individual registered or certified as a nursing assistant under chapter 18.88A RCW who, under the direction and supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist, assists in the delivery of nursing or therapy related activities, or both, to patients of a hospice agency, or hospice care center.

"**Home health aide services**" means services provided by home health aides employed by an in-home services agency licensed to provide home health, hospice, or hospice care center services under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care may include ambulation and exercise, medication assistance level 1 and level 2, reporting changes in client's conditions and needs, completing appropriate records, and personal care or homemaker services, and other nonmedical tasks, as defined in this section.

"**Hospice agency**" means a person or entity administering or providing hospice services directly or through a contract arrangement to individuals in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and volunteer. (Note: For the purposes of this subchapter, requirements for hospice agencies also apply to hospice care centers.)

"**Hospice care center**" means a homelike noninstitutional facility where hospice services are provided, and that meets the requirements for operation under RCW 70.127.280 and applicable rules.

"**Hospice services**" means symptom and pain management provided to a terminally ill individual, and emotional, spiritual, and bereavement support for the individual and individual's family in a place of temporary or permanent residence.

"**Interdisciplinary team**" means the group of individuals involved in client care providing hospice services or hospice care center services including, at a minimum, a physician, registered nurse, social worker, spiritual counselor, and volunteer.

"Palliative" means medical treatment designed to reduce pain or increase comfort, rather than cure.

"Plan of care" means a written document based on assessment of client needs that identifies services to meet these needs.

"Related condition(s)" means any health condition(s) that manifests secondary to or exacerbates symptoms associated with the progression of the condition and/or disease, the treatment being received, or the process of dying. (Examples of related conditions: Medication management of nausea and vomiting secondary to pain medication; skin breakdown prevention/treatment due to peripheral edema.)

"Residence" means a client's home or place of living.

"Revoke" or "revocation" means the choice to stop receiving hospice care.

"Terminally ill" means the client has a life expectancy of six months or less, assuming the client's disease process runs its natural course.

"Twenty-four-hour day" means a day beginning and ending at midnight.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1010, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1010, filed 4/9/99, effective 5/10/99.]

Hospice—Coverage

WAC 388-551-1200 Client eligibility for hospice care. (1) A client who elects to receive hospice care must be eligible for one of the following medical assistance programs, subject to the restrictions and limitations in this chapter and other WAC:

- (a) Categorically needy program (CNP);
- (b) Limited casualty program - medically needy program (LCP-MNP);
- (c) Children's health (V);
- (d) State children's health insurance program (SCHIP);
- (e) CNP—Alien emergency medical;
- (f) LCP-MNP—Alien emergency medical; or
- (g) General assistance-expedited disability (GAX).

(2) A hospice agency is responsible to verify a client's eligibility with the client or the client's home and community services (HCS) office or community services office (CSO).

(3) A client enrolled in one of the department's managed care plans must receive all hospice services, including facility room and board, directly through that plan. The client's managed care plan is responsible for arranging and providing all hospice services for a client enrolled in a managed care plan.

(4) A client who is also eligible for Medicare part A is not eligible for hospice care through the department's hospice program. The department does pay hospice nursing facility room and board for these clients if the client is admitted to a nursing facility or hospice care center (HCC) and is not receiving general inpatient care or inpatient respite care. See also WAC 388-551-1530.

(5) A client who meets the requirements in this section is eligible to receive hospice care through the department's hospice program when all of the following is met:

- (a) The client's physician certifies the client has a life expectancy of six months or less.

(2007 Ed.)

(b) The client elects to receive hospice care and agrees to the conditions of the "election statement" as described in WAC 388-551-1310.

(c) The hospice agency serving the client:

(i) Notifies the department's hospice program within five working days of the admission of all clients, including:

- (A) Medicaid-only clients;
- (B) Medicaid-Medicare dual eligible clients;
- (C) Medicaid clients with third party insurance; and
- (D) Medicaid-Medicare dual eligible clients with third party insurance.

(ii) Meets the hospice agency requirements in WAC 388-551-1300 and 388-551-1305.

(d) The hospice agency provides additional information for a diagnosis when the department requests and determines, on a case-by-case basis, the information that is needed for further review.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1200, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1200, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1210 Covered services, including core services and supplies reimbursed through the hospice daily rate. (1) The department reimburses a hospice agency for providing covered services, including core services and supplies described in this section, through the department's hospice daily rate, subject to the conditions and limitations described in this section and other WAC.

(2) To qualify for reimbursement, covered services, including core services and supplies in the hospice daily rate, must be:

- (a) Related to the client's hospice diagnosis;
- (b) Identified by the client's hospice interdisciplinary team;
- (c) Written in the client's plan of care (POC); and
- (d) Made available to the client by the hospice agency on a twenty-four hour basis.

(3) The hospice daily rate includes the following core services that must be either provided by hospice agency staff, or contracted through a hospice agency, if necessary, to supplement hospice staff in order to meet the needs of a client during a period of peak patient loads or under extraordinary circumstances:

(a) Physician services related to the administration of POC.

(b) Nursing care provided by:

- (i) A registered nurse (RN); or
- (ii) A licensed practical nurse (LPN) under the supervision of an RN.

(c) Medical social services provided by a social worker under the direction of a physician.

(d) Counseling services provided to a client and the client's family members or caregivers.

(4) Covered services and supplies may be provided by a service organization or an individual provider when contracted through a hospice agency. To be reimbursed the hospice daily rate, a hospice agency must:

- (a) Assure all contracted staff meets the regulatory qualification requirements;

(b) Have a written agreement with the service organization or individual providing the services and supplies; and

(c) Maintain professional, financial, and administrative responsibility.

(5) The following covered services and supplies are included in the appropriate hospice daily rate as described in WAC 388-551-1510(6), subject to the conditions and limitations described in this section and other WAC:

(a) Skilled nursing care;

(b) Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a client's terminal illness and related conditions;

(c) Communication with nonhospice providers about care not related to the client's terminal illness to ensure the client's plan of care needs are met and not compromised;

(d) Medical equipment and supplies that are medically necessary for the palliation and management of a client's terminal illness and related conditions;

(e) Home health aide, homemaker, and/or personal care services that are ordered by a client's physician and documented in the POC. (Home health aide services are provided through the hospice agency to meet a client's extensive needs due to the client's terminal illness. These services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services. See 42 CFR 484.36);

(f) Physical therapy, occupational therapy, and speech-language therapy to manage symptoms or enable a client to safely perform ADLs (activities of daily living) and basic functional skills;

(g) Medical transportation services;

(h) A brief period of inpatient care, for general or respite care provided in a Medicare-certified hospice care center, hospital, or nursing facility; and

(i) Other services or supplies that are documented as necessary for the palliation and management of a client's terminal illness and related conditions;

(6) A hospice agency is responsible to determine if a nursing facility has requested authorization for medical supplies or medical equipment, including wheelchairs, for a client who becomes eligible for the hospice program. The department does not pay separately for medical equipment or supplies that were previously authorized by the department and delivered on or after the date the department enrolls the client in the hospice program.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1210, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1210, filed 4/9/99, effective 5/10/99.]

Hospice—Provider Requirements

WAC 388-551-1300 Requirements for a department-approved hospice agency. (1) To become a department-approved hospice agency, the department requires a hospice agency to provide documentation that it is Medicare, Title XVIII certified by the department of health (DOH) as a hospice agency.

(2) A department-approved hospice agency must at all times meet the requirements in chapter 388-551 WAC, subchapter I, Hospice services, and the requirements under the Title XVIII Medicare Program.

[Title 388 WAC—p. 1152]

(3) To ensure quality of care for medical assistance clients, the department's clinical staff may conduct hospice agency site visits.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1300, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1300, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1305 Requirements for becoming a department-approved hospice care center (HCC). (1) To apply to become a department-approved hospice care center, the department requires a hospice agency to:

(a) Be enrolled with the department as a department hospice agency (see WAC 388-551-1300);

(b) Submit a letter of request to:

Hospice Program Manager
Division of Medical Management
Department of Social and Health Services
P.O. Box 45506
Olympia, WA 98504-5506; and

(c) Include documentation that confirms the agency is Medicare certified by department of health (DOH) as a hospice care center and provides one or more of the following levels of hospice care (levels of care are described in WAC 388-551-1500):

(i) Routine home care;

(ii) Inpatient respite care; and

(iii) General inpatient care.

(2) A department-approved hospice care center must at all times meet the requirements in chapter 388-551 WAC, subchapter I, Hospice services, and the requirements under the Title XVIII Medicare Program.

(3) A hospice agency qualifies as a department-approved hospice care center when:

(a) All the requirements in this section are met; and

(b) The department provides the hospice agency with written notification.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1305, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1310 Hospice election periods, election statements, and the hospice certification process. (1) Hospice coverage is available for two ninety-day election periods followed by an unlimited number of sixty-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinstate an election period for hospice care.

(2) The election statement must be filed in the client's hospice medical record within two calendar days following the day the hospice care begins and requires all of the following:

(a) Name and address of the hospice agency that will provide the care;

(b) Documentation that the client is fully informed and understands hospice care and waiver of other Medicaid and/or Medicare services;

(c) Effective date of the election; and

(d) Signature of the client or the client's authorized representative.

(2007 Ed.)

(3) The following describes the hospice certification process:

(a) When a client elects to receive hospice care, the department requires a hospice agency to:

(i) Obtain a signed written certification of the client's terminal illness; or

(ii) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by:

(A) The medical director of the hospice agency or a physician staff member of the interdisciplinary team; and

(B) The client's attending physician (if the client has one).

(iii) Place the signed written certification of the client's terminal illness in the client's medical file:

(A) Within sixty days following the day the hospice care begins; and

(B) Before billing the department for the hospice services.

(b) For subsequent election periods, the department requires the hospice agency to:

(i) Obtain a signed written certification statement of the client's terminal illness; or

(ii) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by the medical director of the hospice agency or a physician staff member of the hospice agency; and

(iii) Place the written certification of the client's terminal illness in the client's medical file:

(A) Within two calendar days following the beginning of a subsequent election period; and

(B) Before billing the department for the hospice services.

(4) When a client's hospice coverage ends within an election period (e.g., the client revokes hospice care), the remainder of that election period is forfeited. The client may reinstate the hospice benefit at any time by providing an election statement and meeting the certification process requirements.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1310, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1310, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1320 Hospice plan of care. (1) A hospice agency must establish a written plan of care (POC) for a client that describes the hospice care to be provided. The POC must be in accordance with department of health (DOH) requirements as described in WAC 246-335-085, and meet the requirements in this section.

(2) A registered nurse or physician must conduct an initial physical assessment of a client and develop the POC with at least one other member of the hospice interdisciplinary team.

(3) At least two other hospice interdisciplinary team members must review the POC no later than two working days after it is developed.

(4) The POC must be reviewed and updated every two weeks by at least three members of the hospice interdisciplinary team that includes at least:

(a) A registered nurse;

(b) A social worker; and

(c) One other hospice interdisciplinary team member.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1320, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1320, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1330 Hospice—Client care and responsibilities of hospice agencies. (1) A hospice agency must facilitate a client's continuity of care with nonhospice providers to ensure that medically necessary care, both related and not related to the terminal illness, is met. This includes:

(a) Determining if the department has approved a request for prescribed medical equipment, such as a wheelchair. If the prescribed item is not delivered to the client before the client becomes covered by a hospice agency, the department will rescind the approval. See WAC 388-543-1500.

(b) Communicating with other department programs and documenting the services a client is receiving in order to prevent duplication of payment and to ensure continuity of care. Other department programs include, but are not limited to, programs administered by the aging and disability services administration (ADSA).

(c) Documenting each contact with nonhospice providers.

(2) When a client resides in a nursing facility, the hospice agency must:

(a) Coordinate the client's care with all providers, including pharmacies and medical vendors; and

(b) Provide the same level of hospice care the hospice agency provides to a client residing in their home.

(3) Once a client chooses hospice care, hospice agency staff must notify and inform the client of the following:

(a) By choosing hospice care from a hospice agency, the client gives up the right to:

(i) Covered Medicaid hospice service and supplies received at the same time from another hospice agency; and

(ii) Any covered Medicaid services and supplies received from any other provider that are necessary for the palliation and management of the terminal illness and related medical conditions.

(b) Services and supplies are not paid through the hospice daily rate if they are:

(i) Proven to be clinically unrelated to the palliation and management of the client's terminal illness and related medical conditions (see WAC 388-551-1210(3));

(ii) Not covered by the hospice daily rate;

(iii) Provided under a Title XIX Medicaid program when the services are similar or duplicate the hospice care services; or

(iv) Not necessary for the palliation and management of the client's terminal illness and related medical conditions.

(4) A hospice agency must have written agreements with all contracted providers.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1330, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1330, filed 4/9/99, effective 5/10/99.]

Hospice—Discharges and Notification

WAC 388-551-1340 When a client leaves hospice without notice. When a client chooses to leave hospice care or refuses hospice care without giving the hospice agency a revocation statement, as required by WAC 388-551-1360, the hospice agency must do all of the following:

(1) Within five working days of becoming aware of the client's decision, inform and notify in writing the department's hospice program manager (see WAC 388-551-1400 for further requirements);

(2) Complete a Medicaid hospice 5-day notification form (DSHS 13-746) and forward a copy to the appropriate home and community services (HCS) office or community services office (CSO) to notify that the client is discharging from the program;

(3) Notify the client, or the client's authorized representative, that the client's discharge has been reported to the department; and

(4) Document the effective date and details of the discharge in the client's hospice record.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1340, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1340, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1350 Discharges from hospice care.

(1) A hospice agency may discharge a client from hospice care when the client:

(a) Is no longer certified for hospice care;

(b) Is no longer appropriate for hospice care; or

(c) The hospice agency's medical director determines the client is seeking treatment for the terminal illness outside the plan of care (POC).

(2) At the time of a client's discharge, a hospice agency must:

(a) Within five working days, complete a Medicaid hospice 5-day notification form (DSHS 13-746) and forward to the department's hospice program manager (see WAC 388-551-1400 for additional requirements), and a copy to the appropriate home and community services office (HCS) or community services office (CSO);

(b) Keep the discharge statement in the client's hospice record;

(c) Provide the client with a copy of the discharge statement; and

(d) Inform the client that the discharge statement must be:

(i) Presented with the client's current medical identification (medical ID) card when obtaining Medicaid covered healthcare services or supplies, or both; and

(ii) Used until the department issues the client a new medical ID card that identifies that the client is no longer a hospice client.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1350, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1350, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1360 Ending hospice care (revocations). (1) A client or a client's authorized representative may

choose to stop hospice care at any time by signing a revocation statement.

(2) The revocation statement documents the client's choice to stop Medicaid hospice care. The revocation statement must include all of the following:

(a) Client's signature (or the client's authorized representative's signature if the client is unable to sign);

(b) Date the revocation was signed; and

(c) Actual date that the client chose to stop receiving hospice care.

(3) The hospice agency must keep any explanation supporting any difference in the signature and revocation dates in the client's hospice records.

(4) When a client revokes hospice care, the hospice agency must:

(a) Within five working days of becoming aware of the client's decision, inform and notify in writing the department's hospice program manager (see WAC 388-551-1400 for additional requirements);

(b) Notify the appropriate home and community services (HCS) office or community services office (CSO) of the revocation by completing and forwarding a copy of the Medicaid hospice 5-day notification form (DSHS 13-746) to the appropriate home and community services (HCS) office or community services office (CSO);

(c) Keep the revocation statement in the client's hospice record;

(d) Provide the client with a copy of the revocation statement; and

(e) Inform the client that the revocation statement must be:

(i) Presented with the client's current medical identification (medical ID) card when obtaining Medicaid covered healthcare services or supplies, or both; and

(ii) Used until the department issues a new medical ID card that identifies that the client is no longer a hospice client.

(5) After a client revokes hospice care, the remaining days within the current election period are forfeited. The client may immediately enter the next consecutive election period. The client does not have to wait for the forfeited days to pass before entering the next consecutive election period.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1360, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24. 99-09-007, § 388-551-1360, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1370 When a hospice client dies.

When a client dies, the hospice agency must:

(1) Within five working days, inform and notify in writing the department's hospice program manager; and

(2) Notify the appropriate home and community services (HCS) office or community services office (CSO) of the client's date of death by completing and forwarding a copy of the Medicaid hospice 5-day notification form (DSHS 13-746) to the appropriate HCS office or CSO.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1370, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1400 Notification requirements for hospice agencies. (1) To be reimbursed for providing hospice services, the hospice agency must complete a Medicaid

hospice 5-day notification form (DSHS 13-746) and forward to the department's hospice program manager within five working days from when a medical assistance client begins the first day of hospice care, or has a change in hospice status. The hospice agency must notify the department's hospice program of:

- (a) The name and address of the hospice agency;
- (b) The date of the client's first day of hospice care;
- (c) A change in the client's primary physician;
- (d) A client's revocation of the hospice benefit (home or institutional);
- (e) The date a client leaves hospice without notice;
- (f) A client's discharge from hospice care;
- (g) A client who admits to a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care);
- (h) A client who discharges from a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care.);
- (i) A client who is eligible for or becomes eligible for Medicare or third party liability (TPL) insurance;
- (j) A client who dies; or
- (k) A client who transfers to another hospice agency. Both the former agency and current agency must provide the department with:

- (i) The client's name, the name of the former hospice agency servicing the client, and the effective date of the client's discharge; and
- (ii) The name of the current hospice agency serving the client, the hospice agency's provider number, and the effective date of the client's admission.

(2) The department does not require a hospice agency to notify the hospice program manager when a hospice client is admitted to a hospital for palliative care.

(3) When a hospice agency does not notify the department's hospice program within five working days of the date of the client's first day of hospice care as required in subsection (1)(c) of this section, the department authorizes the hospice daily rate reimbursement effective the fifth working day prior to the date of notification.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1400, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1400, filed 4/9/99, effective 5/10/99.]

Hospice—Payment

WAC 388-551-1500 Hospice daily rate—Four levels of hospice care. All services, supplies and equipment related to the client's terminal illness and related conditions are included in the hospice daily rate. The department pays for only one of the following four levels of hospice care per day (see WAC 388-551-1510 for payment methods):

(1) **Routine home care.** Routine home care includes daily care administered to the client at the client's residence. The services are not restricted in length or frequency of visits, are dependent on the client's needs, and are provided to achieve palliation or management of acute symptoms.

(2) **Continuous home care.** Continuous home care includes acute skilled care provided to an unstable client dur-

ing a brief period of medical crisis in order to maintain the client in the client's residence and is limited to:

- (a) A minimum of eight hours of acute care provided during a twenty-four-hour day;
- (b) Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care;
- (c) Homemaker, home health aide, and attendant services that may be provided as supplements to the nursing care; and
- (d) In home care only (not care in a nursing facility or a hospice care center).

(3) **Inpatient respite care.** Inpatient respite care includes room and board services provided to a client in a department-approved hospice care center, nursing facility, or hospital. Respite care is intended to provide relief to the client's primary caregiver and is limited to:

- (a) No more than six consecutive days; and
- (b) A client not currently residing in a hospice care center, nursing facility, or hospital.

(4) **General inpatient hospice care.** General inpatient hospice care includes services administered to a client for pain control or management of acute symptoms. In addition:

(a) The services must conform to the client's written plan of care (POC).

(b) This benefit is limited to brief periods of care in department-approved:

- (i) Hospitals;
- (ii) Nursing facilities; or
- (iii) Hospice care centers.

(b) There must be documentation in the client's medical record to support the need for general inpatient level of hospice care.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1500, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1500, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1510 Rates methodology and payment method for hospice agencies. This section describes rates methodology and payment methods for hospice care provided to hospice clients.

(1) The department uses the same rates methodology as Medicare uses for the four levels of hospice care identified in WAC 388-551-1500.

(2) Each of the four levels of hospice care has the following three rate components:

- (a) Wage component;
- (b) Wage index; and
- (c) Unweighted amount.

(3) To allow hospice payment rates to be adjusted for regional differences in wages, the department bases payment rates on the Metropolitan Statistical Area (MSA) county location. MSAs are identified in the department's current published billing instructions.

(4) Payment rates for:

(a) Routine and continuous home care services are based on the county location of the client's residence.

(b) Inpatient respite and general inpatient care services are based on the MSA county location of the providing hospice agency.

(5) The department pays hospice agencies for services (not room and board) at a daily rate calculated as follows:

(a) Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence; or

(b) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

(6) The department:

(a) Pays for routine hospice care, continuous home care, respite care, or general inpatient care for the day of death;

(b) Does not pay room and board for the day of death; and

(c) Does not pay hospice agencies for the client's last day of hospice care when the last day is for the client's discharge, revocation, or transfer.

(7) Hospice agencies must bill the department for their services using hospice-specific revenue codes.

(8) For hospice clients in a nursing facility:

(a) The department pays nursing facility room and board payments at a daily rate directly to the hospice agency at ninety-five percent of the nursing facility's current Medicaid daily rate in effect on the date the services were provided; and

(b) The hospice agency pays the nursing facility at a daily rate no greater than the nursing facility's current Medicaid daily rate.

(9) The department:

(a) Pays a hospice care center a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

(b) Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

(i) A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or

(ii) The day of death.

(10) The daily rate for authorized out-of-state hospice services is the same as for in-state non-MSA hospice services.

(11) The client's notice of action (award) letter states the amount of participation the client is responsible to pay each month towards the total cost of hospice care. The hospice agency receives a copy of the award letter and:

(a) Is responsible to collect the correct amount of the client's participation if the client has any; and

(b) Must show the client's monthly participation on the hospice claim. (Hospice providers may refer to the department's current published billing instructions for how to bill a hospice claim.) If a client has a participation amount that is not reflected on the claim and the department reimburses the amount to the hospice agency, the amount is subject to recoupment by the department.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1510, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1510, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1520 Payment method for nonhospice providers. (1) The department pays for hospitals that provide inpatient care to clients in the hospice program for medical conditions not related to their terminal illness according to chapter 388-550 WAC, Hospital services.

[Title 388 WAC—p. 1156]

(2) The department pays providers who are attending physicians and not employed by the hospice agency, the usual amount through the resource based relative value scale (RBRVS) fee schedule:

(a) For direct physician care services provided to a hospice client;

(b) When the provided services are not related to the terminal illness; and

(c) When the client's providers, including the hospice agency, coordinate the health care provided.

(3) The department's aging and disability services administration (ADSA) pays for services provided to a client eligible under the community options program entry system (COPES) directly to the COPES provider.

(a) The client's monthly participation amount, if there is one, for services provided under COPES is paid separately to the COPES provider; and

(b) Hospice agencies must bill the department's hospice program directly for hospice services, not the COPES program.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1520, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520, 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1520, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1530 Payment method for Medicaid-Medicare dual eligible clients. (1) The department does not pay for any hospice care provided to a client covered by Medicare part A (hospital insurance).

(2) The department may pay for hospice care provided to a client:

(a) Covered by Medicaid part B (medical insurance); and

(b) Not covered by Medicare part A.

(3) For hospice care provided to a Medicaid-Medicare dual eligible client, hospice agencies are responsible to bill:

(a) Medicare before billing the department;

(b) The department for hospice nursing facility room and board;

(c) The department for hospice care center room and board; and

(d) Medicare for general inpatient care or inpatient respite care.

(4) All the limitations and requirements related to hospice care described in this subchapter apply to the payments described in this section.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1530, filed 8/30/05, effective 10/1/05. Statutory Authority: RCW 74.09.520 and 74.08.090, 42 C.F.R. 418.22 and 418.24, 99-09-007, § 388-551-1530, filed 4/9/99, effective 5/10/99.]

WAC 388-551-1800 Pediatric palliative care (PPC) case management/coordination services—General. Through a hospice agency, the department's pediatric palliative care (PPC) case management/coordination services provide the care coordination and skilled care services to clients who have life-limiting medical conditions. Family members and caregivers of clients eligible for pediatric palliative care services may also receive support through care coordination when the services are related to the client's medical needs.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1800, filed 8/30/05, effective 10/1/05.]

(2007 Ed.)

WAC 388-551-1810 Pediatric palliative care (PPC) case management/coordination services—Client eligibility. To receive pediatric palliative care (PPC) case management/coordination services, a person must:

- (1) Be twenty years of age or younger;
- (2) Be a current recipient of the:
 - (a) Categorically needy program (CNP);
 - (b) Limited casualty program - medically needy program (LCP-MNP);
 - (c) CNP—Alien emergency medical;
 - (d) LCP-MNP—Alien emergency medical;
 - (e) Children's health insurance program (SCHIP); and
- (3) Have a life-limiting medical condition that requires case management and coordination of medical services due to at least three of the following circumstances:
 - (a) An immediate medical need during a time of crisis;
 - (b) Coordination with family member(s) and providers required in more than one setting (i.e. school, home, and multiple medical offices or clinics);
 - (c) A life-limiting medical condition that impacts cognitive, social, and physical development;
 - (d) A medical condition with which the family is unable to cope;
 - (e) A family member(s) and/or caregiver who needs additional knowledge or assistance with the client's medical needs; and
 - (f) Therapeutic goals focused on quality of life, comfort, and family stability.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1810, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1820 Pediatric palliative care (PPC) contact—Services included and limitations to coverage.

(1) The department's pediatric palliative care (PPC) case management/coordination services cover up to six pediatric palliative care contacts per client, per calendar month, subject to the limitations in this section and other applicable WAC.

- (2) One pediatric palliative care contact consists of:
 - (a) One visit with a registered nurse, social worker, or therapist (for the purpose of this section, the department defines therapist as a licensed physical therapist, occupational therapist, or speech/language therapist) with the client in the client's residence to address:
 - (i) Pain and symptom management;
 - (ii) Psychosocial counseling; or
 - (iii) Education/training.
 - (b) Two hours or more per month of case management or coordination services to include any combination of the following:
 - (i) Psychosocial counseling services (includes grief support provided to the client, client's family member(s), or client's caregiver prior to the client's death);
 - (ii) Establishing or implementing care conferences;
 - (iii) Arranging, planning, coordinating, and evaluating community resources to meet the client's needs;
 - (iv) Visits lasting twenty minutes or less (for example, visits to give injections, drop off supplies, or make appointments for other PPC-related services.); and
 - (v) Visits not provided in the client's home.

(2007 Ed.)

(3) The department does not pay for a pediatric palliative care contact described in subsection (2) of this section when a client is receiving services from any of the following:

- (a) Home health program;
 - (b) Hospice program;
 - (c) Private duty nursing (private duty nursing can subcontract with PPC to provide services)/medical intensive care;
 - (d) Disease case management program; or
 - (e) Any other department program that provides similar services.
- (4) The department does not pay for a pediatric palliative care contact that includes providing counseling services to a client's family member or the client's caregiver for grief or bereavement for dates of service after a client's death.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1820, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1830 How to become a department-approved pediatric palliative care (PPC) case management/coordination services provider. This section applies to department-enrolled providers who currently do not provide pediatric palliative care (PPC) services to medical assistance clients.

(1) To apply to become a department-approved provider of PPC services, a provider must:

- (a) Be a department-approved hospice agency (see WAC 388-551-1300 and 388-551-1305); and
- (b) Submit a letter to the department's hospice/PPC program manager requesting to become a department-approved provider of PPC and include a copy of the provider's policies and position descriptions with minimum qualifications specific to pediatric palliative care.

(2) A hospice agency qualifies to provide PPC services when:

- (a) All the requirements in this section are met; and
- (b) The department provides the hospice agency with written notification.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-18-033, § 388-551-1830, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1840 Pediatric palliative care (PPC) case management/coordination services—Provider requirements. (1) An eligible provider of pediatric palliative care (PPC) case management/coordination services must do all of the following:

- (a) Meet the conditions in WAC 388-551-1300;
- (b) Confirm that a client meets the eligibility criteria in WAC 388-551-1810 prior to providing the pediatric palliative care services;
- (c) Place in the client's medical record a written order for PPC from the client's physician;
- (d) Determine and document in the client's medical record the medical necessity for the initial and ongoing care coordination of pediatric palliative care services;
- (e) Document in the client's medical record:
 - (i) A palliative plan of care (POC) (a written document based on assessment of a client's individual needs that identifies services to meet those needs).
 - (ii) The medical necessity for those services to be provided in the client's residence; and

[Title 388 WAC—p. 1157]

(iii) Discharge planning.

(f) Provide medically necessary skilled interventions and psychosocial counseling services by qualified interdisciplinary hospice team members;

(g) Assign and make available a PPC case manager (nurse, social worker or therapist) to implement care coordination with community-based providers to assure clarity, effectiveness, and safety of the client's POC;

(h) Complete and fax the pediatric palliative care (PPC) referral and 5-day notification form (DSHS 13-752) to the department's PPC program manager within five working days from date of occurrence of the client's:

(i) Date of enrollment in PPC.

(ii) Discharge from the hospice agency or PPC program when the client:

(A) No longer meets PPC criteria;

(B) Is able to receive all care in the community;

(C) Does not require any services for sixty days; or

(D) Discharges from the PPC program and enrolls in the department's hospice program.

(iii) Transfer to another hospice agency for pediatric palliative care services.

(iv) Death.

(i) Maintain the client's file which includes the POC, visit notes, and all of the following:

(i) The client's start of care date and dates of service;

(ii) Discipline and services provided (in-home or place of service);

(iii) Case management activity and documentation of hours of work; and

(iv) Specific documentation of the client's response to the palliative care and the client's and/or client's family's response to the effectiveness of the palliative care (e.g. the client might have required acute care or hospital emergency room visits without the pediatric palliative care services).

(j) Provide when requested by the department's PPC program manager, a copy of the client's POC, visit notes, and any other documents listing the information identified in subsection (1)(i) of this section.

(2) If the department determines the POC, visit notes, and/or other required information do not meet the criteria for a client's PPC eligibility or does not justify the billed amount, any payment to the provider is subject to recoupment by the department.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1840, filed 8/30/05, effective 10/1/05.]

WAC 388-551-1850 Pediatric palliative care (PPC) case management/coordination services—Rates methodology. (1) The department determines the reimbursement rate for a pediatric palliative care (PPC) contact described in WAC 388-551-1820 using the average of statewide metropolitan statistical area (MSA) home health care rates for skilled nursing, physical therapy, speech-language therapy and occupational therapy.

(2) The department makes adjustments to the reimbursement rate for PPC contacts when the legislature grants a vender rate change. New rates become effective as directed by the legislature and are effective until the next rate change.

(3) The reimbursement rate for authorized out-of-state PPC services is the same as the in-state non-MSA rate.

[Title 388 WAC—p. 1158]

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-18-033, § 388-551-1850, filed 8/30/05, effective 10/1/05.]

SUBCHAPTER II—HOME HEALTH SERVICES

WAC 388-551-2000 Home health services—General.

The purpose of the medical assistance administration (MAA) home health program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in the client's residence, subject to the restrictions and limitations in this subchapter.

Home health skilled services are provided for acute, intermittent, short-term, and intensive courses of treatment. See chapters 388-515 and 388-71 WAC for programs administered to clients who need chronic, long-term maintenance care.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500, 02-15-082, § 388-551-2000, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530, 99-16-069, § 388-551-2000, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2010 Home health services—Definitions. The following definitions and abbreviations and those found in WAC 388-500-0005 apply to this subchapter:

"Acute care" means care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.

"Brief skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client:

(1) An injection;

(2) Blood draw; or

(3) Placement of medications in containers.

"Chronic care" means long-term care for medically stable clients.

"Full skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client:

(1) Observation;

(2) Assessment;

(3) Treatment;

(4) Teaching;

(5) Training;

(6) Management; and

(7) Evaluation.

"Home health agency" means an agency or organization certified under Medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in the patient's place of residence.

"Home health aide" means an individual registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

"Home health aide services" means services provided by a home health aide only when a client has an acute, intermittent, short-term need for the services of a registered nurse,

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physical therapist, occupational therapist, or speech therapist who is employed by or under contract with a home health agency. Such services are provided under the supervision of the previously identified authorized practitioners and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's condition and needs, and completing appropriate records.

"Home health skilled services" means skilled health care (nursing, specialized therapy, and home health aide) services provided in the client's residence on an intermittent or part-time basis by a Medicare-certified home health agency with a current medical assistance administration (MAA) provider number. See also WAC 388-551-2000.

"Long-term care" is a generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the department's aging and adult services administration (AASA) or division of developmental disabilities (DDD).

"Plan of care (POC)" (also known as **"plan of treatment (POT)"**) means a written plan of care that is established and periodically reviewed and signed by both a physician and a home health agency provider. The plan describes the home health care to be provided at the client's residence. See WAC 388-551-2210.

"Residence" means a client's home or place of living. (See WAC 388-551-2030 (2)(g)(ii) for clients in residential facilities whose home health services are not covered through MAA's home health program.)

"Review period" means the three-month period the medical assistance administration (MAA) assigns to a home health agency, based on the address of the agency's main office, during which MAA reviews all claims submitted by that agency.

"Specialized therapy" means skilled therapy services provided to clients that include:

- (1) Physical;
- (2) Occupational; or
- (3) Speech/audiology services.

(See WAC 388-551-2110.)

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2010, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2010, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2020 Home health services—Eligible clients. (1) Clients in the following fee-for-service MAA programs are eligible to receive home health services subject to the limitations described in this chapter. Clients enrolled in a healthy options managed care plan receive all home health services through their designated plan.

- (a) Categorically needy program (CNP);
- (b) Limited casualty program - medically needy program (LCP-MNP);
- (c) General assistance expedited (GA-X) (disability determination pending); and
- (d) Medical care services (MCS) under the following programs:
 - (i) General assistance - unemployable (GA-U); and

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(ii) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) (GA-W).

(2) MAA does not cover home health services under the home health program for clients in the CNP-emergency medical only and LCP-MNP-emergency medical only programs. MAA evaluates a request for home health skilled nursing visits on a case-by-case basis under the provisions of WAC 388-501-0165, and may cover up to two skilled nursing visits within the eligibility enrollment period if the following criteria are met:

- (a) The client requires hospital care due to an emergent medical condition as described in WAC 388-500-0005; and
- (b) MAA authorizes up to two skilled nursing visits for follow-up care related to the emergent medical condition.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2020, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2020, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2030 Home health skilled services—Requirements. (1) MAA reimburses for covered home health skilled services provided to eligible clients, subject to the restrictions or limitations in this section and other applicable published WAC.

(2) Home health skilled services provided to eligible clients must:

- (a) Meet the definition of "acute care" in WAC 388-551-2010.
- (b) Provide for the treatment of an illness, injury, or disability.
- (c) Be medically necessary as defined in WAC 388-500-0005.
- (d) Be reasonable, based on the community standard of care, in amount, duration, and frequency.
- (e) Be provided under a plan of care (POC), as defined in WAC 388-551-2010 and described in WAC 388-551-2210. Any statement in the POC must be supported by documentation in the client's medical records.
- (f) Be used to prevent placement in a more restrictive setting. In addition, the client's medical records must justify the medical reason(s) that the services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting. This includes justification for services for a client's medical condition that requires teaching that would be most effectively accomplished in the client's home on a short-term basis.

(g) Be provided in the client's residence.

(i) MAA does not reimburse for services if provided at the workplace, school, child day care, adult day care, skilled nursing facility, or any other place that is not the client's place of residence.

(ii) Clients in residential facilities contracted with the state and paid by other programs such as home and community programs to provide limited skilled nursing services, are not eligible for MAA-funded limited skilled nursing services unless the services are prior authorized under the provisions of WAC 388-501-0165.

(h) Be provided by:

(i) A home health agency that is Title XVIII (Medicare) certified;

(ii) A registered nurse (RN) prior authorized by MAA when no home health agency exists in the area a client resides; or

(iii) An RN authorized by MAA when the RN is unable to contract with a Medicare-certified home health agency.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2030, filed 7/15/02, effective 8/15/02.]

WAC 388-551-2100 Covered home health services—Nursing. (1) MAA covers home health acute care skilled nursing services listed in this section when furnished by a qualified provider. MAA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165.

(2) MAA covers the following home health acute care skilled nursing services, subject to the limitations in this section:

(a) Full skilled nursing services that require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse if the services involve one or more of the following:

- (i) Observation;
- (ii) Assessment;
- (iii) Treatment;
- (iv) Teaching;
- (v) Training;
- (vi) Management; and
- (vii) Evaluation.

(b) A brief skilled nursing visit if only one of the following activities is performed during the visit:

- (i) An injection;
- (ii) Blood draw; or
- (iii) Placement of medications in containers (e.g., envelopes, cups, medisets).

(c) Home infusion therapy only if the client:

(i) Is willing and capable of learning and managing the client's infusion care; or

(ii) Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

(d) Infant phototherapy for an infant diagnosed with hyperbilirubinemia:

(i) When provided by an MAA-approved infant phototherapy agency; and

(ii) For up to five skilled nursing visits per infant.

(e) Limited high-risk obstetrical services:

(i) For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;

(ii) For up to three home health visits per pregnancy if:

(A) Enrollment in or referral to the following providers of first steps has been verified:

(I) Maternity support services (MSS); or

(II) Maternity case management (MCM); and

(B) The visits are provided by a registered nurse who has either:

(I) National perinatal certification; or

(II) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

(3) MAA limits skilled nursing visits provided to eligible clients to two per day.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2100, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2100, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2110 Home health services—Specialized therapy. (1) MAA limits specialized therapy visits to one per client, per day, per type of specialized therapy. Specialized therapy is defined in WAC 388-551-2010.

(2) MAA does not allow duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2110, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2110, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2120 Home health aide services. (1) MAA limits home health aide visits to one per day.

(2) MAA reimburses for home health aide services, as defined in WAC 388-551-2010, only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:

- (a) Skilled nursing services; or
- (b) Specialized therapy services.

(3) MAA covers home health aide services only when a registered nurse or licensed therapist visits the client's residence at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2120, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2120, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2130 Noncovered home health services. (1) The Health and Recovery Services Administration (HRSA) does not cover the following home health services under the home health program, unless otherwise specified:

(a) Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the department of social and health services' aging and disability services administration (ADSA).

(i) HRSA considers requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ADSA to implement a long-term care skilled nursing plan or specialized therapy plan; and

(ii) On a case-by-case basis, HRSA may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until a long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this section and other applicable published WACs.

(b) Social work services.

(c) Psychiatric skilled nursing services.

(d) Pre- and postnatal skilled nursing services, except as listed under WAC 388-551-2100 (2)(e).

(e) Well-baby follow-up care.

(f) Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing services available.

(g) Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services.

(h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change).

(i) Home health specialized therapies and home health aide visits for clients in the following programs:

(i) CNP - emergency medical only; and

(ii) LCP-MNP - emergency medical only.

(j) Skilled nursing visits for a client when a home health agency cannot safely meet the medical needs of that client within home health services program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care).

(k) More than one of the same type of specialized therapy and/or home health aide visit per day.

(l) HRSA does not reimburse for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure(s).

(m) Home health visits made without a written physician's order, unless the verbal order is:

(i) Documented prior to the visit; and

(ii) The document is signed by the physician within forty-five days of the order being given.

(2) HRSA does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

(3) HRSA evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-551-2130, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2130, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2130, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2200 Home health services—Eligible providers. The following may contract with MAA to provide home health services through the home health program, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) A home health agency that:

(a) Is Title XVIII (Medicare) certified;

(b) Is department of health (DOH) licensed as a home health agency;

(c) Submits a completed, signed core provider agreement to MAA; and

(d) Is assigned a provider number.

(2) A registered nurse (RN) who:

(a) Is prior authorized by MAA to provide intermittent nursing services when no home health agency exists in the area a client resides;

(b) Is unable to contract with a Medicare-certified home health agency;

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(c) Submits a completed, signed core provider agreement to MAA; and

(d) Is assigned a provider number.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2200, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2200, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2210 Home health services—Provider requirements. For any delivered home health service to be payable, MAA requires home health providers to develop and implement an individualized plan of care (POC) for the client.

(1) The POC must:

(a) Be documented in writing and be located in the client's home health medical record;

(b) Be developed, supervised, and signed by a licensed registered nurse or licensed therapist;

(c) Reflect the physician's orders and client's current health status;

(d) Contain specific goals and treatment plans;

(e) Be reviewed and revised by a physician at least every sixty calendar days, signed by a physician within forty-five days of the verbal order, and returned to the home health agency's file; and

(f) Be available to department staff or its designated contractor(s) on request.

(2) The provider must include in the POC all of the following:

(a) The client's name, date of birth, and address (to include name of residential care facility, if applicable);

(b) The primary diagnosis (the diagnosis that is most related to the reason the client qualifies for home health services) or the diagnosis that is the reason for the visit frequency;

(c) All secondary medical diagnoses, including date(s) of onset or exacerbation;

(d) The prognosis;

(e) The type(s) of equipment required;

(f) A description of each planned service and goals related to the services provided;

(g) Specific procedures and modalities;

(h) A description of the client's mental status;

(i) A description of the client's rehabilitation potential;

(j) A list of permitted activities;

(k) A list of safety measures taken on behalf of the client; and

(l) A list of medications which indicates:

(i) Any new prescription; and

(ii) Which medications are changed for dosage or route of administration.

(3) The provider must include in or attach to the POC:

(a) A description of the client's functional limits and the effects;

(b) Documentation that justifies why the medical services should be provided in the client's residence instead of a physician's office, clinic, or other outpatient setting;

(c) Significant clinical findings;

(d) Dates of recent hospitalization;

(e) Notification to the DSHS case manager of admittance; and

(f) A discharge plan, including notification to the DSHS case manager of the planned discharge date and client disposition at time of discharge.

(4) The individual client medical record must comply with community standards of practice, and must include documentation of:

- (a) Visit notes for every billed visit;
- (b) Supervisory visits for home health aide services as described in WAC 388-551-2120(3);
- (c) All medications administered and treatments provided;
- (d) All physician orders, new orders, and change orders, with notation that the order was received prior to treatment;
- (e) Signed physician new orders and change orders;
- (f) Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;
- (g) Interdisciplinary and multidisciplinary team communications;
- (h) Inter-agency and intra-agency referrals;
- (i) Medical tests and results;
- (j) Pertinent medical history; and
- (k) Notations and charting with signature and title of writer.

(5) The provider must document at least the following in the client's medical record:

- (a) Skilled interventions per the POC;
 - (b) Client response to the POC;
 - (c) Any clinical change in client status;
 - (d) Follow-up interventions specific to a change in status with significant clinical findings; and
 - (e) Any communications with the attending physician.
- (6) The provider must include the following documentation in the client's visit notes when appropriate:
- (a) Any teaching, assessment, management, evaluation, client compliance, and client response;
 - (b) Weekly documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided;
 - (c) If a client's wound is not healing, the client's physician has been notified, the client's wound management program has been appropriately altered and, if possible, the client has been referred to a wound care specialist; and
 - (d) The client's physical system assessment as identified in the POC.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2210, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2210, filed 8/2/99, effective 9/2/99.]

WAC 388-551-2220 Home health services—Provider payments. (1) In order to be reimbursed, the home health provider must bill MAA according to the conditions of payment under WAC 388-502-0150 and other issuances.

(2) Payment to home health providers is:

- (a) A set rate per visit for each discipline provided to a client;
 - (b) Based on the county location of the providing home health agency; and
 - (c) Updated by general vendor rate changes.
- (3) For clients eligible for both Medicaid and Medicare, MAA may pay for services described in this chapter only

when Medicare does not cover those services. The maximum payment for each service is Medicaid's maximum payment.

(4) Providers must submit documentation to MAA during the home health agency's review period. Documentation includes, but is not limited to, the requirements listed in WAC 388-551-2210.

(5) After MAA receives the documentation, the MAA medical director or designee reviews the client's medical records for program compliance and quality of care.

(6) MAA may take back or deny payment for any insufficiently documented home health care service when the MAA medical director or designee determines that:

- (a) The service did not meet the conditions described in WAC 388-550-2030; or
- (b) The service was not in compliance with program policy.

(7) Covered home health services for clients enrolled in a Healthy Options managed care plan are paid for by that plan.

[Statutory Authority: RCW 74.08.090, 74.09.520, 74.09.530, and 74.09.500. 02-15-082, § 388-551-2220, filed 7/15/02, effective 8/15/02. Statutory Authority: RCW 74.08.090 and 74.09.530. 99-16-069, § 388-551-2220, filed 8/2/99, effective 9/2/99.]

WAC 388-551-3000 Private duty nursing services for clients seventeen years of age and younger. This section applies to private duty nursing services for eligible clients on fee-for-service programs. Managed care clients receive private duty nursing services through their plans (see chapter 388-538 WAC).

(1) **"Private duty nursing"** means four hours or more of continuous skilled nursing services provided in the home to eligible clients with complex medical needs that cannot be managed within the scope of intermittent home health services. Skilled nursing service is the management and administration of the treatment and care of the client, and may include, but is not limited to:

- (a) Assessments (e.g., respiratory assessment, patency of airway, vital signs, feeding assessment, seizure activity, hydration, level of consciousness, constant observation for comfort and pain management);
- (b) Administration of treatment related to technological dependence (e.g., ventilator, tracheotomy, bilevel positive airway pressure, intravenous (IV) administration of medications and fluids, feeding pumps, nasal stints, central lines);
- (c) Monitoring and maintaining parameters/machinery (e.g., oximetry, blood pressure, lab draws, end tidal CO₂s, ventilator settings, humidification systems, fluid balance, etc.); and
- (d) Interventions (e.g., medications, suctioning, IV's, hyperalimentation, enteral feeds, ostomy care, and tracheostomy care).

(2) To be eligible for private duty nursing services, a client must meet all the following:

- (a) Be seventeen years of age or younger (see chapter 388-71 WAC for information about private duty nursing services for clients eighteen years of age and older);
- (b) Be eligible for categorically needy (CN) or medically needy (MN) scope of care (see WAC 388-501-0060 and 388-501-0065);

(c) Need continuous skilled nursing care that can be provided safely outside an institution; and

(d) Have prior authorization from the department.

(3) The department contracts only with home health agencies licensed by Washington state to provide private duty nursing services and pays a rate established by the department according to current funding levels.

(4) A provider must coordinate with a division of developmental disabilities case manager and request prior authorization by submitting a complete referral to the department, which includes all of the following:

(a) The client's age, medical history, diagnosis, and current prescribed treatment plan, as developed by the individual's physician;

(b) Current nursing care plan that may include copies of current daily nursing notes that describe nursing care activities;

(c) An emergency medical plan which includes notification of electric, gas and telephone companies as well as local fire department;

(d) Psycho-social history/summary which provides the following information:

(i) Family constellation and current situation;

(ii) Available personal support systems;

(iii) Presence of other stresses within and upon the family; and

(iv) Projected number of nursing hours needed in the home, after discussion with the family or guardian.

(e) A written request from the client or the client's legally authorized representative for home care.

(5) The department approves requests for private duty nursing services for eligible clients on a case-by-case basis when:

(a) The information submitted by the provider is complete;

(b) The care provided will be based in the client's home;

(c) Private duty nursing will be provided in the most cost-effective setting;

(d) An adult family member, guardian, or other designated adult has been trained and is capable of providing the skilled nursing care;

(e) A registered or licensed practical nurse will provide the care under the direction of a physician; and

(f) Based on the referral submitted by the provider, the department determines:

(i) The services are medically necessary for the client because of a complex medical need that requires continuous skilled nursing care which can be provided safely in the client's home;

(ii) The client requires more nursing care than is available through the home health services program; and

(iii) The home care plan is safe for the client.

(6) Upon approval, the department will authorize private duty nursing services up to a maximum of sixteen hours per day except as provided in subsection (7) of this section, restricted to the least costly equally effective amount of care.

(7) The department may authorize additional hours:

(a) For a maximum of thirty days if any of the following apply:

(i) The family or guardian is being trained in care and procedures;

(2007 Ed.)

(ii) There is an acute episode that would otherwise require hospitalization, and the treating physician determines that noninstitutionalized care is still safe for the client;

(iii) The family or guardian caregiver is ill or temporarily unable to provide care;

(iv) There is a family emergency; or

(v) The department determines it is medically necessary.

(b) After the department evaluates the request according to the provisions of WAC 388-501-0165 and WAC 388-501-0169.

(8) The department adjusts the number of authorized hours when the client's condition or situation changes.

(9) Any hours of nursing care in excess of those authorized by the department are the responsibility of the client, family or guardian.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-551-3000, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.520. 01-05-040, § 388-551-3000, filed 2/14/01, effective 3/17/01.]

Chapter 388-552 WAC

OXYGEN AND RESPIRATORY THERAPY

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WAC 388-552-001 Scope. (1) This chapter applies to:

(a) Medical assistance administration (MAA) clients who require medically necessary **oxygen** and/or respiratory therapy equipment, supplies, and services in their homes and nursing facilities; and

(b) Providers who furnish **oxygen** and respiratory therapy equipment, supplies and services to eligible MAA clients.

(2) Instructions for clients covered by Medicare are located in Medicare's Durable Medical Equipment Regional Carrier (DMERC) Manual.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-001, filed 6/9/99, effective 7/10/99.]

WAC 388-552-005 Definitions. The following definitions and those in WAC 388-500-0005 apply to this chapter. If a definition in WAC 388-500-0005 differs with the definition in this section, the definition in this section applies. Defined words and phrases are bolded in the text.

"Authorized prescriber" means a health care practitioner authorized by law or rule in the state of Washington to prescribe oxygen and respiratory therapy equipment, supplies, and services.

"Base year," as used in this chapter, means the year in which the oxygen and respiratory therapy billing instructions' current fee schedule is adopted.

"Maximum allowable" means the maximum dollar amount MAA reimburses a provider for a specific service, supply, or piece of equipment.

"Oxygen" means United States Pure (USP) medical grade liquid or gaseous oxygen.

"Oxygen and respiratory therapy billing instructions" means a booklet containing procedures for billing, which is available by writing to Medical Assistance Administration, Division of Program Support, P.O. Box 45562, Olympia, WA, 98504-5562.

"Oxygen system" means all equipment necessary to provide oxygen to a person.

"Portable system" means a small system which allows the client to be independent of the stationary system for several hours, thereby providing mobility outside of the residence.

"Provider" means a person or company with a signed core provider agreement with MAA to furnish **oxygen** and respiratory therapy equipment, supplies, and services to eligible MAA clients.

"Respiratory care practitioner" means a person certified by the department of health according to chapter 18.89 RCW and chapter 246-928 WAC.

"Stationary system" means equipment designed to be used in one location, generally for the purpose of continuous use or frequent intermittent use.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-005, filed 6/9/99, effective 7/10/99.]

CLIENT ELIGIBILITY

WAC 388-552-100 Client eligibility. (1) All MAA fee-for-service clients are eligible for **oxygen** and respiratory therapy equipment, supplies, and services when medically necessary, with the following limitations:

(a) Clients on the medically indigent program are not eligible under this chapter; and

(b) Clients on the categorically needy/qualified Medicare beneficiaries and medically needy/qualified Medicare beneficiaries programs are covered by Medicare and Medicaid as follows:

(i) If Medicare covers the service, MAA will pay the lesser of:

(A) The full co-insurance and deductible amounts due, based upon Medicaid's allowed amount; or

(B) MAA's **maximum allowable** for that service minus the amount paid by Medicare.

(ii) If Medicare does not cover or denies equipment, supplies, or services that MAA covers according to this chapter,

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MAA reimburses at MAA's **maximum allowable**; except, MAA does not reimburse for clients on the qualified Medicare beneficiaries (QMB) only program.

(2) Services for clients enrolled in a healthy options managed care plan receive all **oxygen** and respiratory therapy equipment, supplies, and services through their designated plan, subject to the plan's coverages and limitations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-100, filed 6/9/99, effective 7/10/99.]

PROVIDERS

WAC 388-552-200 Providers—General responsibilities. (1) The provider must verify that the client's original prescription is signed and dated by the **authorized prescriber** no more than ninety days prior to the initial date of service. The prescription must include, at a minimum:

(a) The client's medical diagnosis, prognosis, and documentation of the medical necessity for **oxygen** and/or respiratory therapy equipment, supplies, and/or services, and any modifications;

(b) If **oxygen** is prescribed:

(i) Flow rate of **oxygen**;

(ii) Estimated duration of need;

(iii) Frequency and duration of **oxygen** use; and

(iv) Lab values or **oxygen** saturation measurements upon the client's discharge from the hospital.

(2) The provider must provide instructions to the client and/or caregiver on the safe and proper use of equipment provided.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-200, filed 6/9/99, effective 7/10/99.]

WAC 388-552-210 Required records. (1) A provider must maintain legible, accurate, and complete charts and records for each client. These records must support and justify claims that the provider submits to MAA for reimbursement. Records must include, at a minimum the:

(a) Date(s) of service;

(b) Client's name and date of birth;

(c) Name and title of person performing the service, when it is someone other than the billing practitioner;

(d) Chief complaint or reason for each visit;

(e) Pertinent medical history;

(f) Pertinent findings on examination;

(g) **Oxygen**, equipment, supplies, and/or services prescribed or provided;

(h) The original and subsequent prescriptions according to the requirements in WAC 388-552-200 and 388-552-220;

(i) Description of treatment (when applicable);

(j) Recommendations for additional treatments, procedures, or consultations;

(k) X-rays, tests, and results;

(l) Plan of treatment/care/outcome;

(m) Logs of oxygen saturations and lab values taken to substantiate the medical necessity of continuous **oxygen**, as required by WAC 388-552-220;

(n) Logs of oximetry readings if required by WAC 388-552-380 for a client seventeen years of age or younger; and

(o) Recommendations and evaluations if required by WAC 388-552-230 for the infant apnea monitor program.

(2) The provider must make required charts and records available to DSHS or its contractor(s) upon request.

(3) MAA may require additional information in order to process a submitted claim.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-210, filed 6/9/99, effective 7/10/99.]

WAC 388-552-220 Requirements for oxygen providers. Oxygen providers must:

(1) Obtain a renewed prescription every six months if the client's condition warrants continued service;

(2) Verify, at least every six months, that **oxygen** saturations or lab values substantiate the need for continued **oxygen** use for each client. The provider may perform the **oxygen** saturation measurements. MAA does not accept lifetime certificates of medical need (CMNs).

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-220, filed 6/9/99, effective 7/10/99.]

WAC 388-552-230 Requirements for infant apnea monitors. (1) MAA does not reimburse for apnea monitors unless the provider has a respiratory care practitioner or registered nurse with expertise in pediatric respiratory care who is responsible for their apnea monitor program.

(2) MAA does not require a confirming second opinion for the initial rental period for diagnoses of apnea of prematurity, primary apnea, obstructed airway, or congenital conditions associated with apnea. For other diagnoses, a neonatologist's confirming assessment and recommendation must be maintained as a second opinion in the client's file. The initial rental period must not exceed six months.

(3) Regardless of diagnosis, the provider must maintain in the client's file, a neonatologist's clinical evaluation justifying each subsequent rental period.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-230, filed 6/9/99, effective 7/10/99.]

WAC 388-552-240 Requirements for respiratory care practitioners. (1) A respiratory care practitioner must comply with chapter 18.89 RCW and chapter 246-928 WAC to qualify for reimbursement.

(2) A respiratory care practitioner must complete at least the following in each client visit:

(a) Check equipment and ensure equipment settings continue to meet the client's needs; and

(b) Communicate with the client's physician if there are any concerns or recommendations.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-240, filed 6/9/99, effective 7/10/99.]

COVERAGE

WAC 388-552-300 Coverage. (1) MAA covers medically necessary oxygen and respiratory therapy equipment, supplies, and services subject to the limitations in this chapter. MAA approves additional oxygen and respiratory therapy equipment, supplies, and services on a case-by-case basis if medically necessary.

(2007 Ed.)

(2) MAA does not reimburse for a service or product if any of the following apply:

(a) The service or product is not covered by MAA;

(b) The service or product is not medically necessary;

(c) The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; or

(d) The client and provider do not meet the requirements in this chapter.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-300, filed 6/9/99, effective 7/10/99.]

WAC 388-552-310 Coverage—Oxygen and oxygen equipment. (1) MAA reimburses for **oxygen** provided to:

(a) Clients eighteen years of age or older with:

(i) $PO_2 \leq$ fifty-five mm on room air; or

(ii) $SpO_2 \leq$ eighty-eight percent on room air; or

(iii) $PaO_2 \leq$ fifty-five mm on room air.

(b) Clients seventeen years of age or younger to maintain SpO_2 at:

(i) Ninety-two percent; or

(ii) Ninety-four percent in a child with cor pulmonale or pulmonary hypertension.

(2) MAA may cover spare tanks of **oxygen** and other equipment if the provider and attending physician document that travel distance or potential weather conditions could reasonably be expected to interfere with routine delivery of such equipment and supplies.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-310, filed 6/9/99, effective 7/10/99.]

WAC 388-552-320 Coverage—Continuous positive airway pressure (CPAP) and supplies. (1) MAA covers the rental and/or purchase of medically necessary CPAP equipment and related accessories when all of the following apply:

(a) The results of a prior sleep study indicate the client has sleep apnea;

(b) The client's attending physician determines that the client's sleep apnea is chronic;

(c) CPAP is the least costly, most effective treatment modality;

(d) The item is to be used exclusively by the client for whom it is requested;

(e) The item is FDA-approved; and

(f) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA covers the rental of CPAP equipment for a maximum of two months. Thereafter, if the client's primary physician determines the equipment is tolerated and beneficial to the client, MAA reimburses for its purchase.

(3) Refer to **oxygen and respiratory therapy billing instructions** to determine which CPAP accessories are covered.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-320, filed 6/9/99, effective 7/10/99.]

WAC 388-552-330 Coverage—Ventilator therapy, equipment, and supplies. (1) MAA covers medically neces-

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sary ventilator equipment rental and related disposable supplies when all of the following apply:

(a) The ventilator is to be used exclusively by the client for whom it is requested;

(b) The ventilator is FDA-approved; and

(c) The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).

(2) MAA's monthly rental payment includes medically necessary accessories, including, but not limited to: Humidifiers, nebulizers, alarms, temperature probes, adapters, connectors, fittings, and tubing.

(3) MAA covers a secondary (back-up) ventilator at fifty percent of the monthly rental if medically necessary.

(4) MAA covers the purchase of durable accessories for client-owned ventilator systems according to the fee schedule in the current **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-330, filed 6/9/99, effective 7/10/99.]

WAC 388-552-340 Coverage—Infant apnea monitor program. (1) A provider must comply with WAC 388-552-230 to qualify for reimbursement for the infant apnea monitor program.

(2) MAA covers infant apnea monitors on a rental basis.

(3) MAA includes all home visits, follow-up calls, and training in the rental allowance.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-340, filed 6/9/99, effective 7/10/99.]

WAC 388-552-350 Coverage—Respiratory and ventilator therapy. (1) MAA covers prescribed medically necessary respiratory and ventilator therapy services in the home.

(2) Therapy services must be provided by a certified respiratory care practitioner;

(3) MAA does not reimburse separately for respiratory and ventilator therapy services provided to clients residing in nursing facilities. This service is included in the nursing facility's per diem.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-350, filed 6/9/99, effective 7/10/99.]

WAC 388-552-360 Coverage—Suction pumps and supplies. (1) MAA covers suction pumps and supplies when medically necessary for deep oral or tracheostomy suctioning.

(2) MAA may cover one stationary and one portable suction pump for the same client if warranted by the client's condition. The provider and attending physician must document that either:

(a) Travel distance or potential weather conditions could reasonably be expected to interfere with the delivery of medically necessary replacement equipment; or

(b) The client requires suctioning while away from the client's place of residence.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-360, filed 6/9/99, effective 7/10/99.]

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WAC 388-552-370 Coverage—Inhalation drugs and solutions. Inhalation drugs and solutions are included in the prescription drug program. Refer to chapter 388-530 WAC.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-370, filed 6/9/99, effective 7/10/99.]

WAC 388-552-380 Coverage—Oximeters. (1) MAA covers oximeters for clients seventeen years of age or younger when the client has one of the following conditions:

(a) Chronic lung disease, is on supplemental **oxygen**, and is at risk for desaturation with sleep, stress, or feeding;

(b) A compromised or artificial airway, and is at risk for major obstructive events or aspiration events; or

(c) Chronic lung disease, requires ventilator or BIPAP support, and may be at risk for atelectasis or pneumonia as well as hypoventilation.

(2) The provider must review oximetry needs and fluctuations in **oxygen** levels monthly, and log results in the client's records.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-380, filed 6/9/99, effective 7/10/99.]

WAC 388-552-390 Coverage—Nursing facilities. (1) MAA reimburses according to this chapter for the chronic use of medically necessary **oxygen**, and **oxygen** and respiratory equipment and supplies to eligible clients who reside in nursing facilities.

(2) Nursing facilities are reimbursed in their per diem rate for:

(a) **Oxygen** and **oxygen** equipment and supplies used in emergency situations; and

(b) Respiratory and ventilator therapy services.

(3) Nursing facilities with a "piped" **oxygen** system may submit a written request to MAA for permission to bill MAA for oxygen. See **oxygen and respiratory therapy billing instructions**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-390, filed 6/9/99, effective 7/10/99.]

REIMBURSEMENT

WAC 388-552-400 Reimbursement for covered services. (1) A provider must bill MAA according to the procedures and codes in the current **oxygen and respiratory therapy billing instructions**.

(2) MAA does not reimburse separately for telephone calls, mileage, or travel time. These services are included in the reimbursement for other equipment and/or services.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-400, filed 6/9/99, effective 7/10/99.]

WAC 388-552-410 Reimbursement methods. MAA bases the decision to rent or purchase medical equipment for a client, or pay for repairs to client-owned equipment, on the least costly and/or equally effective alternative.

(1) **Rental.**

(a) Types of rental equipment:

(i) Equipment that normally requires frequent maintenance (such as ventilators and concentrators) is reimbursed on a rental basis for as long as medically necessary; and

(2007 Ed.)

(ii) Equipment with lower maintenance requirements (such as suction pumps and humidifiers) is reimbursed on a rental basis for a specified rental period, after which the equipment is considered purchased and owned by the client. Refer to the **oxygen and respiratory therapy billing instructions** for detailed information.

(b) The monthly rental rate includes, but is not limited to:

(i) A full service warranty covering the rental period;

(ii) Any adjustments, modifications, repairs or replacements required to keep the equipment in good working condition on a continuous basis throughout the total rental period;

(iii) All medically necessary accessories and disposable supplies, unless separately billable according to current **oxygen and respiratory therapy billing instructions**;

(iv) Instructions to the client and/or caregiver for safe and proper use of the equipment; and

(v) Cost of pick-up and delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

(2) Purchase.

(a) Purchased equipment becomes the property of the client;

(b) MAA reimburses for:

(i) Equipment that is new at the time of purchase, unless otherwise specified in current **oxygen and respiratory therapy billing instructions**; and

(ii) One maintenance and service visit every six months for purchased equipment.

(c) MAA does not reimburse for:

(i) Defective equipment;

(ii) The cost of materials covered under the manufacturer's warranty; or

(iii) Repair or replacement of equipment if evidence indicates malicious damage, culpable neglect, or wrongful disposition.

(d) The reimbursement rate for purchased equipment includes, but is not limited to:

(i) A manufacturer's warranty for a minimum warranty period of one year for medical equipment, not including disposable/nonreusable supplies;

(ii) Instructions to the client and/or caregiver for safe and proper use of the equipment; and

(iii) The cost of delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

(e) The provider must make warranty information, including date of purchase and warranty period, available to MAA upon request.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-410, filed 6/9/99, effective 7/10/99.]

WAC 388-552-420 Reimbursement methodology.

MAA, at its discretion, uses the following methods to determine the **maximum allowable** amount for each purchased and rented item and service:

(1) Monthly rental reimbursement methodology.

(a) Medicare's fee as of October 31 of the year prior to the base year; or

(b) A **maximum allowable** equal to:

(i) One-tenth of the purchase **maximum allowable** for that product; or

(ii) If MAA does not reimburse for the purchase of that product, one-tenth of the amount calculated using the methodology in subsection (1) of this section.

(2) Purchase reimbursement methodology.

(a) Medicare's fee as of October 31 of the year prior to the **base year**; or

(b) A **maximum allowable** equal to the seventieth percentile price of an array of input prices.

(i) The number of input prices included in each array may be limited by MAA based on consideration of product quality, cost, available alternatives, and client needs.

(ii) An input price used in the **maximum allowable** calculation is the lesser of:

(A) Eighty percent of the manufacturer's list or suggested retail price as of October 31 of the **base year**; or

(B) One hundred thirty-five percent of the wholesale acquisition cost as of October 31 of the **base year**.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.09.520 and 74.09.530. 99-13-049, § 388-552-420, filed 6/9/99, effective 7/10/99.]

Chapter 388-553 WAC

HOME INFUSION THERAPY/PARENTERAL NUTRITION PROGRAM

WAC

388-553-100	Home infusion therapy/parenteral nutrition program—General.
388-553-200	Home infusion therapy/parenteral nutrition program—Definitions.
388-553-300	Home infusion therapy/parenteral nutrition program—Client eligibility and assignment.
388-553-400	Home infusion therapy/parenteral nutrition program—Provider requirements.
388-553-500	Home infusion therapy/parenteral nutrition program—Coverage, services, limitations, prior authorization, and reimbursement.

WAC 388-553-100 Home infusion therapy/parenteral nutrition program—General. The medical assistance administration's (MAA's) home infusion therapy/parenteral nutrition program provides the supplies and equipment necessary for parenteral infusion of therapeutic agents to medical assistance clients. An eligible client receives equipment, supplies, and parenteral administration of therapeutic agents in a qualified setting to improve or sustain the client's health.

[Statutory Authority: RCW 74.08.090, 74.09.530. 04-11-007, § 388-553-100, filed 5/5/04, effective 6/5/04.]

WAC 388-553-200 Home infusion therapy/parenteral nutrition program—Definitions. The following terms and definitions apply to the home infusion therapy/parenteral nutrition program:

"Infusion therapy" means the provision of therapeutic agents or nutritional products to individuals by parenteral infusion for the purpose of improving or sustaining a client's health.

"Intradialytic parenteral nutrition (IDPN)" means intravenous nutrition administered during hemodialysis. IDPN is a form of parenteral nutrition.

"Parenteral infusion" means the introduction of a substance by means other than the gastrointestinal tract, referring particularly to the introduction of substances by intravenous, subcutaneous, intramuscular or intramedullary means.

"Parenteral nutrition" (also known as total parenteral nutrition (TPN)) means the provision of nutritional requirements intravenously.

[Statutory Authority: RCW 74.08.090, 74.09.530. 04-11-007, § 388-553-200, filed 5/5/04, effective 6/5/04.]

WAC 388-553-300 Home infusion therapy/parenteral nutrition program—Client eligibility and assignment. (1) Clients in the following medical assistance administration (MAA) programs are eligible to receive home infusion therapy and parenteral nutrition, subject to the limitations and restrictions in this section and other applicable WAC:

- (a) Categorically needy program (CNP);
- (b) Categorically needy program - Children's health insurance program (CNP-CHIP);
- (c) General assistance - Unemployable (GA-U); and
- (d) Limited casualty program - Medically needy program (LCP-MNP).

(2) Clients enrolled in an MAA managed care plan are eligible for home infusion therapy and parenteral nutrition through that plan.

(3) Clients eligible for home health program services may receive home infusion related services according to WAC 388-551-2000 through 388-551-3000.

(4) To receive home infusion therapy, a client must:

- (a) Have a written physician order for all solutions and medications to be administered.
- (b) Be able to manage their infusion in one of the following ways:
 - (i) Independently;
 - (ii) With a volunteer caregiver who can manage the infusion; or
 - (iii) By choosing to self-direct the infusion with a paid caregiver (see WAC 388-71-0580).
- (c) Be clinically stable and have a condition that does not warrant hospitalization.

(d) Agree to comply with the protocol established by the infusion therapy provider for home infusions. If the client is not able to comply, the client's caregiver may comply.

(e) Consent, if necessary, to receive solutions and medications administered in the home through intravenous, enteral, epidural, subcutaneous, or intrathecal routes. If the client is not able to consent, the client's legal representative may consent.

(f) Reside in a residence that has adequate accommodations for administering infusion therapy including:

- (i) Running water;
- (ii) Electricity;
- (iii) Telephone access; and
- (iv) Receptacles for proper storage and disposal of drugs and drug products.

(5) To receive parenteral nutrition, a client must meet the conditions in subsection (4) of this section and:

- (a) Have one of the following that prevents oral or enteral intake to meet the client's nutritional needs:
 - (i) Hyperemesis gravidarum; or

(ii) An impairment involving the gastrointestinal tract that lasts three months or longer.

(b) Be unresponsive to medical interventions other than parenteral nutrition; and

(c) Be unable to maintain weight or strength.

(6) A client who has a functioning gastrointestinal tract is not eligible for parenteral nutrition program services when the need for parenteral nutrition is only due to:

- (a) A swallowing disorder;
 - (b) Gastrointestinal defect that is not permanent unless the client meets the criteria in subsection (7) of this section;
 - (c) A psychological disorder (such as depression) that impairs food intake;
 - (d) A cognitive disorder (such as dementia) that impairs food intake;
 - (e) A physical disorder (such as cardiac or respiratory disease) that impairs food intake;
 - (f) A side effect of medication; or
 - (g) Renal failure or dialysis, or both.
- (7) A client with a gastrointestinal impairment that is expected to last less than three months is eligible for parenteral nutrition only if:

(a) The client's physician or appropriate medial provider has documented in the client's medical record the gastrointestinal impairment is expected to last less than three months;

(b) The client meets all the criteria in subsection (4) of this section;

(c) The client has a written physician order that documents the client is unable to receive oral or tube feedings; and

(d) It is medically necessary for the gastrointestinal tract to be totally nonfunctional for a period of time.

(8) A client is eligible to receive intradialytic parenteral nutrition (IDPN) solutions when:

(a) The parenteral nutrition is not solely supplemental to deficiencies caused by dialysis; and

(b) The client meets the criteria in subsection (4) and (5) of this section and other applicable WAC.

[Statutory Authority: RCW 74.08.090, 74.09.530. 04-11-007, § 388-553-300, filed 5/5/04, effective 6/5/04.]

WAC 388-553-400 Home infusion therapy/parenteral nutrition program—Provider requirements.

(1) Eligible providers of home infusion supplies and equipment and parenteral nutrition solutions must:

(a) Have a signed core provider agreement with the medical assistance administration (MAA); and

(b) Be one of the following provider types:

- (i) Pharmacy provider;
- (ii) Durable medical equipment (DME) provider; or
- (iii) Infusion therapy provider.

(2) MAA pays eligible providers for home infusion supplies and equipment and parenteral nutrition solutions only when the providers:

(a) Are able to provide home infusion therapy within their scope of practice;

(b) Have evaluated each client in collaboration with the client's physician, pharmacist, or nurse to determine whether home infusion therapy/parenteral nutrition is an appropriate course of action;

(c) Have determined that the therapies prescribed and the client's needs for care can be safely met;

(d) Have assessed the client and obtained a written physician order for all solutions and medications administered to the client in the client's residence or in a dialysis center through intravenous, epidural, subcutaneous, or intrathecal routes;

(e) Meet the requirements in WAC 388-502-0020, including keeping legible, accurate and complete client charts, and providing the following documentation in the client's medical file:

(i) For a client receiving infusion therapy, the file must contain:

- (A) A copy of the written prescription for the therapy;
- (B) The client's age, height, and weight; and
- (C) The medical necessity for the specific home infusion service.

(ii) For a client receiving parenteral nutrition, the file must contain:

- (A) All the information listed in (e)(i) of this subsection;
- (B) Oral or enteral feeding trials and outcomes, if applicable;
- (C) Duration of gastrointestinal impairment; and
- (D) The monitoring and reviewing of the client's lab values:
 - (I) At the initiation of therapy;
 - (II) At least once per month; and
 - (III) When the client and/or the client's lab results are unstable.

[Statutory Authority: RCW 74.08.090, 74.09.530, 04-11-007, § 388-553-400, filed 5/5/04, effective 6/5/04.]

WAC 388-553-500 Home infusion therapy/parenteral nutrition program—Coverage, services, limitations, prior authorization, and reimbursement. (1) The home infusion therapy/parenteral nutrition program covers the following for eligible clients, subject to the limitations and restrictions listed:

(a) Home infusion supplies, limited to one month's supply per client, per calendar month.

(b) Parenteral nutrition solutions, limited to one month's supply per client, per calendar month.

(c) One type of infusion pump, one type of parenteral pump, and/or one type of insulin pump per client, per calendar month and as follows:

(i) All rent-to-purchase infusion, parenteral, and/or insulin pumps must be new equipment at the beginning of the rental period.

(ii) The department covers the rental payment for each type of infusion, parenteral, or insulin pump for up to twelve months. (The department considers a pump purchased after twelve months of rental payments.)

(iii) The department covers only one purchased infusion pump or parenteral pump per client in a five-year period.

(iv) The department covers only one purchased insulin pump per client in a four-year period.

(2) Covered supplies and equipment that are within the described limitations listed in subsection (1) of this section do not require prior authorization for reimbursement.

(3) Requests for supplies and/or equipment that exceed the limitations or restrictions listed in this section require prior authorization and are evaluated on an individual basis

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according to the provisions of WAC 388-501-0165 and 388-501-0169.

(4) Department reimbursement for equipment rentals and purchases includes the following:

- (a) Instructions to a client or a caregiver, or both, on the safe and proper use of equipment provided;
- (b) Full service warranty;
- (c) Delivery and pickup; and
- (d) Setup, fitting, and adjustments.

(5) Except as provided in subsection (6) of this section, the department does not pay separately for home infusion supplies and equipment or parenteral nutrition solutions:

(a) When a client resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

(b) When a client has elected and is eligible to receive the department's hospice benefit, unless both of the following apply:

- (i) The client has a preexisting diagnosis that requires parenteral support; and
- (ii) The preexisting diagnosis is not related to the diagnosis that qualifies the client for hospice.

(6) The department pays separately for a client's infusion pump, parenteral nutrition pump, insulin pump, solutions, and/or insulin infusion supplies when the client:

- (a) Resides in a nursing facility; and
- (b) Meets the criteria in WAC 388-553-300.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700, 06-24-036, § 388-553-500, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530, 04-11-007, § 388-553-500, filed 5/5/04, effective 6/5/04.]

Chapter 388-554 WAC ENTERAL NUTRITION PROGRAM

WAC

388-554-100	Enteral nutrition program—General.
388-554-200	Enteral nutrition program—Definitions.
388-554-300	Enteral nutrition program—Client eligibility.
388-554-400	Enteral nutrition program—Provider requirements.
388-554-500	Orally administered enteral nutrition products—Coverage, limitations, and reimbursement.
388-554-600	Tube-delivered enteral nutrition products and related equipment and supplies—Coverage, limitations, and reimbursement.
388-554-700	Enteral nutrition products and supplies—Prior authorization requirements.
388-554-800	Enteral nutrition program requirements for WIC program-eligible clients.

WAC 388-554-100 Enteral nutrition program—General. The medical assistance administration's (MAA's) enteral nutrition program covers the products, equipment, and supplies to provide medically necessary enteral nutrition to eligible medical assistance clients.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW, 05-04-059, § 388-554-100, filed 1/28/05, effective 3/1/05.]

WAC 388-554-200 Enteral nutrition program—Definitions. The following terms and definitions and those found in WAC 388-500-0005 apply to the enteral nutrition program:

"BMI" see "body mass index."

"Body mass index (BMI)" is a number that shows body weight adjusted by height, and is calculated using inches and pounds or meters and kilograms.

"Enteral nutrition" means the use of medically necessary nutritional products alone, or in combination with traditional food, when a client is unable to consume enough traditional food to meet nutritional requirements. Enteral nutritional solutions can be given orally or via feeding tubes.

"Enteral nutrition equipment" means durable medical feeding pumps and intravenous (IV) poles used in conjunction with nutrition supplies to dispense formula to a client.

"Enteral nutrition product" means enteral nutrition formulas and/or products.

"Enteral nutrition supplies" means the supplies, such as nasogastric, gastrostomy and jejunostomy tubes, necessary to allow nutritional support via the alimentary canal or any route connected to the gastrointestinal system.

"Growth chart" is a series of percentile curves that illustrate the distribution of select body measurements (i.e., height, weight, and age) in children published by the Centers for Disease Control and Prevention, National Center for Health Statistics. CDC growth charts: United States. <http://www.cdc.gov/growthcharts/>

"Nonfunctioning digestive tract" is caused by a condition that affects the body's alimentary organs and their ability to break down and digest nutrients.

"Orally administered enteral nutrition products" means enteral nutrition solutions and products that a client consumes orally for nutritional support.

"Tube-delivery" means the provision of nutritional requirements through a tube into the stomach or small intestine.

"WIC program" (Women, infants and children (WIC) program) is a special supplemental nutrition program managed by the department of health (DOH) that serves to safeguard the health of children up to age five, and low-income pregnant and breastfeeding women who are at nutritional risk by providing them with healthy, nutritious foods to supplement diets, information on healthy eating, and referral to health care.

"Women, infants and children (WIC) program." See **"WIC program."**

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-200, filed 1/28/05, effective 3/1/05.]

WAC 388-554-300 Enteral nutrition program—Client eligibility. (1) Clients in the following medical assistance programs are eligible to receive oral enteral nutrition products and tube-delivered enteral nutrition products and necessary equipment and supplies, subject to the limitations in this chapter and other applicable WAC:

- (a) Categorically needy program (CNP);
 - (b) Children's health insurance program (CHIP) (same scope of coverage as CNP);
 - (c) General assistance - Unemployable (GA-U);
 - (d) Limited casualty program - Medically needy program (LCP-MNP);
 - (e) Alien emergency medical program - CNP; and
 - (f) Alien emergency medical program - LCP-MNP.
- (2) All clients younger than age twenty-one must be evaluated by a certified dietitian with a current provider num-

ber within thirty days of initiation of enteral nutrition products, and periodically (at the discretion of the certified dietitian) while receiving enteral nutrition products. See WAC 388-554-400 (2)(h) for provider requirements.

(3) Clients enrolled in an MAA managed care plan are eligible for oral enteral nutrition products and tube-delivered enteral nutrition products and necessary equipment and supplies through that plan. If a client becomes enrolled in a managed care plan before MAA completes the purchase (or rental, if applicable) of prescribed enteral products, necessary equipment and supplies:

(a) MAA rescinds the purchase until the managed care primary care provider (PCP) evaluates the client; and

(b) The managed care plan's applicable reimbursement policies apply to the purchase of the products, equipment, or supplies, or rental of the equipment, as applicable.

(4) To receive orally administered enteral nutrition products, a client must:

(a) Have a valid written physician order from a physician, advanced registered nurse practitioner (ARNP), or physician assistant-certified (PA-C) for all enteral nutrition products;

(b) When required, have the provider obtain prior authorization as described in WAC 388-554-700;

(c) Meet the conditions in this section and other applicable WAC;

(d) Be able to manage their feedings in one of the following ways:

(i) Independently; or

(ii) With a caregiver who can manage the feedings; and

(e) Have at least one of the following medical conditions, subject to the criteria listed:

(i) Malnutrition/malabsorption as a result of a stated primary diagnosed disease. The client must have:

(A) A weight-for-length less than or equal to the fifth percentile if the client is younger than age three; or

(B) A body mass index (BMI) of:

(I) Less than or equal to the fifth percentile if the client is older than age three and younger than age eighteen; or

(II) Less than or equal to 18.5 if the client is age eighteen or older.

(ii) Acquired immune deficiency syndrome (AIDS). The client must be in a wasting state and have:

(A) A weight-for-length less than or equal to the fifth percentile if the client is younger than age three; or

(B) A BMI of:

(I) Less than or equal to the fifth percentile if the client is older than age three and younger than age eighteen; or

(II) Less than or equal to 18.5 if the client is age eighteen or older.

(iii) Amino acid, fatty acid, and carbohydrate metabolic disorders;

(iv) Dysphagia. The client must:

(A) Need to transition from tube feedings to oral feedings or require thickeners to aid swallowing; and

(B) Be evaluated by:

(I) A speech therapist; or

(II) An occupational therapist who specializes in dysphagia.

(v) Chronic renal failure. The client:

(A) Must be receiving dialysis; and

(B) Have a fluid restrictive diet in order to use nutrition bars.

(vi) Malignant cancer(s). The client must be receiving chemotherapy.

(vii) Decubitus pressure ulcers. The client must have:

(A) Stage three or greater decubitus pressure ulcers; and

(B) An albumin level of 3.2 or below.

(viii) Failure to thrive. The client must have a disease or medical condition that is only organic in nature and not due to cognitive, emotional, or psychological impairment. In addition, the client must have:

(A) A weight-for-length less than or equal to the fifth percentile if the client is younger than age three;

(B) A BMI of less than or equal to the fifth percentile if the client is at least age three but younger than age eighteen; and

(C) A BMI of less than or equal to 18.5, an albumin level of 3.5 or below, and a cholesterol level of one hundred sixty or below if the client is age eighteen or older.

(5) A client is eligible to receive delivery of orally administered enteral nutrition products in quantities sufficient to meet the client's medically authorized needs, not to exceed a one-month supply. To receive the next month's delivery of authorized products, the client's record must show documentation of the need to refill the products. See WAC 388-554-400 for provider requirements.

(6) To receive tube-delivered enteral nutrition products, necessary equipment and supplies, a client must:

(a) Have a valid written physician order from a physician, ARNP, or PA-C;

(b) Meet the conditions in this section and other applicable WAC; and

(c) Be able to manage their tube feedings in one of the following ways:

(i) Independently; or

(ii) With a caregiver who can manage the feedings; and

(d) Have at least one of the following medical conditions, subject to the criteria listed:

(i) A nonfunction or disease of the structures that normally permit food to reach the small bowel; or

(ii) A disease or condition of the small bowel that impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength that is properly proportioned to the client's overall health status.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-300, filed 1/28/05, effective 3/1/05.]

WAC 388-554-400 Enteral nutrition program—Provider requirements. (1) A provider of all oral enteral nutrition products and tube-delivered enteral nutrition products and necessary equipment and supplies must:

(a) Have a current core provider agreement with the medical assistance administration (MAA); and

(b) Be one of the following provider types:

(i) Pharmacy provider; or

(ii) Durable medical equipment (DME) provider.

(2) To be paid for oral enteral nutrition products and tube-delivered enteral nutrition products and necessary equipment and supplies, an eligible provider must:

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(a) Meet the requirements in WAC 388-502-0020 and other applicable WAC;

(b) Obtain prior authorization (PA), if required, before delivery to the client and before billing MAA. See WAC 388-554-700 for PA requirements;

(c) Deliver orally administered enteral nutrition products in quantities sufficient to meet a client's medically authorized needs, not to exceed a one-month supply;

(d) Bill MAA for the authorized products and submit a claim for payment to MAA with a date of service being the same as the shipping date;

(e) Confirm with the client and document in the client's record that the next month's delivery of authorized orally administered enteral nutrition products is necessary (see WAC 388-554-300(5)). MAA will not reimburse automatic periodic delivery of products;

(f) Notify and inform the client's physician if the client has indicated the product is not being used as prescribed;

(g) Keep legible, accurate, and complete charts in the client's record to justify the medical necessity of the items provided and include:

(i) For each item billed, a copy of the prescription. The prescription must:

(A) Be signed and dated by the prescribing physician;

(B) List the client's medical condition and exact daily caloric amount of needed enteral product; and

(C) State the reason why the client is unable to consume enough traditional food to meet nutritional requirements.

(ii) The medical reason the specific enteral product, equipment, and/or supply is prescribed; and

(iii) For a client who meets the women, infants and children (WIC) program's target population as defined in WAC 388-554-200, verification from the WIC program that the client:

(A) Is not eligible for WIC program services;

(B) Is eligible for WIC program services, but nutritional needs exceed the WIC program's maximum per calendar month allotment; or

(C) The WIC program cannot provide the prescribed product.

(h) For a client younger than age twenty-one, retain a copy of each required certified dietitian evaluation, as described in WAC 388-554-300(2).

(3) MAA may recoup any payment made to a provider for authorized enteral nutrition products if the requirements in subsection (2) of this section and other applicable WAC are not met.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-400, filed 1/28/05, effective 3/1/05.]

WAC 388-554-500 Orally administered enteral nutrition products—Coverage, limitations, and reimbursement. (1) The enteral nutrition program covers and reimburses medically necessary orally administered enteral nutrition products, subject to:

(a) Prior authorization requirements under WAC 388-554-700;

(b) Duration periods determined by the department;

(c) Delivery requirements under WAC 388-554-400(2); and

(d) The provisions in other applicable WAC.

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(2) Except as provided in subsection (3) of this section, the department does not pay separately for orally administered enteral nutrition products:

(a) When a client resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

(b) When a client has elected and is eligible to receive the department's hospice benefit, unless both of the following apply:

(i) The client has a pre-existing medical condition that requires enteral nutritional support; and

(ii) The pre-existing medical condition is not related to the diagnosis that qualifies the client for hospice.

(3) The department pays separately for a client's orally administered enteral nutrition products when the client:

(a) Resides in a nursing facility;

(b) Meets the criteria in WAC 388-554-300; and

(c) Needs enteral nutrition products to meet one hundred percent of the client's nutritional needs.

(4) The department does not cover or pay for orally administered enteral nutrition products when the client's nutritional need can be met using traditional foods, baby foods, and other regular grocery products that can be pulverized or blenderized and used to meet the client's caloric and nutritional needs.

(5) The department:

(a) Determines reimbursement for oral enteral nutrition products according to a set fee schedule;

(b) Considers Medicare's current fee schedule when determining maximum allowable fees;

(c) Considers vendor rate increases or decreases as directed by the Legislature; and

(d) Evaluates and updates the maximum allowable fees for oral enteral nutrition products at least once per year.

(6) The department evaluates a request for orally administered enteral nutrition products that are in excess of the enteral nutrition program's limitations or restrictions, according to the provisions of WAC 388-501-0165 and 388-501-0169.

(7) The department evaluates a request for orally administered enteral nutrition products that are listed as noncovered in this chapter according to the provisions of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-554-500, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-500, filed 1/28/05, effective 3/1/05.]

WAC 388-554-600 Tube-delivered enteral nutrition products and related equipment and supplies—Coverage, limitations, and reimbursement. (1) The enteral nutrition program covers and reimburses the following, subject to the limitations listed in this section and the provisions in other applicable WAC:

(a) Tube-delivered enteral nutrition products;

(b) Tube-delivery supplies;

(c) Enteral nutrition pump rental and purchase;

(d) Nondisposable intravenous (IV) poles required for enteral nutrition product delivery; and

(e) Repairs to equipment.

(2) The department covers up to twelve months of rental payments for enteral nutrition equipment. After twelve months of rental, the department considers the equipment purchased and it becomes the client's property.

(3) The department requires a provider to furnish clients new or used equipment that includes full manufacturer and dealer warranties for one year.

(4) The department covers only one:

(a) Purchased pump per client in a five year period; and

(b) Purchased nondisposable IV pole per client for that client's lifetime.

(5) The department's reimbursement for covered enteral nutrition equipment and necessary supplies includes all of the following:

(a) Any adjustments or modifications to the equipment that are required within three months of the date of delivery. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Fitting and set-up; and

(c) Instruction to the client or the client's caregiver in the appropriate use of the equipment and necessary supplies.

(6) A provider is responsible for any costs incurred to have another provider repair equipment if all of the following apply:

(a) Any equipment that the department considers purchased requires repair during the applicable warranty period;

(b) The provider is unable to fulfill the warranty; and

(c) The client still needs the equipment.

(7) If a rental equipment the department considers to have been purchased must be replaced during the warranty period, the department recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the equipment delivered to the client. All of the following must apply:

(a) The provider is unable to fulfill the warranty; and

(b) The client still needs the equipment.

(8) The department rescinds any authorization for prescribed equipment if the equipment was not delivered to the client before the client:

(a) Loses medical eligibility;

(b) Becomes covered by a hospice agency and the equipment is used in the treatment of the terminal diagnosis or related condition(s);

(c) Becomes eligible for a department-contracted managed care plan; or

(d) Dies.

(9) Except as provided in subsection (10) of this section, the department does not pay separately for tube-delivered enteral nutrition products or necessary equipment or supplies when a client:

(a) Resides in a state-owned facility (i.e., state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital).

(b) Has elected and is eligible to receive the department's hospice benefit, unless both of the following apply:

(i) The client has a preexisting medical condition that requires enteral nutritional support; and

(ii) The preexisting medical condition is not related to the diagnosis that qualifies the client for hospice.

(10) The department pays separately for a client's tube-delivered enteral nutrition products and necessary equipment and supplies when:

- (a) The client resides in a nursing facility;
- (b) The client meets the eligibility criteria in WAC 388-554-300; and
- (c) Use of enteral nutrition products meets one hundred percent of the client's nutritional needs.

(11) The department determines reimbursement for tube-delivered enteral nutrition products and necessary equipment and supplies using the same criteria described in WAC 388-554-500(5).

(12) The department evaluates a request for tube-delivered enteral nutrition products and necessary equipment and supplies that are in excess of the enteral nutrition program's limitations or restrictions, according to the provisions of WAC 388-501-0165 and 388-501-0169.

(13) The department evaluates a request for tube-delivered enteral nutrition products and necessary equipment and supplies, that are listed as noncovered in this chapter, under the provision of WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-554-600, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-600, filed 1/28/05, effective 3/1/05.]

WAC 388-554-700 Enteral nutrition products and supplies—Prior authorization requirements. (1) All requests for oral enteral nutrition products, repairs to equipment, and replacement of necessary supplies for tube-delivery of enteral nutrition products require prior authorization as described in this section. See also WAC 388-501-0165.

(2) When MAA receives an initial request for prior authorization, the prescription(s) for those items cannot be older than three months from the date MAA receives the request.

(3) MAA may authorize orally administered enteral nutrition products that are listed in MAA's published issuances, including billing instructions and numbered memoranda, only if medical necessity is established and the provider furnishes all of the following information to MAA:

(a) A copy of the signed and dated physician order completed by the prescribing physician, advanced registered nurse practitioner (ARNP), or physician assistant-certified (PA-C), which includes client's medical condition and exact daily caloric amount of prescribed enteral nutrition product;

(b) Documentation from the client's physician, ARNP, or PA-C that verifies all of the following:

(i) The client has one of the medical conditions listed in WAC 388-554-300 (4)(e);

(ii) The client's physical limitations and expected outcome;

(iii) The client's current clinical nutritional status, including the relationship between the client's diagnosis and nutritional need;

(iv) For a client age eighteen or older, the client's recent weight loss history and a comparison of the client's actual weight to ideal body weight and current body mass index (BMI);

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(v) For a client younger than age eighteen, the client's growth history and a comparison to expected weight gain, and:

(A) An evaluation of the weight-for-length percentile if the client is younger than age three; or

(B) An evaluation of the BMI if the client is older than age three and younger than age eighteen.

(v) Documentation explaining why less costly, equally effective products or traditional foods are not appropriate (see WAC 388-554-500(4));

(vi) The client's likely expected outcome if enteral nutritional support is not provided; and

(vii) Number of days or months the enteral nutrition products, equipment, and/or necessary supplies are required.

(4) A provider may resubmit a request for prior authorization for oral enteral nutrition products or replacement of necessary supplies for tube-delivery of enteral nutrition products that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-700, filed 1/28/05, effective 3/1/05.]

WAC 388-554-800 Enteral nutrition program requirements for WIC program-eligible clients. Clients who qualify for supplemental nutrition from the women, infants, and children (WIC) program must receive supplemental nutrition through that program. The medical assistance administration (MAA) may cover the enteral nutrition products and supplies for WIC program-eligible clients only when all of the following are met:

(1) The provider requests prior authorization for the enteral nutrition product or supply;

(2) Documentation from the WIC program is attached to the request form that verifies:

(a) The client's enteral nutrition need is in excess of WIC program allocations; or

(b) The WIC program cannot supply the prescribed product; and

(3) The client meets the enteral nutrition program requirements in this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-800, filed 1/28/05, effective 3/1/05.]

Chapter 388-556 WAC

MEDICAL CARE—OTHER SERVICES PROVIDED

WAC

388-556-0100	Chemical dependency treatment services.
388-556-0200	Chiropractic services for children.
388-556-0300	Personal care services.
388-556-0400	Limitations on services available to recipients of categorically needy medical assistance.
388-556-0500	Medical care services under state-administered cash programs.
388-556-0600	Mental health services.

WAC 388-556-0100 Chemical dependency treatment services. The department covers chemical dependency treatment services, as defined in chapter 388-805 WAC, for Medicaid and children's health clients. Coverage is limited to services performed by providers defined in WAC 388-502-0010.

[Statutory Authority: RCW 74.08.090, 74.09.035, and 74.50.055. 00-18-032, § 388-556-0100, filed 8/29/00, effective 9/29/00.]

WAC 388-556-0200 Chiropractic services for children. (1) MAA will pay only for chiropractic services:

- (a) For MAA clients who are:
 - (i) Under twenty-one years of age; and
 - (ii) Referred by a screening provider under the healthy kids/early and periodic screening, diagnosis, and treatment (EPSDT) program.
- (b) That are:
 - (i) Medically necessary, safe, effective, and not experimental;
 - (ii) Provided by a chiropractor licensed in the state where services are provided; and
 - (iii) Within the scope of the chiropractor's license.
- (c) Limited to:
 - (i) Chiropractic manipulative treatments of the spine; and
 - (ii) X rays of the spine.
- (2) Chiropractic services are paid according to fees established by MAA using methodology set forth in WAC 388-531-1850.

[Statutory Authority: RCW 74.08.090, 74.09.035. 00-16-031, § 388-556-0200, filed 7/24/00, effective 8/24/00.]

WAC 388-556-0300 Personal care services. The department pays for personal care services for a Title XIX categorically needy Medicaid client as provided under chapter 388-71 WAC, Home and community programs.

[Statutory Authority: RCW 74.08.090. 00-17-057, § 388-556-0300, filed 8/9/00, effective 9/9/00.]

WAC 388-556-0400 Limitations on services available to recipients of categorically needy medical assistance. (1) Organ transplants are limited to the cornea, heart, heart-lung, kidney, kidney-pancreas, liver, pancreas, single lung, and bone marrow.

(2) The department shall provide treatment, dialysis, equipment, and supplies for acute and chronic nonfunctioning kidneys when the client is in the home, hospital, or kidney center as described under WAC 388-540-005.

(3) Detoxification and medical stabilization are provided to chemically-using pregnant women in a hospital.

(4) The department shall provide detoxification of acute alcohol or other drug intoxication only in a certified detoxification center or in a general hospital having a detoxification provider agreement with the department.

(5) The department shall provide outpatient chemical dependency treatment in programs qualified under chapter 275-25 WAC and certified under chapter 275-19 WAC or its successor.

(6) The department may require a second opinion and/or consultation before the approval of any elective surgical procedure.

(7) The department designates diagnoses that may require surgical intervention:

- (a) Performed in other than a hospital in-patient setting; and
- (b) Requiring prior approval by the department for a hospital admission.

[Title 388 WAC—p. 1174]

[Statutory Authority: RCW 74.08.090. 01-02-075, § 388-556-0400, filed 12/29/00, effective 1/29/01. 00-11-183, recodified as § 388-556-0400, filed 5/24/00, effective 5/24/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-86-005, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-86-005, filed 10/25/95, effective 10/28/95; 93-17-038 (Order 3620), § 388-86-005, filed 8/11/93, effective 9/11/93; 92-03-084 (Order 3309), § 388-86-005, filed 1/15/92, effective 2/15/92; 90-17-122 (Order 3056), § 388-86-005, filed 8/21/90, effective 9/21/90; 90-12-051 (Order 3009), § 388-86-005, filed 5/31/90, effective 7/1/90; 89-18-033 (Order 2860), § 388-86-005, filed 8/29/89, effective 9/29/89; 89-13-005 (Order 2811), § 388-86-005, filed 6/8/89; 88-06-083 (Order 2600), § 388-86-005, filed 3/2/88. Statutory Authority: 1987 1st ex.s. c 7. 88-02-034 (Order 2580), § 388-86-005, filed 12/31/87. Statutory Authority: RCW 74.08.090. 87-12-050 (Order 2495), § 388-86-005, filed 6/1/87; 84-02-052 (Order 2060), § 388-86-005, filed 1/4/84; 83-17-073 (Order 2011), § 388-86-005, filed 8/19/83; 83-01-056 (Order 1923), § 388-86-005, filed 12/15/82; 82-10-062 (Order 1801), § 388-86-005, filed 5/5/82; 82-01-001 (Order 1725), § 388-86-005, filed 12/3/81; 81-16-033 (Order 1685), § 388-86-005, filed 7/29/81; 81-10-015 (Order 1647), § 388-86-005, filed 4/27/81; 80-15-034 (Order 1554), § 388-86-005, filed 10/9/80; 78-06-081 (Order 1299), § 388-86-005, filed 6/1/78; 78-02-024 (Order 1265), § 388-86-005, filed 1/13/78; Order 994, § 388-86-005, filed 12/31/74; Order 970, § 388-86-005, filed 9/13/74; Order 911, § 388-86-005, filed 3/1/74; Order 858, § 388-86-005, filed 9/27/73; Order 781, § 388-86-005, filed 3/16/73; Order 738, § 388-86-005, filed 11/22/72; Order 680, § 388-86-005, filed 5/10/72; Order 630, § 388-86-005, filed 11/24/71; Order 581, § 388-86-005, filed 7/20/71; Order 549, § 388-86-005, filed 3/31/71, effective 5/1/71; Order 453, § 388-86-005, filed 5/20/70, effective 6/20/70; Order 419, § 388-86-005, filed 12/31/69; Order 264 (part); § 388-86-005, filed 11/24/67.]

WAC 388-556-0500 Medical care services under state-administered cash programs. Medical care services (MCS) are state-administered medical care services provided to a client receiving cash benefits under the general assistance-unemployable (GA-U) program or the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program. For a client eligible for MCS:

(1) The department of social and health services (DSHS) covers only the medically necessary services within the applicable program limitations listed in the MCS column under WAC 388-501-0060.

(2) DSHS does not cover medical services received outside the state of Washington unless the medical services are provided in a border area listed under WAC 388-501-0175.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-556-0500, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.035. 01-01-009, § 388-556-0500, filed 12/6/00, effective 1/6/01.]

WAC 388-556-0600 Mental health services. Mental health-related services are available to eligible clients under chapter 388-862 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.530, 71.24.035. 00-24-053, § 388-556-0600, filed 11/30/00, effective 12/31/00.]

Chapter 388-561 WAC

TRUSTS, ANNUITIES, AND LIFE ESTATES— EFFECT ON MEDICAL PROGRAMS

WAC

388-561-0001	Definitions.
388-561-0100	Trusts.
388-561-0200	Annuities.
388-561-0300	Life estates.

WAC 388-561-0001 Definitions. "Annuitant" means a person or entity that receives the income from an annuity.

(2007 Ed.)

"Annuity" means a policy, certificate or contract that is an agreement between two parties in which one party pays a lump sum to the other, and the other party agrees to guarantee payment of a set amount of money over a set amount of time. The annuity may be purchased at one time or over a set period of time and may be bought individually or with a group. It may be revocable or irrevocable. The party guaranteeing payment can be an:

- (1) Individual; or
- (2) Insurer or similar body licensed and approved to do business in the jurisdiction in which the annuity is established.

"Beneficiary" means an individual(s) designated in the trust who benefits from the trust. The beneficiary can also be called the grantee. The beneficiary and the grantor may be the same person.

"Designated for medical expenses" means the trustee may use the trust to pay the medical expenses of the beneficiary. The amount of the trust that is designated for medical expenses is considered an available resource to the beneficiary. Payments are a third party resource.

"Disbursement" or "distribution" means any payment from the principal or proceeds of a trust, annuity, or life estate to the beneficiary or to someone on their behalf.

"Discretion of the trustee" means the trustee may decide what portion (up to the entire amount) of the principal of the trust will be made available to the beneficiary.

"Exculpatory clause" means there is some language in the trust that legally limits the authority of the trustee to distribute funds from a trust if the distribution would jeopardize eligibility for government programs including Medicaid.

"For the sole benefit of" means that for a transfer to a spouse, blind or disabled child, or disabled individual, the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary.

"Grantor" means an individual who uses his assets or funds to create a trust. The grantor may also be the beneficiary.

"Income beneficiary" means the person receiving the payments may only get the proceeds of the trust. The principal is not available for disbursements. If this term is used, the principal of the trust is an unavailable resource.

"Irrevocable" means the legal instrument cannot be changed or terminated in any way by anyone.

"Life estate" means an ownership interest in a property only during the lifetime of the person(s) owning the life estate. In some cases, the ownership interest lasts only until the occurrence of some specific event, such as remarriage of the life estate owner. A life estate owner may not have the legal title or deed to the property, but may have rights to possession, use, income and/or selling their life estate interest in the property.

"Principal" means the assets that make up the entity. The principal includes income earned on the principal that has not been distributed. The principal is also called the corpus.

"Proceeds" means the income earned on the principal. It is usually interest, dividends, or rent. When the proceeds are not distributed, they become part of the principal.

"Pooled trust" means a trust meeting all of the following conditions:

- (1) It contains funds of more than one disabled individual, combined for investment and management purposes;
- (2) It is for the sole benefit of disabled individuals (as determined by SSA criteria);
- (3) It was created by the disabled individuals, their parents, grandparents, legal guardians, or by a court;
- (4) It is managed by a nonprofit association with a separate account maintained for each beneficiary; and
- (5) It contains a provision that upon the death of the individual, for any funds not retained by the trust, the state will receive all amounts remaining in the individual's separate account up to the total amount of Medicaid paid on behalf of that individual.

"Revocable" means the legal instrument can be changed or terminated by the grantor, or by petitioning the court. A legal instrument that is called irrevocable, but that can be terminated if some action is taken, is revocable for the purposes of this section.

"Sole-benefit trust" means an irrevocable trust established for the sole-benefit of a spouse, blind or disabled child, or disabled individual. In a sole-benefit trust no one but the individual named in the trust receives benefit from the trust in any way either at the time the trust is established or at any time during the life of the primary beneficiary. A sole-benefit trust may allow for reasonable costs to trustees for management of the trust and reasonable costs for investment of trust funds.

"Special needs trust" means an irrevocable trust meeting all of the following conditions:

- (1) It is for the sole benefit of a disabled individual (as determined by SSA criteria) under sixty-five years old;
- (2) It was created by the individual's parent, grandparent, legal guardian, or by a court; and
- (3) It contains a provision that upon the death of the individual, the state will receive the amounts remaining in the trust up to the total amount of Medicaid paid on behalf of the individual.

"Testamentary trust" means a trust created by a will from the estate of a deceased person. The trust is paid out according to the will.

"Trust" means property (such as a home, cash, stocks, or other assets) is transferred to a trustee for the benefit of the grantor or another party. The department includes in this definition any other legal instrument similar to a trust. For annuities, refer to WAC 388-561-0200.

"Trustee" means an individual, bank, insurance company or any other entity that manages and administers the trust for the beneficiary.

"Undue hardship" means the client would be unable to meet shelter, food, clothing, and health care needs if the department applied the transfer of assets penalty.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.-575. 03-06-048, § 388-561-0001, filed 2/28/03, effective 4/1/03. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0001, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0100 Trusts. (1) The department determines how trusts affect eligibility for medical programs.

(2) The department disregards trusts established, on or before April 6, 1986, for the sole benefit of a client who lives in an intermediate care facility for the mentally retarded (ICMR).

(3) For trusts established on or before August 10, 1993 the department counts the following:

(a) If the trust was established by the client, client's spouse, or the legal guardian, the maximum amount of money (payments) allowed to be distributed under the terms of the trust is considered available income to the client if all of the following conditions apply:

(i) The client could be the beneficiary of all or part of the payments from the trust;

(ii) The distribution of payments is determined by one or more of the trustees; and

(iii) The trustees are allowed discretion in distributing payments to the client.

(b) If an irrevocable trust doesn't meet the conditions under subsection (3)(a) then it is considered either:

(i) An **unavailable** resource, if the client established the trust for a beneficiary other than the client or the client's spouse; or

(ii) An **available** resource in the amount of the trust's assets that:

(A) The client could access; or

(B) The trustee distributes as actual payments to the client and the department applies the transfer of assets rules of WAC 388-513-1364 or 388-513-1365.

(c) If a revocable trust doesn't meet the description under subsection (3)(a):

(i) The full amount of the trust is an available resource of the client if the trust was established by:

(A) The client;

(B) The client's spouse, and the client lived with the spouse; or

(C) A person other than the client or the client's spouse only to the extent the client had access to the assets of the trust.

(ii) Only the amount of money actually paid to the client from the trust is an available resource when the trust was established by:

(A) The client's spouse, and the client did not live with the spouse; or

(B) A person other than the client or the client's spouse; and

(C) Payments were distributed by a trustee of the trust.

(iii) The department considers the funds a resource, not income.

(4) For trusts established on or after August 11, 1993:

(a) The department considers a trust as if it were established by the client when:

(i) The assets of the trust, as defined under WAC 388-470-0005, are at least partially from the client;

(ii) The trust is not established by will; and

(iii) The trust was established by:

(A) The client or the client's spouse;

(B) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the client or the client's spouse; or

(C) A person, including a court or administrative body, acting at the direction of or upon the request of the client or the client's spouse.

(b) Only the assets contributed to the trust by the client are available to the client when part of the trust assets were contributed by any other person.

(c) The department does not consider:

(i) The purpose for establishing a trust;

(ii) Whether the trustees have, or exercise, any discretion under the terms of the trust;

(iii) Restrictions on when or whether distributions may be made from the trust; or

(iv) Restrictions on the use of distributions from the trust.

(d) For a revocable trust established as described under subsection (4)(a) of this section:

(i) The full amount of the trust is an available resource of the client;

(ii) Payments from the trust to or for the benefit of the client are income of the client; and

(iii) Any payments from the trust, other than payments described under subsection (4)(d)(ii), are considered a transfer of client assets.

(e) For an irrevocable trust established as described under subsection (4)(a) of this section:

(i) Any part of the trust from which payment can be made to or for the benefit of the client is an available resource. When payment is made from such irrevocable trusts, we will consider the payments as:

(A) Income to the client when payment is to or for the client's benefit; or

(B) The transfer of an asset when payment is made to any person for any purpose other than the client's benefit;

(ii) A trust from which a payment cannot be made to or for the client's benefit is a transfer of assets. For such a trust, the transfer of assets is effective the date:

(A) The trust is established; or

(B) The client is prevented from receiving benefit, if this is after the trust is established.

(iii) The value of the trust includes any payments made from the trust after the effective date of the transfer.

(5) For trusts established on or after August 1, 2003:

(a) The department considers a trust as if it were established by the client when:

(i) The assets of the trust, as defined under WAC 388-470-0005, are at least partially from the client or the client's spouse;

(ii) The trust is not established by will; and

(iii) The trust was established by:

(A) The client or the client's spouse;

(B) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the client or the client's spouse; or

(C) A person, including a court or administrative body, acting at the direction of or upon the request of the client or the client's spouse.

(b) Only the assets contributed other than by will to the trust by either the client or the client's spouse are available to the client or the client's spouse when part of the trust assets were contributed by persons other than the client or the client's spouse.

(c) The department does not consider:

- (i) The purpose for establishing a trust;
- (ii) Whether the trustees have, or exercise, any discretion under the terms of the trust;
- (iii) Restrictions on when or whether distributions may be made from the trust; or
- (iv) Restrictions on the use of the distributions from the trust.

(d) For a revocable trust established as described under subsection (5)(a) of this section:

- (i) The full amount of the trust is an available resource of the client;
- (ii) Payments from the trust to or for the benefit of the client are income of the client; and
- (iii) Any payments from the trust, other than payments described under subsection (5)(d)(ii), are considered a transfer of client assets.

(e) For an irrevocable trust established as described under subsection (5)(a) of this section:

(i) Any part of the trust from which payment can be made to or for the benefit of the client or the client's spouse is an available resource. When payment is made from such irrevocable trusts, the department will consider the payment as:

(A) Income to the client or the client's spouse when payment is to or for the benefit of either the client or the client's spouse; or

(B) The transfer of an asset when payment is made to any person for any purpose other than the benefit of the client or the client's spouse;

(ii) A trust from which a payment cannot be made to or for the benefit of the client or client's spouse is a transfer of assets. For such a trust, the transfer of assets is effective the date:

(A) The trust is established; or

(B) The client or client's spouse is prevented from receiving benefit, if this is after the trust is established.

(iii) The value of the trust includes any payments made from the trust after the effective date of the transfer.

(6) Trusts established on or after August 11, 1993 are not considered available resources if they contain the assets of either:

(a) A person sixty-four years of age or younger who is disabled as defined by SSI criteria (as described in WAC 388-503-0510) and the trust:

(i) Is established for the sole benefit of this person by their parent, grandparent, legal guardian, or a court; and

(ii) Stipulates that the state will receive all amounts remaining in the trust upon the death of the client, up to the amount of Medicaid spent on the client's behalf; or

(b) A person regardless of age, who is disabled as defined by SSI criteria (as described in WAC 388-503-0510), and the trust meets the following criteria:

(i) It is irrevocable;

(ii) It is established and managed by a nonprofit association;

(iii) A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;

(iv) Accounts in the trust are established solely for the benefit of the disabled individual as defined by the SSI program;

(v) Accounts in the trust are established by:

(A) The individual;

(B) The individual's spouse, where the spouse is acting in the place of or on behalf of the individual;

(C) The individual's parent, grandparent, legal guardian;

(D) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(E) A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(vi) It stipulates that either:

(A) The state will receive all amounts remaining in the client's separate account upon the death of the client, up to the amount of Medicaid spent on the client's behalf; or

(B) The funds will remain in the trust to benefit other disabled beneficiaries of the trust.

(7) Trusts established on or after August 1, 2003 are not considered available resources if they contain the assets of either:

(a) A person sixty-four years of age or younger who is disabled as defined by SSI criteria (as described in WAC 388-503-0510) and the trust:

(i) Is irrevocable;

(ii) Is established for the sole benefit of this person by their parent, grandparent, legal guardian, or a court; and

(iii) Stipulates that the state will receive all amounts remaining in the trust upon the death of the client, the end of the disability, or the termination of the trust, whichever comes first, up to the amount of Medicaid spent on the client's behalf; or

(b) A person regardless of age, who is disabled as defined by SSI criteria (as described in WAC 388-503-0510), and the trust meets the following criteria:

(i) It is irrevocable;

(ii) It is established and managed by a nonprofit association;

(iii) A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;

(iv) Accounts in the trust are established solely for the benefit of the disabled individual as defined by the SSI program;

(v) Accounts in the trust are established by:

(A) The individual;

(B) The individual's spouse, where the spouse is acting in the place of or on behalf of the individual;

(C) The individual's parent, grandparent, legal guardian;

(D) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(E) A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(vi) It stipulates that either:

(A) The state will receive all amounts remaining in the client's separate account upon the death of the client, the end of the disability, or the termination of the trust, whichever comes first, up to the amount of Medicaid spent on the client's behalf; or

(B) The funds will remain in the trust to benefit other disabled beneficiaries of the trust.

(8) Trusts described in subsection (6)(a) and (7)(a) continue to be considered an unavailable resource even after the individual becomes age sixty-five. However, additional transfers made to the trust after the individual reaches age sixty-five would be considered an available resource and would be subject to a transfer penalty.

(9) The department does not apply a penalty period to transfers into a trust described in subsections (6)(b) and (7)(b) if the trust is established for the benefit of a disabled individual under age sixty-five as described in WAC 388-513-1364 and the transfer is made to the trust before the individual reaches age sixty-five.

(10) The department considers any payment from a trust to the client to be unearned income. Except for trusts described in subsection (6), the department considers any payment to or for the benefit of either the client or client's spouse as described in subsections (4)(e) and (5)(e) to be unearned income.

(11) The department will only count income received by the client from trusts and not the principal, if:

(a) The beneficiary has no control over the trust; and

(b) It was established with funds of someone other than the client, spouse or legally responsible person.

(12) This section does not apply when a client establishes that undue hardship exists.

(13) WAC 388-513-1364, 388-513-1365, and 388-513-1366 apply under this section when the department determines that a trust or a portion of a trust is a transfer of assets.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. 03-13-113, § 388-561-0100, filed 6/17/03, effective 8/1/03. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0100, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0200 Annuities. (1) The department determines how annuities affect eligibility for medical programs.

(2) A revocable annuity is considered an available resource.

(3) The income from an irrevocable annuity, meeting the requirements of this section, is considered in determining eligibility and the amount of participation in the total cost of care. The annuity itself is not considered a resource or income.

(4) An annuity established on or after May 1, 2001 will be considered an available resource unless it:

(a) Is irrevocable;

(b) Is paid out in equal monthly amounts within the actuarial life expectancy of the annuitant;

(c) Is issued by an individual, insurer or other body licensed and approved to do business in the jurisdiction in which the annuity is established; and

(d) Names the department as the beneficiary of the remaining funds up to the total of Medicaid funds spent on the client during the client's lifetime. This subsection only applies if the annuity is in the client's name.

(5) An irrevocable annuity established on or after May 1, 2001 that is not scheduled to be paid out in equal monthly amounts, can still be considered an unavailable resource if:

(a) The full pay out is within the actuarial life expectancy of the client; and

(b) The client:

(i) Changes the scheduled pay out into equal monthly payments within the actuarial life expectancy of the annuitant; or

(ii) Requests that the department calculate and budget the payments as equal monthly payments within the actuarial life expectancy of the annuitant. The income from the annuity remains unearned income to the annuitant.

(6) An irrevocable annuity, established prior to May 1, 2001 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource transferred without adequate consideration at the time it was purchased. A penalty period of ineligibility, determined according to WAC 388-513-1365, may be imposed equal to the amount of the annuity to be paid out in excess of the annuitant's actuarial life expectancy.

(7) An irrevocable annuity, established on or after May 1, 2001 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource transferred without adequate consideration at the time it was purchased. A penalty may be imposed equal to the amount of the annuity to be paid out in excess of the annuitant's actuarial life expectancy. The penalty for a client receiving:

(a) Long-term care benefits will be a period of ineligibility (see WAC 388-513-1365).

(b) Other medical benefits will be ineligibility in the month of application.

(8) An irrevocable annuity is considered unearned income when the annuitant is:

(a) The client;

(b) The spouse of the client;

(c) The blind or disabled child of the client; or

(d) A person designated to use the annuity for the sole benefit of the client, client's spouse, or a blind or disabled child of the client.

(9) An annuity is not considered an available resource when there is a joint owner, co-annuitant or an irrevocable beneficiary who will not agree to allow the annuity to be cashed, UNLESS the joint owner or irrevocable beneficiary is the community spouse. In the case of a community spouse, the cash surrender value of the annuity is considered an available resource and counts toward the maximum community spouse resource allowance.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0200, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0300 Life estates. (1) The department determines how life estates affect eligibility for medical programs.

(2) A life estate is an excluded resource when either of the following conditions apply:

(a) It is property other than the home, which is essential to self-support or part of an approved plan for self-support; or

(b) It cannot be sold due to the refusal of joint life estate owner(s) to sell.

(3) Remaining interests of excluded resources in subsection (2) may be subject to transfer of asset penalties under WAC 388-513-1365.

(4) Only the client's proportionate interest in the life estate is considered when there is more than one owner of the life estate.

(5) A client or a client's spouse, who transfers legal ownership of a property to create a life estate, may be subject to transfer-of-resource penalties under WAC 388-513-1365.

(6) When the property of a life estate is transferred for less than fair market value (FMV), the department treats the transfer in one of two ways:

(a) For noninstitutional medical, the value of the uncompensated portion of the resource is combined with other non-excluded resources; or

(b) For institutional medical, a period of ineligibility will be established according to WAC 388-513-1365.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0300, filed 3/5/01, effective 5/1/01.]

Chapter 388-700 WAC **JUVENILE REHABILITATION** **ADMINISTRATION—PRACTICES AND** **PROCEDURES** (Formerly chapter 275-37 WAC)

WAC

388-700-0005 What definitions apply to this chapter?

BACKGROUND CHECKS

388-700-0010 When are background checks required?
388-700-0015 What crimes prohibit "regular access" to juveniles?
388-700-0020 What are the reporting requirements for criminal convictions?
388-700-0025 Is a contracting agency required to do background checks?

SEXUAL MISCONDUCT BY JRA EMPLOYEES

388-700-0030 What action must be taken if there is a belief that sexual misconduct by a JRA employee has occurred?
388-700-0035 What disciplinary action is required if there is evidence that sexual misconduct by a JRA employee has occurred?

SEXUAL MISCONDUCT BY JRA CONTRACTORS

388-700-0040 What action must be taken if there is a belief that sexual misconduct by a JRA contractor has occurred?
388-700-0045 What action is required if there is evidence that sexual misconduct by a JRA contractor has occurred?

SEXUAL MISCONDUCT BY JRA EMPLOYEES OR CONTRACTORS

388-700-0050 What action will be taken if an employee or contractor has sexual intercourse or sexual contact against their will?

WAC 388-700-0005 What definitions apply to this chapter? The following definitions apply to this chapter:

"Assistant secretary" means the assistant secretary of the juvenile rehabilitation administration.

"Community facility" means a group care facility operated for the care of juveniles committed to the department under RCW 13.40.185. A county detention facility that houses juveniles committed to the department under RCW 13.40.185 pursuant to an interagency agreement with the department is not a community facility.

"Contractor" means a department of social and health services (DSHS)/juvenile rehabilitation administration (JRA) contractor and all employees and all subcontractors of that contractor.

(2007 Ed.)

"Department" means the department of social and health services.

"JRA" means the juvenile rehabilitation administration, department of social and health services.

"JRA youth" or **"juvenile"** means a juvenile offender under the jurisdiction of JRA or a youthful offender under the jurisdiction of the department of corrections who is placed in a JRA facility.

"Limited access" means supervised access to a juvenile(s) that is the result of the person's regularly scheduled activities or work duties.

"Preponderance of the evidence" means a determination by the secretary that the alleged sexual misconduct more likely than not occurred, or an admission of sexual misconduct has been made.

"Program administrator" means institution superintendent, regional administrator, or their designees.

"Reasonable cause" means a reason that would motivate a person of ordinary intelligence under the circumstances to believe that an act of sexual misconduct may have occurred.

"Regular access" means unsupervised access to a juvenile(s), for more than a nominal amount of time, that is the result of the person's regularly scheduled activities or work duties.

"Secretary" means the secretary of the department of social and health services.

"Sexual contact" means any touching of the sexual or other intimate parts of a person done for the purpose of gratifying sexual desire of either party or a third party.

"Sexual intercourse" has its ordinary meaning and:

- (1) Occurs upon any penetration, however slight; and
- (2) Also means any penetration of the vagina or anus however slight, by an object, when committed on one person by another, whether such persons are of the same or opposite sex, except when such penetration is accomplished for medically recognized treatment or diagnostic purposes; and
- (3) Also means any act of sexual contact between persons involving the sex organs of one person and the mouth or anus of another whether such persons are of the same or opposite sex.

"Suspend" means to remove from unsupervised access to any JRA youth.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0005, filed 11/27/00, effective 12/28/00.]

BACKGROUND CHECKS

WAC 388-700-0010 When are background checks required? JRA must conduct background checks on prospective employees, volunteers, and individual contracted service providers who will have regular access to juveniles. Background checks may be conducted on prospective employees, volunteers, and individual contracted service providers who will have limited access to juveniles.

(1) Procedures must be established in order to investigate and determine suitability of a person in a position who will have regular access or limited access to juveniles.

(2) Employees, volunteers or individual contracted service providers who are authorized for regular access do not require the presence of another person cleared through the

designated background check process during the performance of their duties.

(3) The presence of another person cleared through the designated background check process is required for people authorized to have limited access to juveniles.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0010, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0015 What crimes prohibit "regular access" to juveniles? Effective September 1, 1998, potential employees, volunteers, and individual contracted service providers must not be hired, engaged, or authorized in a position which allows regular access if the individual has been convicted of:

(1) Any felony sex offense as defined in RCW 9.94A.030 and 9A.44.130;

(2) Any crime specified in chapter 9A.44 RCW when the victim was a juvenile in the custody of or under the jurisdiction of JRA as stated in RCW 13.40.570; or

(3) Any violent offense as defined in RCW 9.94A.030.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0015, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0020 What are the reporting requirements for criminal convictions? Effective September 1, 1998 employees, volunteers, and individual contracted service providers who are authorized for regular access to a juvenile(s) must report any conviction of a crime identified in WAC 388-700-0015. The report must be made to the person's supervisor within seven days of conviction. Failure to report within seven days constitutes misconduct under Title 50 RCW. Employees, volunteers, and individual contracted service providers who have been convicted of offenses in WAC 388-700-0015 must not have regular access to a juvenile(s).

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0020, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0025 Is a contracting agency required to do background checks? JRA must require background checks to be conducted on prospective employees and volunteers of contracting agencies if the person will have regular access to juveniles.

(1) Requirements of WAC 388-700-0010, 388-700-0015, and 388-700-0020 must be met by contracted service providers.

(2) The contracted service provider or designee of an agency contracting with JRA for the provision of a community facility must ensure background check investigations are conducted according to department licensing requirements.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0025, filed 11/27/00, effective 12/28/00.]

SEXUAL MISCONDUCT BY JRA EMPLOYEES

WAC 388-700-0030 What action must be taken if there is a belief that sexual misconduct by a JRA employee has occurred? If there is reasonable cause to believe that sexual intercourse or sexual contact between a JRA employee and a JRA youth has occurred, the secretary must immediately remove the JRA employee from access to

JRA youth, and follow reporting requirements in chapter 26.44 RCW, Reporting abuse and neglect of a child.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0030, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0035 What disciplinary action is required if there is evidence that sexual misconduct by a JRA employee has occurred? If the preponderance of the evidence finds that sexual intercourse or sexual contact between a JRA employee and a JRA youth has occurred, or upon a guilty plea or conviction for any crime specified in chapter 9A.44 RCW when the victim was an offender, the secretary must immediately institute proceedings to terminate the employee.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0035, filed 11/27/00, effective 12/28/00.]

SEXUAL MISCONDUCT BY JRA CONTRACTORS

WAC 388-700-0040 What action must be taken if there is a belief that sexual misconduct by a JRA contractor has occurred? The secretary requires the individual contractor, or employee of a contractor, when there is reasonable cause to believe he/she has had sexual intercourse or sexual contact with a JRA youth, to be immediately removed from access to any JRA youth, and follow reporting requirements in chapter 26.44 RCW, Reporting abuse and neglect of a child.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0040, filed 11/27/00, effective 12/28/00.]

WAC 388-700-0045 What action is required if there is evidence that sexual misconduct by a JRA contractor has occurred? (1) If there is a preponderance of evidence that sexual intercourse or sexual contact between a JRA contractor and a JRA youth occurred, the secretary must inform the contractor that the individual employee is disqualified from employment with a contractor in any position with access to JRA youth.

(2) A contract with a contractor who has had an employee who has been disqualified for employment based on a preponderance of evidence that he or she has had sexual intercourse or sexual contact with a JRA youth, must not be renewed until the secretary determines that significant progress has been made by the contractor to reduce the likelihood that any of its employees or subcontractors have sexual intercourse or sexual contact with a JRA youth.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0045, filed 11/27/00, effective 12/28/00.]

SEXUAL MISCONDUCT BY JRA EMPLOYEES OR CONTRACTORS

WAC 388-700-0050 What action will be taken if an employee or contractor has sexual intercourse or sexual contact against their will? DSHS will not take any action against a person who is employed or contracted by JRA who has sexual intercourse or sexual contact with a JRA youth and it is found to have been against the employed or contracted person's will.

[Statutory Authority: RCW 13.40.570. 00-24-014, § 388-700-0050, filed 11/27/00, effective 12/28/00.]

Chapter 388-710 WAC CONSOLIDATED JUVENILE SERVICES PROGRAMS

WAC

388-710-0005	Definitions.
388-710-0010	Establishment of a consolidated juvenile services program.
388-710-0015	General provisions.
388-710-0020	Organization.
388-710-0025	Administration.
388-710-0030	Monitoring of performance and evaluation of program impact.
388-710-0035	Distribution of funds and fiscal management.
388-710-0040	Exceptions to rules.

WAC 388-710-0005 Definitions. "Administration" means activities and costs necessary for management and support of a consolidated juvenile services program.

"Application" means the document requesting state funds for specific projects under the consolidated juvenile services program.

"Community input" means information received from local entities which must include, unless impracticable: Providers, judges, law enforcement, juvenile court staff, social service agencies, schools, tribes, organizations representing communities of color, as well as other persons with an interest in juvenile justice. An existing advisory group, committee, or public forum may be used to gather input provided such groups include representation from the entities listed above.

"Director" means the director of the division of community programs/juvenile rehabilitation administration or his or her designee.

"Division" means the division of community programs of the juvenile rehabilitation administration.

"Outcome" means specific changes in the lives of youth and families which lead to a decrease in recidivism.

"Participating county" means a county or counties applying under this chapter.

"Program administrator" or "administrator" means the person designated to administer the consolidated juvenile services program in the juvenile court.

"Project" means a specific intervention or program performed as a part of consolidated juvenile services.

"Project supervisor" or "supervisor" means a person designated to supervise a project or projects in the consolidated juvenile services program.

"Regional administrator" means the regional administrator of one of the division's six administrative regions, or his or her designee.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0005, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0010 Establishment of a consolidated juvenile services program. (1) Request to participate.

A request by a county or group of counties to participate under this chapter must include a signed resolution or letter of intent submitted to the regional administrator by the executive body expressing intent to participate. The request must include a statement that consolidated juvenile services funds

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will not be used to replace county funds for existing programs. For those counties with juvenile detention facilities, the counties must include a statement indicating standards of operation as outlined under RCW 13.06.050 are in place.

(2) Program planning process and approval.

(a) Each participating county must develop a program application for the delivery of services and must agree to comply with the provisions of this chapter.

(b) The application must incorporate community input and respond to community comments, which must include but not be limited to:

(i) Efforts to identify and utilize existing community services;

(ii) Appropriate linkage to and support from other elements of the existing juvenile justice, education, and social service systems to reduce or eliminate barriers to effective family centered service delivery;

(iii) Efforts to address racial disproportionality; and

(iv) Efforts to address issues specific to the Americans with Disabilities Act as it relates to client and family service delivery.

(c) Written guidelines and instructions for the application must be provided by the division. The application must be developed in consultation with the regional administrator to ensure the coordination of state, county, and private sector resources within regional boundaries and must be submitted to the regional administrator for review and approval.

(d) The division may provide technical assistance in the development of the application.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0010, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0015 General provisions. (1) Access to services and use of existing community resources. Program administrators must ensure all juveniles participating in the program have access to appropriate services, activities, and opportunities.

(2) All juveniles served by projects covered under this chapter must be afforded judicial due process in all contacts, especially those which may result in a more restrictive intervention.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0015, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0020 Organization. The organizational structure of the program is the prerogative of the juvenile court participating under this chapter and must not be dictated by these standards.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0020, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0025 Administration. (1) Administrators and supervisors are responsible for the implementation of the program and the accomplishment of stated activities and outcomes.

(2) Administrators or supervisors must meet at least annually with the regional administrator to review progress toward the achievement of outcomes.

(3) Case records and management information.

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(a) Juvenile offender records must minimally contain a case plan, based upon assessed factors related to risk to reoffend, methods of intervention and a termination/closing report summarizing case activity and outcomes.

(b) The provisions of chapter 13.50 RCW pertaining to the maintenance and confidentiality of social and legal information apply to all programs and projects covered under this chapter.

(c) Administrators and/or supervisors must provide necessary statistical data to maintain the division's management information system and must maintain sufficient data to evaluate program effectiveness and outcomes.

(4) Change in project.

(a) Modification of a project requires the advance written approval of the regional administrator.

(b) The administrator must send written notification to the regional administrator prior to the movement of funds between programs. The regional administrator must confirm in writing all notifications received.

(c) Contract amendments must be processed through the juvenile rehabilitation administration regional office and are necessary when:

(i) Total contract budget amounts are increased or decreased;

(ii) A project is added or deleted;

(iii) The total number of full-time employees in the consolidated programs increases from the original contract number.

(5) Each participating county must ensure program staff receive training necessary to implement programs covered under this chapter.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0025, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0030 Monitoring of performance and evaluation of program impact. (1) It is the responsibility of the administrator to submit monthly reports, annual narrative reports, corrective action plans and reports, and other reports as specified in the division's application, budget, and monitoring instructions to the regional administrator.

(2) The regional administrator must submit to the director a biennial report of each program.

(3) The regional administrator, may at any time, request a formal program/project or fiscal audit and may also request other available technical services to assist in monitoring and evaluating the program/projects.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0030, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0035 Distribution of funds and fiscal management. Funding constraints.

(1) Funds for programs covered by this chapter must be utilized for the achievement of the outcomes stated for each project.

(2) Failure on the part of any project to perform in accordance with the provisions of this chapter may result in the termination or reduction of funds.

(3) The administrator is responsible for the management of all fiscal matters related to the program. The program must comply with state and local policies and procedures, the terms and conditions of the contract, and the application,

[Title 388 WAC—p. 1182]

budget, and monitoring instructions as outlined by the juvenile rehabilitation administration.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0035, filed 7/24/00, effective 8/24/00.]

WAC 388-710-0040 Exceptions to rules. The juvenile court may request in writing to the director a waiver of the specific requirements of this chapter when the imposition of such requirements can be shown to be detrimental or impractical to overall program operations. The director must consider each waiver request individually and promptly advise the applicant in writing of the director's decision regarding the waiver and explain the basis for such decision.

[Statutory Authority: RCW 13.06.030. 00-16-032, § 388-710-0040, filed 7/24/00, effective 8/24/00.]

Chapter 388-720 WAC

COLLECTION OF COSTS OF SUPPORT, TREATMENT, AND CONFINEMENT OF JUVENILES UNDER RCW 13.40.220

(Formerly chapter 275-47 WAC)

WAC

388-720-0010	Definitions.
388-720-0020	Cost reimbursement schedule and ability to pay.
388-720-0030	Hearing.
388-720-0040	Modifications.
388-720-0050	Powers of the administrative law judge.

WAC 388-720-0010 Definitions. (1) "Juvenile" means juvenile offender sentenced to confinement in the department, other than an offender for whom a parent is approved to receive adoption support under chapter 74.13 RCW.

(2) "Department" means the department of social and health services, state of Washington.

(3) "Gross income" means the total income from all sources, received by the parent, the juvenile, or other children of the parent remaining in the household, other than a stepchild, as determined by the department.

(4) "Parent" means the parent of the juvenile or other person legally obligated to care for and support the juvenile, not including a stepparent.

(5) "Parents and dependents" means the juvenile's parent or parents, a stepparent living in the home who has no income, any child on whom the parent may claim a federal income tax deduction, not including the juvenile confined to the department, and any stepchild for whom the parent is the sole means of support.

[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0010, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-010, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0020 Cost reimbursement schedule and ability to pay. As provided for in RCW 13.40.220 the office of financial recovery may negotiate payment schedules and the methods used to satisfy costs of support, treatment and confinement with parents and other legally obligated persons, on behalf of the department. The results of the application of this rule may be appealed as provided for in RCW 13.490.220 (4) and (6) and Part IV Adjudicative Proceedings, of chapter 34.05 RCW, Administrative Procedure Act. A par-

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ent or other legally obligated person shall pay a percentage of gross income to the department for the cost of support, treatment and confinement of the juvenile. Ability to pay will be

determined by the application of the information provided by a parent or other legally obligated person in the financial information statement to the reimbursement schedule below:

Monthly Gross Income	Percentage of Gross Income Ordered for Reimbursement of Costs							
	Number of Parents and Dependents Remaining in Household							
	1	2	3	4	5	6	7	8+
TANF or \$0 - 600	0	0	0	0	0	0	0	0
\$601 - 1000	8%	6%	4%	2%	0	0	0	0
\$1001 - 2000	12%	10%	8%	6%	4%	2%	0	0
\$2001 - 3000	16%	14%	12%	10%	8%	6%	4%	2%
\$3001 - 4000+	18%	16%	14%	12%	10%	8%	6%	4%

(1) Within fifteen days of receipt of the financial information statement, a parent or other legally obligated person shall complete, sign and mail the statement to the department. Based on the statement and on other information available to it, the department shall determine the parent's gross income, the number of parents and dependents, and the reimbursement obligation, and shall serve on the parent a notice and finding of financial responsibility.

(2) If a parent or legally obligated person fails to timely provide a financial statement, the reimbursement obligation shall be twenty-three hundred dollars per month.

(3) If the juvenile's parents or other legally obligated person reside in separate households, each parent shall be liable for reimbursement.

(4) The gross income of a parent shall be reduced by the amount the parent pays in spousal maintenance to the juvenile's parent, which is gross income to the receiving parent. The gross income of a parent or other legally obligated person shall be reduced by the amount of current child support paid for any child, including the juvenile offender. This credit shall be available when the support is paid to any section of the department or to any other person legally entitled to receive those support payments, pursuant to court order or administrative order for a child the parent did not claim as a dependent under the reimbursement schedule.

(5) Reimbursement may not exceed the cost of care as determined by the department.

(6) The reimbursement obligation commences the day the juvenile enters the custody of the department, regardless of when the notice and finding of financial responsibility is received by the parent. A monthly reimbursement obligation shall be reduced on a pro rata basis for any days in which the juvenile was not in the custody of the department.

(7) The parent or other legally obligated person of the juvenile shall be exempt from the payment of the cost of the juvenile's care in the state facility if the parent or other legally obligated person receives adoption support or is eligible to receive adoption support for the juvenile offender; or if the parent, or other legally obligated person, or such person's child, spouse, or spouse's child, was the victim of the offense for which the juvenile was committed to the department.

[Statutory Authority: RCW 13.40.220. 04-05-080, § 388-720-0020, filed 2/17/04, effective 3/19/04; 00-22-019, recodified as § 388-720-0020, filed 10/20/00, effective 11/20/00; 96-24-075, § 275-47-020, filed 12/2/96, effective 1/2/97; 94-15-009 (Order 3752), § 275-47-020, filed 7/8/94, effective 8/8/94.]

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WAC 388-720-0030 Hearing. A parent may request a hearing under RCW 13.40.220(5) to contest a notice and finding of financial responsibility issued by the department. The department shall ensure the hearing is governed by chapter 34.05 RCW and chapter 388-02 WAC. The sole issues at the hearing include whether the:

(1) Person receiving the notice and finding of financial responsibility is a parent of the juvenile; and

(2) Department correctly:

(a) Determined the parent's gross income and the number of parents and dependents; and

(b) Calculated the reimbursement obligation in accordance with the reimbursement schedule as described under WAC 388-720-0020.

[Statutory Authority: RCW 13.40.220. 00-22-019, amended and recodified as § 388-720-0030, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-030, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0040 Modifications. (1) A parent may modify the parent's financial statement upon a change in gross income or in the number of persons residing in the household only if the change decreases the reimbursement obligation by one hundred dollars per month or more. A decrease may be granted only from the date on which the request for modification is made, and may not be applied retroactively.

(2) A parent shall file a financial statement modification if a change in gross income or the number of persons residing in the household increases the reimbursement obligation by one hundred dollars per month or more. An increase may be applied retroactively.

(3) The department will issue a new notice and finding of financial responsibility upon receipt of a modified financial statement as defined in subsections (1) or (2) of this section. The department may also issue a new notice based upon its own review if the conditions of subsection (1) or (2) of this section are met.

[Statutory Authority: RCW 13.40.220. 00-22-019, recodified as § 388-720-0040, filed 10/20/00, effective 11/20/00; 94-15-009 (Order 3752), § 275-47-040, filed 7/8/94, effective 8/8/94.]

WAC 388-720-0050 Powers of the administrative law judge. The administrative law judge in the final order rendered after the hearing conducted in accordance with WAC 388-720-0030 shall include the name and age of the juvenile in that final order. The administrative law judge shall also indicate the parent's or other legally obligated person's monthly liability amount for the period of the juvenile's con-

finement beginning with the date the child enters the custody of the department. The administrative law judge shall not establish in the final order any amount constituting a repayment figure of any accrued obligation of the parent but shall indicate in the final order that any accrued obligation shall be paid by the parent to the department's office of financial recovery (OFR) and that OFR will be responsible for determining the method of repayment of the parent's accrued obligation.

The administrative law judge shall also include a statement in the final order that the parent's financial obligation is collectible by OFR and that should the parent fail to comply with any payment plan entered into by OFR and the parent, or the parent fails to pay the amount set out in the final order, OFR shall be authorized to take legal collection action to recover the amounts due from the parent. Legal collection action can include, but is not limited to:

(1) The filing of liens against the real and personal property of the parent; or

(2) The issuance of a garnishment order against the wages, bank accounts, or other property of the responsible persons.

[Statutory Authority: RCW 34.05.020, 13.40.220, 03-01-044, § 388-720-0050, filed 12/10/02, effective 1/10/03. Statutory Authority: RCW 13.40.220, 00-22-019, amended and recodified as § 388-720-0050, filed 10/20/00, effective 11/20/00; 96-24-075, § 275-47-050, filed 12/2/96, effective 1/2/97.]

Chapter 388-730 WAC
PLACEMENT OF JUVENILE OFFENDERS
COMMITTED TO THE JUVENILE
REHABILITATION ADMINISTRATION (JRA)
 (Formerly chapter 275-46 WAC)

WAC

388-730-0010	Definitions.
388-730-0015	Assessment.
388-730-0020	Security classifications.
388-730-0030	Maximum security.
388-730-0040	Medium security.
388-730-0050	Institutional minimum.
388-730-0060	Minimum security.
388-730-0065	Special placement restrictions.
388-730-0070	Residential disciplinary standards.
388-730-0080	Documenting and reporting violations committed by juveniles in residential facilities.
388-730-0090	Service provider penalty schedule.

WAC 388-730-0010 Definitions. As used in this chapter:

"Community facility" means a group care facility operated for the care of juveniles committed to the department under RCW 13.40.185. A county detention facility that houses juveniles committed to the department under RCW 13.40.185 pursuant to an interagency agreement with the department is not a community facility.

"Community placement eligibility requirements" means requirements developed by JRA that must be met by a youth to demonstrate progress in treatment and low public safety risk, which justify an institutional minimum or minimum security classification for the youth.

"Initial security classification assessment" means a written instrument, developed by JRA and administered by diagnostic staff, to determine to what extent a juvenile is a

threat to public safety for the purpose of determining the juvenile's security classification when the juvenile initially is committed to JRA.

"JRA" means juvenile rehabilitation administration, department of social and health services.

"Juvenile" means a person under the age of twenty-one who has been sentenced to a term of confinement under the supervision of the department under RCW 13.40.185.

"Program administrator" means institution superintendent, regional administrator, or their designees.

"Residential treatment and care program" means a single family residence operated for the care of juveniles committed to the department under RCW 13.40.185.

"Separate living unit" means sleeping quarters and areas used for daily living activities not specific to treatment and education programs located in a building, wing, or on a different floor which separates resident groups.

"Service provider" means the entity that operates a community facility or is contracted to provide a residential treatment and care program.

"Specialized treatment program" means a program that addresses additional rehabilitation needs such as sex offender treatment, drug/alcohol treatment, mental health interventions, gang intervention, gender/age specific intervention and other programs meeting specific rehabilitation needs of juveniles.

[Statutory Authority: RCW 13.40.460 and 72.05.150, 03-03-070, § 388-730-0010, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW, 00-22-019, recodified as § 388-730-0010, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.-210, 13.40.460 and [13.40.]480, 98-18-056, § 275-46-010, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460, 96-18-041, § 275-46-010, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0015 Assessment. (1) Risk assessment and treatment needs must be the basis of placement decisions involving juveniles.

(2) JRA must ensure juveniles are assessed to determine appropriate placement and treatment programming. Ongoing risk and needs assessment must occur during a juvenile's commitment to JRA.

(3) Risk assessment must include:

- (a) Risk to public safety;
- (b) Risk for sexually aggressive behavior; and
- (c) Risk for vulnerability to sexual aggression.

(4) JRA must use a security classification system to assist in placement decisions.

(5) Student records and information as described in RCW 72.05.425 are required for juvenile offender risk assessment, security classification assignment, and JRA community placement decisions. Designated school officials must ensure student records are provided to the identified juvenile court or JRA representative as required in RCW 28A.600.475 and 13.40.480.

[Statutory Authority: Chapter 72.05 RCW, 00-22-019, recodified as § 388-730-0015, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480, 98-18-056, § 275-46-015, filed 8/31/98, effective 9/1/98.]

WAC 388-730-0020 Security classifications. (1) There are four JRA security classifications:

- (a) Maximum;
- (b) Medium;
- (c) Institutional minimum; and
- (d) Minimum.

(2) A juvenile's initial security classification is determined using the initial security classification assessment. A juvenile's security classification may be changed at any time, and be reviewed at regular intervals as determined by JRA policy.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0020, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-020, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-020, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0030 Maximum security. (1) A maximum security classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment; or

(b) Following the initial security classification, it is determined the juvenile:

(i) Does not meet the community placement eligibility requirements for minimum security; and

(ii) Requires maximum security restrictions to protect public safety, encourage the juvenile to participate in treatment and follow facility rules, or enhance the safe and orderly operation of the facility.

(2) A juvenile classified as maximum security must:

(a) Reside in an institution with the capability of:

- (i) Security windows;
- (ii) Locked exterior doors;
- (iii) Lockable single-person rooms; and
- (iv) A security fence.

(b) Be permitted movement between secured buildings only if accompanied by a close staff escort;

(c) Be confined to facility grounds, except for court appearances or emergencies, in which case a staff escort, and transportation in restraints and in a security vehicle, are required; and

(d) Be allowed authorized leave only for emergency and medical purposes pursuant to RCW 13.40.205.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0030, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-030, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-030, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0040 Medium security. (1) A medium security classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment; or

(b) Following the initial security classification, it is determined the juvenile:

(i) Does not meet the community placement eligibility requirements for minimum security; and

(ii) Requires medium security restrictions to protect public safety, encourage the juvenile to participate in treatment

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and follow facility rules, or enhance the safe and orderly operation of the facility.

(2) A juvenile classified as medium security must:

(a) Reside in an institution with the capability of at least:

(i) Lockable exterior doors or fire exit doors fitted with alarms; and

(ii) A security fence or windows without egress.

(b) Receive during movement a staff escort, continuous visual surveillance, or telephone/radio staff verification of departures and arrivals, unless the program administrator determines such measures are unnecessary;

(c) Be confined to facility grounds, except for:

(i) Participation in work crews or other programs outside the facility that require a close staff escort; and

(ii) Court appearances or emergencies, in which case a staff escort, and transportation in a security vehicle and/or in restraints, are required.

(d) Be allowed authorized leave only for emergency or medical purposes pursuant to RCW 13.40.205.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0040, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-040, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-040, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0050 Institutional minimum. (1) An institutional minimum classification must be assigned to a juvenile if:

(a) Indicated by the initial security classification assessment;

(b) Indicated by the community placement eligibility requirements unless a recent incident indicates the juvenile no longer meets these requirements; or

(c) The assistant secretary for JRA or designee approves an override of the medium security classification.

(2) Even if eligible under subsection (1) of this section, a juvenile must not receive an institutional minimum security classification if:

(a) The assistant secretary for JRA, or designee, signs an administrative override disapproving institutional minimum classification and assigning the juvenile a higher security classification; or

(b) The juvenile is a sex offender who meets the requirements for civil commitment referral under chapter 71.09 RCW or is classified as a risk level III under RCW 13.40.217.

(3) A juvenile classified as institutional minimum security:

(a) Must reside in an institution with the capability of at least:

(i) Lockable exterior doors or fire exit doors fitted with alarms; and

(ii) A security fence or windows without egress.

(b) May be permitted:

(i) Unescorted movement on facility grounds;

(ii) Participation in work crews or other programs outside the facility with a close staff escort;

(iii) Unescorted participation in community work, educational and community service programs, and family treatment or other activities to strengthen family ties, for up to twelve hours per day; and

(iv) Authorized leave pursuant to RCW 13.40.205.

(4) A juvenile on institutional minimum security must be transferred to minimum security upon the availability of an appropriate community placement if:

(a) Ten percent of the juvenile's sentence, and in no case less than thirty days, has been served in a secure facility; and

(b) All placement assessment requirements have been met.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0050, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-050, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-050, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0060 Minimum security. (1) The provisions of WAC 388-730-0050 also apply to a juvenile classified as minimum security, except the juvenile must reside in a community facility, residential treatment and care program, or a community commitment program facility (CCP) rather than in an institution.

(2) Juveniles must not be placed in a community facility or residential treatment and care program until:

(a) Ten percent of the juvenile's sentence, and in no case less than thirty days, has been served in a secure facility; and

(b) All placement assessment requirements have been met.

(3) In addition to the provisions of WAC 388-730-0050 (3)(b)(iii), minimum security juveniles may be permitted unescorted participation in treatment programs in the community that do not involve the family for up to twelve hours per day.

[Statutory Authority: RCW 13.40.460 and 72.05.150. 03-03-070, § 388-730-0060, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0060, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-060, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-060, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0065 Special placement restrictions. Certain placement restrictions apply to community facilities and residential treatment and care programs that are commonly used by and under the jurisdiction of both JRA and the children's administration.

(1) When juveniles under commitment to JRA are assessed as a high to moderate risk for sexually aggressive behavior, they may not be placed in a community facility or residential treatment and care program with youths under the jurisdiction of children's administration unless:

(a) They are placed in a separate living unit solely for juveniles currently under the jurisdiction of JRA; or

(b) They are placed in a program that contracts specifically for the provision of services to sexually aggressive youth.

(2) Juveniles under commitment to JRA for a class A felony may not be placed in these community facilities unless:

(a) They are housed in a separate living unit solely for juveniles currently under the jurisdiction of JRA;

(b) They are placed in a community facility or residential treatment and care program that is a specialized treatment

program and the juvenile is not assessed as sexually aggressive under RCW 13.40.470; or

(c) They are placed in a community facility or residential treatment and care program that is a specialized treatment program housing one or more sexually aggressive youth and the juvenile is not assessed as sexually vulnerable under RCW 13.40.470.

[Statutory Authority: RCW 13.40.460 and 72.05.150. 03-03-070, § 388-730-0065, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW. 00-22-019, recodified as § 388-730-0065, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-065, filed 8/31/98, effective 9/1/98.]

WAC 388-730-0070 Residential disciplinary standards. (1) Serious violations by a juvenile include:

(a) Escape or attempted escape;

(b) Violence toward others with intent to harm and/or resulting in significant bodily injury;

(c) Involvement in or conviction of a criminal offense under investigation by law enforcement or awaiting adjudication for behavior that occurred during current placement;

(d) Extortion or blackmail that threatens the safety or security of the facility or community;

(e) Setting or causing an unauthorized fire with intent to harm self, others, or property, or with reckless disregard for the safety of others;

(f) Possession or manufacture of weapons or explosives, or tools intended to assist in escape;

(g) Interfering with staff or service providers in performing duties relating to the security and/or safety of the facility or community;

(h) Intentional property damage in excess of one thousand five hundred dollars;

(i) Possession, use, or distribution of drugs or alcohol, or use of inhalants;

(j) Rioting or inciting others to riot;

(k) Refusal of urinalysis or search; or

(l) Other behaviors which threaten the safety or security of the facility, its staff, or residents or the community.

(2) Other violations by a juvenile placed in a community facility or residential treatment and care program include:

(a) Unaccounted for time when a juvenile is away from the community facility or residential treatment and care program;

(b) Violation of conditions of authorized leave;

(c) Intimidation or coercion against any person;

(d) Misuse of medication such as hoarding medication or taking another person's medication;

(e) Self-mutilation, self tattooing, body piercing, or assisting others to do the same;

(f) Intentional destruction of property valued at less than fifteen hundred dollars;

(g) Fighting;

(h) Unauthorized withdrawal of funds with intent to commit other violations;

(i) Suspensions or expulsions from school or work;

(j) Violations of school, employment or volunteer work agreements related to custody and security concerns;

(k) Escape talk;

(l) Sexual contact or any other behavior, not defined as a serious violation, resulting in a referral to the department of licensing, child protective services, or law enforcement; or

(m) Lewd or disruptive behavior in the community.

(3) Juveniles must be held accountable when there is reasonable cause to believe they have committed a violation.

(a) Whenever a juvenile placed in a community facility or residential treatment and care program commits a serious violation, the juvenile must be returned to an institution. The JRA program administrator who receives a service provider report of a serious violation must make arrangements to transfer the juvenile to an institution as soon as possible. Juveniles may be placed in a secure JRA or contracted facility pending transportation to an institution.

(b) Sanctions for serious violations committed by juveniles in an institution, and additional sanctions for serious violations committed by juveniles returned to an institution, must include one or more of the following:

- (i) Loss of privileges for up to thirty days;
- (ii) Loss of program level; or
- (iii) Room confinement up to seventy-two hours.

(c) Sanctions for serious violations may also include, but are not limited to, one or more of the following:

- (i) Change in release date;
- (ii) Referral for prosecution;
- (iii) Transfer to an intensive management unit;
- (iv) Increase in security classification;
- (v) Reprimand and loss of points;
- (vi) Restitution; or
- (vii) Community service.

(d) Sanctions for violations listed in WAC 388-730-0070(2) may include transfer to a higher security facility and must include one or more of the following:

- (i) Loss or privileges;
- (ii) Loss of program level;
- (iii) Room confinement up to seventy-two hours;
- (iv) Change in release date;
- (v) Reprimand and/or loss of points;
- (vi) Additional restitution; or
- (vii) Community service.

(4) When a sanction is imposed, the juvenile must also receive a counseling intervention to address the violation.

(5) If the proposed sanctions for any violation includes extending the juvenile's established release date, the juvenile must be entitled to:

(a) Notice of an administrative review to consider extension of the release date and a written statement of the incident;

(b) An opportunity to be heard before a neutral review chairperson;

(c) Present oral or written statements, and call witnesses unless testimony of a witness would be irrelevant, repetitive, unnecessary, or would disrupt the orderly administration of the facility;

(d) Imposition of the sanction only if the administrative review chairperson finds by a preponderance of the evidence that the serious violation did occur; and

(e) A written decision, stating the reasons for the decision, by the administrative review chairperson.

(6) Each superintendent, regional administrator and service provider must clearly post, or make readily available, the

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list of serious violations and possible sanctions in all living units.

(7) Each program administrator must adopt procedures for implementing the requirements of this section.

[Statutory Authority: RCW 13.40.460 and 72.05.150. 03-03-070, § 388-730-0070, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0070, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.-]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-070, filed 8/31/98, effective 9/1/98. Statutory Authority: RCW 13.40.460. 96-18-041, § 275-46-070, filed 8/29/96, effective 9/29/96.]

WAC 388-730-0080 Documenting and reporting violations committed by juveniles in residential facilities.

(1) All serious violations and violations listed in WAC 388-730-0070(2) must be documented in an incident report. The incident report must include:

- (a) Circumstances leading up to the violation(s);
- (b) A description of the violation;
- (c) Response by staff;
- (d) Response by the juvenile(s) involved in the incident;

and

(e) Sanctions imposed or recommended for the violation(s).

(2) Service providers must:

(a) Forward all incident reports to the JRA program administrator no later than twenty-four hours after the behavior is discovered; and

(b) Verbally report serious violations to the JRA program administrator immediately.

[Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0080, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.-]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-080, filed 8/31/98, effective 9/1/98.]

WAC 388-730-0090 Service provider penalty schedule.

(1) Whenever a service provider contracts with the JRA to operate a community facility or residential treatment and care program, the contracted service provider must report any known violation as required in WAC 388-730-0080.

(2) If the contracted service provider fails to report violations within the prescribed time frames, the JRA must impose one or more of the following remedies:

(a) Imposition of a corrective action plan to be completed as determined by the program administrator.

(b) Imposition of the following monetary penalties:

(i) The first time fines are imposed on a service provider, the penalty must be at the rate of fifty dollars per day for each juvenile involved in a violation that was not reported as required. The penalty must be assessed for each day the report was late, and may continue until a corrective action plan is approved by the program administrator.

(ii) Subsequent fines imposed on the service provider during the same calendar year must be at the rate of seventy-five dollars per day for each juvenile involved in a violation that was not reported as required. The penalty must be assessed for each day the report was late, and may continue until a corrective action plan is approved by the program administrator.

(c) Order to stop placement until a corrective action plan is submitted, approved by the program administrator, and implemented.

(d) Termination of the contract for convenience if it is determined such termination is in the best interests of the department.

[Statutory Authority: RCW 13.40.460 and 72.05.150. 03-03-070, § 388-730-0090, filed 1/15/03, effective 2/15/03. Statutory Authority: Chapter 72.05 RCW. 00-22-019, amended and recodified as § 388-730-0090, filed 10/20/00, effective 11/20/00. Statutory Authority: RCW 72.05.400, [72.05.]405, [72.05.]410, [72.05.]415, [72.05.]425, [72.05.]430, [72.05.]435, [72.05.]440, 74.15.210, 13.40.460 and [13.40.]480. 98-18-056, § 275-46-090, filed 8/31/98, effective 9/1/98.]

Chapter 388-740 WAC

JUVENILE PAROLE REVOCATION

(Formerly chapter 275-30 WAC)

WAC

388-740-0010	Definitions.
388-740-0030	Parole arrest warrant.
388-740-0040	Parole revocation petition.
388-740-0060	Parole revocation hearing.
388-740-0070	Confinement.

WAC 388-740-0010 Definitions. "Department" means the department of social and health services.

"Detention" means physical custody in Washington state by the department of social and health services in a juvenile rehabilitation administration operated or contracted facility or a Washington state detention facility as defined in RCW 13.40.020(9).

"Juvenile parole officer" means a state employee, or person under contract to the state, whose responsibilities include supervising juvenile parolees.

"Juvenile parolee" means a person under age twenty-one released from a juvenile rehabilitation administration residential facility and placed under the supervision of a juvenile parole officer.

"Modification of parole conditions" means a change in the "order of parole conditions" provided by the juvenile parole officer with full knowledge of the change by the juvenile parolee.

"Parole" means a period of supervision following release from a juvenile rehabilitation administration residential facility, during which time certain parole conditions are to be followed.

"Parole conditions" mean interventions or expectations that include, but are not limited to, those listed in RCW 13.40.210, intended to facilitate the juvenile parolee's reintegration into the community and/or to reduce the likelihood of reoffending.

"Secretary" means secretary of the department of social and health services or his/her designee.

"Violation" means behavior by a juvenile parolee contrary to written parole conditions which may result in sanctions that include, but are not limited to, modification of parole conditions and/or confinement.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, amended and recodified as § 388-740-0010, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-010, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-010, filed 10/5/88.]

[Title 388 WAC—p. 1188]

WAC 388-740-0030 Parole arrest warrant. (1) A juvenile parole officer:

(a) Must issue a parole arrest warrant when the juvenile parole officer has reason to believe a juvenile parolee possessed a firearm or used a deadly weapon during the parole period; or

(b) May issue a parole arrest warrant when the juvenile parole officer has reason to believe a juvenile parolee has violated a condition of parole, other than possession of a firearm or use of a deadly weapon.

(2) The parole arrest warrant, on department forms, must include a statement of the nature of the violation(s) and the date it occurred.

(3) A juvenile parolee held in detention for an alleged violation of parole conditions is entitled to an informal hearing to determine whether there is probable cause to believe a parole violation occurred and whether continued detention pending a parole revocation hearing is necessary. The hearing must be:

(a) Held within twenty-four hours (excluding Saturdays, Sundays, and holidays) of being placed in detention for an alleged violation of parole conditions; and

(b) Conducted by a parole supervisor or designee not directly involved in the case. The parole supervisor or designee must:

(i) Interview both the juvenile parolee and a juvenile parole staff with knowledge of the alleged violation(s). If such a parole staff is unavailable, documentation of the allegation(s) may be reviewed in place of the staff interview; and

(ii) Issue a decision, immediately following the hearing, with reasons for either releasing the juvenile parolee or authorizing continued detention. The decision must be documented on department forms. In no event shall a juvenile parolee be held in detention for an alleged violation of parole conditions longer than seventy-two hours (excluding Saturdays, Sundays, and holidays) without a parole revocation petition being filed pursuant to WAC 275-30-040.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0030, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-030, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-030, filed 10/5/88.]

WAC 388-740-0040 Parole revocation petition. (1) The juvenile parole officer:

(a) Must initiate a parole revocation petition if the juvenile parole officer has reason to believe the juvenile parolee possessed a firearm or used a deadly weapon during the parole period; or

(b) May initiate a parole revocation petition if the juvenile parole officer has reason to believe the juvenile parolee has violated a condition of parole, other than possession of a firearm or use of a deadly weapon.

(2) The petition, on department forms, must include:

(a) A statement of the nature of the violation and the date it occurred;

(b) The relief requested by the juvenile parole officer as a result of the violation;

(c) Notice of the juvenile parolee's right to be represented by an attorney, either one of his/her own choosing or one appointed at public expense;

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- (d) A parole revocation hearing waiver agreement;
- (e) The dated signature of the regional administrator or designee; and

(f) If the parole revocation hearing is not waived, notice of the time, date, and location of the parole revocation hearing and notice that failure to appear may result in default.

(3) An initial copy of the petition that includes the information described in subsection (2)(a) through (e) must:

- (a) Be provided to the juvenile parolee or the juvenile parolee's attorney; and
- (b) Be provided to the juvenile parolee's parent/guardian, if reasonably possible. The juvenile parole officer must document the date and time he/she provided the initial copy of the petition to the juvenile parolee or the juvenile parolee's attorney.

(4) A juvenile parolee, only through an attorney, may waive the right to a parole revocation hearing and agree to the parole revocation and agreed upon relief. The decision to waive must be documented with dated signatures on the original petition.

(5) If the juvenile parolee through his/her attorney does not waive the right to a hearing, the parole revocation petition must be filed with the local office of the state office of administrative hearings within seventy-two hours (excluding Saturdays, Sundays, and holidays) of:

- (a) The juvenile parolee being placed in detention for an alleged violation of parole conditions; or
- (b) The juvenile parolee or his/her attorney being provided with a copy of the petition under subsection (3) of this section if the juvenile parolee is not detained.

(6) The filed petition must include notice that failure to appear may result in default, and the time, date, and location of the parole revocation hearing, as determined by the state office of administrative hearings. A copy of the filed petition must:

- (a) Be served either personally or by certified mail, return receipt requested, on the juvenile parolee or the juvenile parolee's attorney; and
- (b) Be provided to the juvenile parolee's parent/guardian, if reasonably possible.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0060, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-040, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 88-20-083 (Order 2709), § 275-30-040, filed 10/5/88.]

WAC 388-740-0060 Parole revocation hearing. (1)

After the petition is filed a parole revocation hearing must be held to determine whether the alleged parole violation occurred unless the juvenile parolee waives his/her right to a parole revocation hearing. If the juvenile parolee is held in detention as described under WAC 275-30-030, the administrative law judge must hold the hearing within seventy-two hours (excluding Saturdays, Sundays, and holidays) of the petition being served. Otherwise the administrative law judge must hold a hearing no sooner than seven days after the petition is served, but no later than fourteen days after the petition is served.

(2) At the parole revocation hearing, the juvenile may waive the right to be represented by an attorney. A juvenile

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waiving the right to an attorney may either contest or agree to the parole revocation.

(3) The administrative law judge must:

(a) Conduct a parole revocation hearing in accordance with chapter 10-08 WAC except as otherwise indicated in these rules;

(b) Grant the parole revocation petition if the administrative law judge finds, by a preponderance of the evidence, the violation occurred and the violation warrants revocation;

(c) Order the relief requested in the petition, if the parole revocation petition is granted;

(d) Issue an oral decision immediately following the parole revocation hearing;

(e) Issue a written decision within forty-eight hours of the hearing; and

(f) Provide a copy of the decision to the juvenile parole officer, the juvenile parolee and his/her attorney, the juvenile parolee's parent/guardian, and the department. The administrative law judge's decision shall constitute a final administrative decision.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0060, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-060, filed 1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 90-22-072 (Order 3091), § 275-30-060, filed 11/6/90, effective 12/7/90; 88-20-083 (Order 2709), § 275-30-060, filed 10/5/88.]

WAC 388-740-0070 Confinement. (1)

A juvenile's confinement for violating one or more conditions of parole, as alleged in a parole revocation petition, may not exceed thirty days. Confinement may be continuous, or for a portion of each day, or for certain days each week with the balance of time under supervision. The department must give the juvenile credit against any period of confinement for days served in detention pending a parole revocation hearing. The juvenile must serve his or her confinement in a county detention facility as defined in RCW 13.40.020, a juvenile rehabilitation administration facility, or, if the juvenile parolee is eighteen years old or older, the juvenile may serve his or her confinement in a county jail.

(2) If a juvenile's parole is revoked two or more times during one parole period, the secretary or designee must approve any period of confinement exceeding a combined total of thirty days.

(3) Instead of confinement under subsection (1) of this section, the secretary or designee may return the offender to confinement in an institution for the remainder of the sentence range if:

(a) The offense for which the offender was sentenced is rape in the first or second degree, rape of a child in the first or second degree, child molestation in the first degree, indecent liberties with forcible compulsion, or a sex offense that is also a serious violent offense as defined under RCW 9.94A.030; or

(b) As otherwise authorized in RCW 13.40.210.

(4) Unless conditions of parole are otherwise amended, the order of parole conditions in effect at the time the parole was revoked shall be deemed reinstated immediately following any period of confinement.

[Statutory Authority: RCW 13.40.020, 13.24.010. 00-17-046, recodified as § 388-740-0070, filed 8/7/00, effective 8/27/00. Statutory Authority: RCW 72.01.090, 72.05.130 and 13.40.210. 99-03-077, § 275-30-070, filed

1/19/99, effective 2/19/99. Statutory Authority: RCW 13.40.210. 90-22-072 (Order 3091), § 275-30-070, filed 11/6/90, effective 12/7/90; 88-20-083 (Order 2709), § 275-30-070, filed 10/5/88.]

Chapter 388-745 WAC

TRANSFER OF JUVENILE OFFENDER TO THE DEPARTMENT OF CORRECTIONS

(Formerly chapter 275-33 WAC)

WAC

388-745-020	Notification to juvenile.
388-745-030	Composition of board.
388-745-040	Attendance at hearing.
388-745-050	Consideration of evidence.
388-745-060	Record of decision.

WAC 388-745-020 Notification to juvenile. A juvenile being considered for transfer to DOC shall be notified in writing at least five days in advance of the review board hearing convened to consider the matter. Notification to the juvenile offender will include the reasons the transfer is being considered and a copy of the rules pertaining to the review board hearing. Prior to any review board hearing, the juvenile being considered for transfer to DOC, or the juvenile's attorney, shall have the right of access to, and adequate opportunity to examine any files or records of the department pertaining to the proposed transfer of the juvenile to the department of corrections.

[00-16-078, recodified as § 388-745-020, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-020, filed 4/30/84.]

WAC 388-745-030 Composition of board. The review board will be composed of the director of DJR or designee and two other juvenile rehabilitation administrators appointed by the chairman.

[00-16-078, recodified as § 388-745-030, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-030, filed 4/30/84.]

WAC 388-745-040 Attendance at hearing. Attendance at a review board shall be limited to parties directly concerned. The chairperson may exclude unauthorized persons unless the parties agree to their presence. Parties shall have the right to present evidence, cross-examine witnesses and make recommendations to the board. All relevant and material evidence is admissible which, in the opinion of the chairperson, is the best evidence reasonably obtainable, having due regard for its necessity, availability and trustworthiness.

[00-16-078, recodified as § 388-745-040, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-040, filed 4/30/84.]

WAC 388-745-050 Consideration of evidence. At the conclusion of the hearing, the review board will consider all evidence presented and make a decision whether continued placement of the juvenile offender in an institution for juvenile offenders presents a continuing and serious threat to the safety of others in the institution.

[Title 388 WAC—p. 1190]

[00-16-078, recodified as § 388-745-050, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-050, filed 4/30/84.]

WAC 388-745-060 Record of decision. The chair of the review board will prepare a written record of the decision and reasons therefore. The review board shall be recorded manually, or by mechanical, electronic, or other device capable of transcription.

[00-16-078, recodified as § 388-745-060, filed 7/28/00, effective 7/28/00. Statutory Authority: RCW 13.40.280. 84-10-032 (Order 2097), § 275-33-060, filed 4/30/84.]

Chapter 388-750 WAC

IMPACT ACCOUNT—CRIMINAL JUSTICE COST REIMBURSEMENT

WAC

388-750-010	Definitions.
388-750-020	Limitation of funds.
388-750-030	Institutions and eligible impacted political subdivisions.
388-750-040	Maximum allowable reimbursement for law enforcement costs.
388-750-050	Maximum allowable reimbursement for prosecutorial costs.
388-750-060	Maximum allowable reimbursement for judicial costs.
388-750-070	Maximum allowable reimbursement for jail facilities.
388-750-080	Billing procedure.
388-750-090	Exceptions.
388-750-100	Effective date.
388-750-110	Audits.

WAC 388-750-010 Definitions. The following words and phrases shall have the following meaning when used in these regulations regarding the interpretation of regulations for the reimbursement from impacts caused by criminal behavior of state institutional residents:

"Department" means the department of social and health services.

"Incremental" means efforts or costs incurred by cities, towns, and/or counties that are not otherwise incurred and are only as a result of the criminal behavior of state institutional residents.

"Resident" means any person committed to a state institution by the courts for confinement as an offender pursuant to chapters 10.64, 10.77, and 13.40 RCW.

"Institution" means any state institution operated by the department for the confinement of offenders committed under chapters 10.64, 10.77, and 13.40 RCW.

"Law enforcement cost" means costs incurred to apprehend escapees or to investigate crimes committed by institutional residents within or outside state institutions listed in this chapter.

"Resident" means any person committed to a state institution by the courts for confinement as an offender under chapters 10.64, 10.77, and 13.40 RCW.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-010, filed 11/14/00, effective 12/15/00.]

WAC 388-750-020 Limitation of funds. The secretary shall make reimbursement to the extent funds are available. Reimbursement shall be strictly limited to political subdivisions in which state institutions, as defined in WAC 388-750-030, are located. Only incremental costs directly, specifically, and exclusively associated with criminal activities of

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offenders who are residents of state institutions shall be considered for reimbursement. Reimbursement shall be restricted to fully documented law enforcement, prosecutorial, judicial, and jail facilities costs. No such costs shall be paid under these rules if they are reimbursable under other chapters of the Washington Administrative Code. During each biennium, claims for incidents which occurred during the biennium will be paid in the order in which they are received until the biennial appropriation is fully expended.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-020, filed 11/14/00, effective 12/15/00.]

WAC 388-750-030 Institutions and eligible impacted political subdivisions. Reimbursement shall be limited to the following city, town, and county governments impacted by the offenses from residents committed to institutions listed in this section.

Institution	Cities/County
(1) Echo Glen Children's Center	Snoqualmie/King
(2) Green Hill Training School	Chehalis/Lewis
(3) Maple Lane School	Rochester/Thurston
(4) Mission Creek Youth Camp	Belfair/Mason
(5) Naselle Youth Camp	Naselle/Pacific
(6) Woodinville Treatment Center	Woodinville/King
(7) Canyon View Community Facility	East Wenatchee/Douglas
(8) Sunrise Community Facility	Ephrata/Grant
(9) Twin Rivers Community Facility	Richland/Benton
(10) Oakridge Community Facility	Tacoma/Pierce
(11) Park Creek Treatment Center	Kittitas/Kittitas
(12) Ridgeview Community Facility	Yakima/Yakima
(13) Western State Hospital	Steilacoom/Pierce
(14) Eastern State Hospital	Medical Lake/Spokane/Spokane
(15) Child Study and Treatment Center	Steilacoom/Pierce

(16) For any institution not listed in this section, reimbursement shall be limited to the political subdivisions where the institution is located. The institutions include juvenile community facilities, community treatment and community care facilities, as defined in WAC 388-750-010.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-030, filed 11/14/00, effective 12/15/00.]

WAC 388-750-040 Maximum allowable reimbursement for law enforcement costs. The department shall limit reimbursement to the specific political subdivisions listed in WAC 388-750-030. The maximum reimbursement rates shall be twenty-three dollars and ninety-six cents per hour. These reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-040, filed 11/14/00, effective 12/15/00.]

WAC 388-750-050 Maximum allowable reimbursement for prosecutorial costs. The department shall reimburse claims, at the rate set forth in WAC 388-750-040, for pretrial investigations of crimes committed inside or outside institutions, to the political subdivision courts in WAC 388-750-040. If, after investigation, criminal charges are filed, the department may reimburse documented prosecutorial and defense attorney fees. Reimbursement shall not exceed the following rates for each attorney, reimbursement includes costs for paralegals: Fifty-seven dollars and thirty-two cents per hour. These maximum allowable reimbursement rates

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may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-050, filed 11/14/00, effective 12/15/00.]

WAC 388-750-060 Maximum allowable reimbursement for judicial costs. (1) The department shall limit judicial costs strictly to cases involving inmates of institutions listed in WAC 388-750-030 and the listed subdivision in which they reside. Reimbursement shall be limited to judges, court reporters, transcript typing, and witness and jury fees.

(2) The department shall reimburse judges hearing cases including services provided by court clerks and bailiffs at fifty-seven dollars and thirty-two cents per hour. Reimburse court reporters at the rate of twenty-four dollars and seventy-one cents per hour. Reimburse for the typing of transcripts at four dollars and seventy-nine cents per page. If required, reimburse expert witnesses at eighty dollars and forty-three cents per hour.

(3) Reimbursement for witness fees (other than experts) and jury fees shall be at the rate established by the local governmental legislative authority but not in excess of thirty-six dollars and eleven cents per day.

(4) These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-060, filed 11/14/00, effective 12/15/00.]

WAC 388-750-070 Maximum allowable reimbursement for jail facilities. The department shall limit jail facility cost reimbursement strictly to incremental costs as defined in WAC 388-750-010. Requests for reimbursement shall be fully documented and shall include the resident's name and all appropriate admission and release dates. Limit reimbursement to thirty-four dollars and eighty cents per resident day. The department shall not reimburse for costs incurred for holding persons regarding parole revocations or for holding persons involved in civil litigation. The department shall reimburse costs of providing security when residents require hospitalization at the rate of fourteen dollars and nineteen cents per hour. These maximum allowable reimbursement rates may be exceeded only in the event that an exception is granted by the secretary as per WAC 388-750-090.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-070, filed 11/14/00, effective 12/15/00.]

WAC 388-750-080 Billing procedure. Requests for reimbursement should be made on the standard Washington State Invoice Voucher, Form A19, with supporting documentation attached. All claims may be subject to periodic audits at the discretion of the secretary, per WAC 388-750-110.

(1) All requests for reimbursement under this section shall note the name of the offender for whom costs were incurred, and the institution to which the offender was assigned.

(2) Requests for reimbursement may only be submitted by the jurisdiction's responsible fiscal officer, e.g., city man-

ager, city supervisor, county auditor, county administrator, etc.

(3) All requests for reimbursement must be submitted to: DSHS and the pertinent Accounts Payable Section of either Juvenile Rehabilitation Administration, Mailstop 45720, Olympia, Washington 98504; or Mental Health Division, Mail Stop 45320, Olympia, Washington 98504.

(4) If the appropriation for a biennium is fully expended prior to the end of the biennium, political subdivisions should continue to submit claims for the purpose of providing justification for requests for adequate funding levels in future biennia.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-080, filed 11/14/00, effective 12/15/00.]

WAC 388-750-090 Exceptions. The secretary, of the department, may allow exceptions to these rules.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-090, filed 11/14/00, effective 12/15/00.]

WAC 388-750-100 Effective date. Claims submitted according to this chapter may only be for costs incurred for appropriate actions, as defined in this chapter, taken by criminal justice agencies on or after August 30, 1979.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-100, filed 11/14/00, effective 12/15/00.]

WAC 388-750-110 Audits. The department has the right to audit any or all claims.

[Statutory Authority: RCW 72.72.040. 00-23-061, § 388-750-110, filed 11/14/00, effective 12/15/00.]

Chapter 388-800 WAC CHEMICAL DEPENDENCY ASSISTANCE PROGRAMS

WAC

388-800-0005	What is the purpose of this chapter?
388-800-0020	What detoxification services will the department pay for?
388-800-0025	What information does the department use to decide if I am eligible for the detoxification program?
388-800-0030	Who is eligible for detoxification services?
388-800-0035	How long am I eligible to receive detoxification services?
388-800-0040	What is ADATSA?
388-800-0045	What services are offered by ADATSA?
388-800-0048	Who is eligible for ADATSA?
388-800-0050	When am I eligible for ADATSA treatment services?
388-800-0055	What clinical incapacity must I meet to be eligible for ADATSA treatment services?
388-800-0057	Will I still be eligible for ADATSA outpatient services if I abstain from using alcohol or drugs, become employed, or have a relapse?
388-800-0060	What is the role of the certified chemical dependency service provider in determining ADATSA eligibility?
388-800-0065	What are the responsibilities of the certified chemical dependency service provider in determining eligibility?
388-800-0070	What happens after I am found eligible for ADATSA services?
388-800-0075	What criteria does the certified chemical dependency service provider use to plan my treatment?
388-800-0085	Do I have to contribute to the cost of residential treatment?
388-800-0090	What happens when I withdraw or am discharged from treatment?

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388-800-0100	What are the groups that receive priority for ADATSA services?
388-800-0110	What cash benefits am I eligible for through ADATSA if I am in residential treatment?
388-800-0115	What cash benefits can I receive through ADATSA if I am in outpatient treatment?
388-800-0120	As an eligible ADATSA client, when would I get state-funded medical assistance?
388-800-0130	What are ADATSA shelter services?
388-800-0135	When am I eligible for ADATSA shelter services?
388-800-0140	What incapacity criteria must I meet to be eligible for ADATSA shelter services?
388-800-0145	How does the department review my eligibility for ADATSA shelter services?
388-800-0150	Who is my protective payee?
388-800-0155	What are the responsibilities of my protective payee?
388-800-0160	What are the responsibilities of an intensive protective payee?
388-800-0165	What happens if my relationship with my protective payee ends?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-800-0080	What are the time limits for receiving types of chemical dependency treatment through ADATSA? [Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0080, filed 7/28/00, effective 9/1/00.] Repealed by 03-02-079, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.50.080 and 2002 c 64.
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WAC 388-800-0005 What is the purpose of this chapter? This chapter explains chemical dependency treatment services available through public assistance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0005, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0020 What detoxification services will the department pay for? (1) The department only pays for services that are:

- (a) Provided to eligible persons (see WAC 388-800-0030);
- (b) Directly related to detoxification; and
- (c) Performed by a certified detoxification center or by a general hospital that has a contract with the department to provide detoxification services.

(2) The department limits on paying for detoxification services are:

- (a) Three days for an acute alcoholic condition; or
- (b) Five days for acute drug addiction.

(3) The department only pays for detoxification services when notified within ten working days of the date detoxification began and all eligibility factors are met.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0020, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0025 What information does the department use to decide if I am eligible for the detoxification program? (1) The department uses the information you provide on the department's application form to determine if you are eligible for the detoxification program.

(2) The department may require an interview, documents or other verification if the department has questions about or needs to confirm the information you provided on your application.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0025, filed 7/28/00, effective 9/1/00.]

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WAC 388-800-0030 Who is eligible for detoxification services? (1) You are eligible for detoxification services if you:

(a) Receive benefits from temporary aid for needy families (TANF), general assistance unemployable (GAU), a medical assistance program, or Supplemental Security Income (SSI); or

(b) Do not have a combined nonexempt income and/or resources that exceed the payment standards for TANF.

(2) To determine your financial eligibility for the detoxification program the department deducts or exempts the following:

(a) A home;

(b) Household furnishings and personal clothing essential for daily living;

(c) Other personal property used to reduce need for assistance or for rehabilitation;

(d) A used and useful automobile;

(e) Mandatory expenses of employment;

(f) Total income and resources of a noninstitutionalized SSI beneficiary;

(g) Support payments paid under a court order; and

(h) Payments to a wage earner plan specified by a court in bankruptcy proceedings, or previously contracted major household repairs, when failure to make such payments will result in garnishment of wages or loss of employment.

(3) The following resources are not exempt:

(a) Cash;

(b) Marketable securities; and

(c) Any other resource not specifically exempted that can be converted to cash.

(4) If you receive detoxification services you shall not incur a deductible as a factor of eligibility for the covered period of detoxification.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0030, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0035 How long am I eligible to receive detoxification services? You are eligible for detoxification services from the date detoxification begins through the end of the month in which you complete the detoxification.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0035, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0040 What is ADATSA? (1) ADATSA stands for the Alcohol and Drug Addiction Treatment and Support Act which is a legislative enactment providing state-financed treatment and support to chemically dependent indigent persons.

(2) ADATSA provides eligible people with:

(a) Treatment if you are chemically dependent and would benefit from it; or

(b) A program of shelter services if you are chemically dependent and your chemical dependency has resulted in incapacitating physiological or cognitive impairments.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0040, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0045 What services are offered by ADATSA? If you qualify for the ADATSA program you may be eligible for:

(1) Alcohol/drug treatment services and support described under WAC-388-800-0080.

(2) Shelter services as described under WAC 388-800-0130.

(3) Medical care services as described under WAC 388-556-0500, 388-501-0060, and 388-501-0065.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-800-0045, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0045, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0045, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0048 Who is eligible for ADATSA? To be eligible for ADATSA services you must:

(1) Be eighteen years of age or older;

(2) Be a resident of Washington as defined in WAC 388-468-0005;

(3) Meet citizenship requirements as described in WAC 388-424-0015(3).

(4) Provide your Social Security number; and

(5) Meet the same income and resource criteria for the GA-U program; OR be receiving federal assistance under SSI or TANF.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-800-0048, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0048, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0050 When am I eligible for ADATSA treatment services? (1) You are eligible for ADATSA treatment services when you meet the:

(a) Financial eligibility criteria in WAC 388-800-0048; and

(b) Incapacity eligibility criteria in WAC 388-800-0055.

(2) If you are able to access, at no cost, state-approved chemical dependency treatment comparable to ADATSA treatment services, you may choose it rather than ADATSA.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0050, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0055 What clinical incapacity must I meet to be eligible for ADATSA treatment services? You are clinically eligible for ADATSA treatment services when you:

(1) Are diagnosed as having a mild, moderate, or severe dependency on a psychoactive substance class other than nicotine or caffeine, using the current criteria for Psychoactive Substance Dependence in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (DSM IV or its successor);

(2) Have not abstained from alcohol and drug use for the last ninety days, excluding days spent while incarcerated;

(3) Have not been gainfully employed in a job in the competitive labor market at any time during the last thirty days. For the purposes of this chapter, "gainfully employed" means performing in a regular and predictable manner an activity for pay or profit. Gainful employment does not include noncompetitive jobs such as work in a department-approved sheltered workshop or sporadic or part-time work, if the person, due to functional limitation, is unable to compete with unimpaired workers in the same job; and

(4) Are incapacitated, i.e., unable to work. Incapacity exists if you are one or more of the following:

- (a) Currently pregnant or up to two months postpartum;
- (b) Diagnosed as at least moderately psychoactive substance dependent and referred for treatment by child protective services;
- (c) Diagnosed as severely psychoactive substance dependent and currently an intravenous drug user;
- (d) Diagnosed as severely psychoactive substance dependent and has at least one prior admission to a department-approved alcohol/drug treatment or detoxification program;
- (e) Diagnosed as severely psychoactive substance dependent and have had two or more arrests for offenses directly related to the chemical dependency; or
- (f) Lost two or more jobs during the last six months as a direct result of chemical dependency.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0055, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0055, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0057 Will I still be eligible for ADATSA outpatient services if I abstain from using alcohol or drugs, become employed, or have a relapse? When you are successfully participating in ADATSA outpatient treatment services you are still considered incapacitated and eligible for ADATSA treatment through completion of the planned treatment, even if you:

- (1) Become employed;
- (2) Abstain from alcohol or drug use; or
- (3) Relapse (resumption of your psychoactive substance abuse dependence).

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0057, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0060 What is the role of the certified chemical dependency service provider in determining ADATSA eligibility? (1) A department-certified chemical dependency service provider determines your clinical incapacity based on alcoholism and/or drug addiction.

(2) The certified chemical dependency service provider provides a written current assessment needed to determine your eligibility.

(3) This assessment is the department's sole source of medical evidence required for the diagnosis and evaluation of your chemical dependency and its effects on employability.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0060, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0060, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0065 What are the responsibilities of the certified chemical dependency service provider in determining eligibility? (1) The role of the certified chemical dependency service provider is to:

- (a) Provide your diagnostic evaluation and decide your initial treatment placement;
- (b) Conduct a face-to-face diagnostic assessment, according to WAC 388-805-310, to determine if you:
 - (i) Are chemically dependent;

(ii) Meet incapacity standards for treatment under WAC 388-800-0055; and

(iii) Are willing, able, and eligible to undergo a course of ADATSA chemical dependency treatment, once determined incapacitated.

(c) Determines a course of treatment based on your individual assessment of alcohol/drug involvement and treatment needs in accordance with RCW 70.96A.100.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0065, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0065, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0070 What happens after I am found eligible for ADATSA services? Once your financial and clinical eligibility is established, the certified chemical dependency service provider:

- (1) Develops your ADATSA treatment plan;
- (2) Arranges your initial chemical dependency treatment placements taking into account the treatment priorities described under WAC 388-800-0100;
- (3) Provides you with written notification of your right to return to the community service office (CSO) at any time while receiving ADATSA treatment;
- (4) Provides you with written notification of your right to request a fair hearing to challenge any action affecting eligibility for ADATSA treatment; and
- (5) Notifies the CSO promptly of your placement or eligibility status changes.

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0070, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0070, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0075 What criteria does the certified chemical dependency service provider use to plan my treatment? When evaluating a treatment plan which will benefit you the most, the certified chemical dependency service provider considers clinical or medical factors utilizing the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC).

[Statutory Authority: RCW 74.50.080 and 2002 c 64. 03-02-079, § 388-800-0075, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0075, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0085 Do I have to contribute to the cost of residential treatment? Once you have been determined financially eligible to receive ADATSA residential treatment services the department does not require you to contribute toward the cost of care.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0085, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0090 What happens when I withdraw or am discharged from treatment? (1) You will be terminated from ADATSA treatment services if you leave treatment.

(2) If you are discharged from treatment for any other reason, you will be referred to the next appropriate level of treatment.

(3) If you are absent from any residential treatment services for less than seventy-two hours you may reenter that program without being considered as having dropped out. This is done at the discretion of the treatment service administrator and without requiring you to apply for readmittance through the certified chemical dependency service provider.

(4) Once you voluntarily leave treatment you must reappear and be referred again to the certified chemical dependency service provider to receive further ADATSA treatment services.

(5) If you are terminated from treatment you are not eligible for benefits beyond the month in which treatment services end. Rules regarding advance and adequate notice still apply, but you are not eligible for continued assistance pending a fair hearing.

[Statutory Authority: RCW 74.50.080 and 2002 c 64, 03-02-079, § 388-800-0090, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0090, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0100 What are the groups that receive priority for ADATSA services? (1) When assigning treatment admissions, the ADATSA/Adult assessment certified chemical dependency service provider:

(a) Gives first priority to you if you are a pregnant woman or a parent with a child under eighteen years old in the home;

(b) Provides priority access for admission if you are:

(i) Referred by the department's children's protective services (CPS) program; and/or

(ii) An injecting drug user (IDU).

(2) If you are completing residential treatment you have priority access to outpatient treatment.

[Statutory Authority: RCW 74.50.080 and 2002 c 64, 03-02-079, § 388-800-0110, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0100, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0110 What cash benefits am I eligible for through ADATSA if I am in residential treatment? When you are in ADATSA residential treatment and are below the department payment standard for clothing and personal incidentals (CPI) you may be eligible to receive CPI.

[Statutory Authority: RCW 74.50.080 and 2002 c 64, 03-02-079, § 388-800-0110, filed 12/30/02, effective 1/30/03. Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0110, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0115 What cash benefits can I receive through ADATSA if I am in outpatient treatment? When you are in ADATSA outpatient treatment, you may be eligible for a treatment living allowance for housing and other living expenses.

(1) Your living allowance maximum amount will be based on the current ADATSA payment standard as provided under WAC 388-478-0030.

(2) Your outpatient provider will act as your protective payee and administer your living allowance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0115, filed 7/28/00, effective 9/1/00.]

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WAC 388-800-0120 As an eligible ADATSA client, when would I get state-funded medical assistance? You are eligible for state-funded medical assistance when you are in one of the following situations:

(1) You meet the requirements in WAC 388-800-0048 and are waiting to receive ADATSA treatment services;

(2) When you are participating in ADATSA residential or outpatient treatment;

(3) You choose opiate dependency (methadone maintenance) chemical dependency treatment services instead of other ADATSA treatment, but only if these treatment services are from a state-approved, publicly funded opiate dependency/methadone maintenance program; or

(4) You meet the requirements of WAC 388-800-0135, for shelter services but choose not to receive shelter assistance.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0120, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0130 What are ADATSA shelter services? (1) Your shelter assistance in independent housing consists of a monthly shelter assistance payment through an intensive protective payee defined under WAC 388-800-0160; and

(2) You continue to receive benefits for ADATSA shelter if you request a fair hearing within the advance notice period before termination is to occur.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0130, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0135 When am I eligible for ADATSA shelter services? You are eligible for ADATSA shelter services when you meet the:

(1) Financial eligibility criteria in WAC 388-800-0040; and

(2) Incapacity eligibility criteria in WAC 388-800-0140.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0135, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0140 What incapacity criteria must I meet to be eligible for ADATSA shelter services? You are eligible for ADATSA shelter services when you:

(1) Are actively addicted, meaning having used alcohol or drugs within the sixty-day period immediately preceding the latest assessment center evaluation, as determined by the ADATSA/Adult assessment center; and

(2) Have resulting physiological or organic damage, or have resulting cognitive impairment not expected to dissipate within sixty days of sobriety or detoxification, which either:

(a) Limits your functioning because of physiological or organic damage that result in a significant restriction on ability to perform work activities, or

(b) At least a moderate impairment of your ability to understand, remember, and follow complex instructions; and

(c) An overall moderate impairment in your ability to:

(i) Learn new tasks;

(ii) Exercise judgment;

(iii) Make decisions, and

(iv) Perform routine tasks without undue supervision.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0140, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0145 How does the department review my eligibility for ADATSA shelter services? The department:

(1) Redetermines your incapacity and financial and medical eligibility for ADATSA shelter every six months or more often; and

(2) Provides you adequate and advance notice of adverse action.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0145, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0150 Who is my protective payee? Your protective payee is either:

(1) Your outpatient treatment provider while in ADATSA treatment; or

(2) An agency under contract with the department to provide you with intensive protective payee services if you are an ADATSA shelter client.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0150, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0155 What are the responsibilities of my protective payee? Your protective payee:

(1) Has the authority and responsibility to make decisions about the expenditure of your outpatient treatment stipends;

(2) Encourages you to participate in the decision-making process. The amount of decision making the protective payee allows you depends upon the level of responsibility you demonstrate; and

(3) Disburses funds to meet your basic needs of shelter, utilities, food, clothing, and personal incidentals.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0155, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0160 What are the responsibilities of an intensive protective payee? If you are receiving shelter services, your intensive protective payee provides you with case management services including, but not be limited to:

(1) Disbursing payment for shelter and utilities, such as a check directly to the landlord, mortgage company, utility company, etc.;

(2) Directing payment to vendors directly for goods or services provided to you including personal and incidental expenses.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0160, filed 7/28/00, effective 9/1/00.]

WAC 388-800-0165 What happens if my relationship with my protective payee ends? If the relationship with your protective payee is terminated for any reason, the protective payee shall return any remaining funds to the department or its designee.

[Statutory Authority: RCW 74.08.090, 74.50.80 [74.50.080]. 00-16-077, § 388-800-0165, filed 7/28/00, effective 9/1/00.]

[Title 388 WAC—p. 1196]

Chapter 388-805 WAC

CERTIFICATION REQUIREMENTS FOR CHEMICAL DEPENDENCY SERVICE PROVIDERS (Formerly chapter 440-22 WAC)

WAC

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- 388-805-850 What are the requirements for treatment accountability for safer communities (TASC) providers and services? [Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-850, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-850, filed 11/21/00, effective 1/1/01.] Repealed by 06-11-096, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8.
- 388-805-900 What are the requirements for outpatient child care when a parent is in treatment? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-900, filed 11/21/00, effective 1/1/01.]

388-805-905

Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

What are the requirements for outpatient child care admission and health history? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-905, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-910

What are the requirements for outpatient child care policies? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-910, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-915

What are the requirements for an outpatient child care activity program? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-915, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-920

What are the requirements for outpatient child care behavior management and discipline? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-920, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-925

What are the requirements for outpatient child care diaper changing? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-925, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-930

What are the requirements for outpatient child care food service? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-930, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

388-805-935

What are the staffing requirements for outpatient child care services? [Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-935, filed 11/21/00, effective 1/1/01.] Repealed by 03-20-020, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8.

SECTION I—PURPOSE AND DEFINITIONS

WAC 388-805-001 What is the purpose of this chapter? These rules describe the standards and processes necessary to be a certified chemical dependency treatment program. The rules have been adopted under the authority and purposes of the following chapters of law.

(1) Chapter 10.05 RCW, Deferred prosecution—Courts of limited jurisdiction;

(2) Chapter 46.61 RCW, Rules of the road;

(3) Chapter 49.60 RCW, Discrimination—Human rights commission;

(4) Chapter 70.96A RCW, Treatment for alcoholism, intoxication and drug addiction; and

(5) Chapter 74.50 RCW, Alcoholism and Drug Addiction Treatment and Support Act (ADATSA).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW, 00-23-107, § 388-805-001, filed 11/21/00, effective 1/1/01.]

WAC 388-805-005 What definitions are important throughout this chapter? "Added service" means the add-

ing of certification for chemical dependency levels of care to an existing certified agency at an approved location.

"Addiction counseling competencies" means the knowledge, skills, and attitudes of chemical dependency counselor professional practice as described in Technical Assistance Publication No. 21, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services 1998.

"Administrator" means the person designated responsible for the operation of the certified treatment service.

"Adult" means a person eighteen years of age or older.

"Alcoholic" means a person who has the disease of alcoholism.

"Alcoholism" means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

"Approved supervisor" means a person who meets the education and experience requirements described in WAC 246-811-030 and 246-811-045 through 246-811-049 and who is available to the person being supervised.

"Authenticated" means written, permanent verification of an entry in a patient treatment record by an individual, by means of an original signature including first initial, last name, and professional designation or job title, or initials of the name if the file includes an authentication record, and the date of the entry. If patient records are maintained electronically, unique electronic passwords, biophysical or passcard equipment are acceptable methods of authentication.

"Authentication record" means a document that is part of a patient's treatment record, with legible identification of all persons initialing entries in the treatment record, and includes:

- (1) Full printed name;
- (2) Signature including the first initial and last name; and
- (3) Initials and abbreviations indicating professional designation or job title.

"Bloodborne pathogens" means pathogenic microorganisms that are present in human blood and can cause disease in humans. The pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

"Branch site" means a physically separate certified site where qualified staff provides a certified treatment service, governed by a parent organization. The branch site is an extension of a certified provider's services to one or more sites.

"Certified treatment service" means a discrete program of chemical dependency treatment offered by a service provider who has a certificate of approval from the department of social and health services, as evidence the provider meets the standards of chapter 388-805 WAC.

"Change in ownership" means one of the following conditions:

(1) When the ownership of a certified chemical dependency treatment provider changes from one distinct legal owner to another distinct legal owner;

(2) When the type of business changes from one type to another such as, from a sole proprietorship to a corporation; or

(3) When the current ownership takes on a new owner of five percent or more of the organizational assets.

"Chemical dependency" means a person's alcoholism or drug addiction or both.

"Chemical dependency counseling" means face-to-face individual or group contact using therapeutic techniques that are:

(1) Led by a chemical dependency professional (CDP), or CDP trainee under supervision of a CDP;

(2) Directed toward patients and others who are harmfully affected by the use of mood-altering chemicals or are chemically dependent; and

(3) Directed toward a goal of abstinence for chemically dependent persons.

"Chemical dependency professional" means a person certified as a chemical dependency professional by the Washington state department of health under chapter 18.205 RCW.

"Child" means a person less than eighteen years of age, also known as adolescent, juvenile, or minor.

"Clinical indicators" include, but are not limited to, inability to maintain abstinence from alcohol or other nonprescribed drugs, positive drug screens, patient report of a subsequent alcohol/drug arrest, patient leaves program against program advice, unexcused absences from treatment, lack of participation in self-help groups, and lack of patient progress in any part of the treatment plan.

"Community relations plan" means a plan to minimize the impact of an opiate substitution treatment program as defined by the Center for Substance Abuse Guidelines for the Accreditation of Opioid Treatment Programs, section XVIII.

"County coordinator" means the person designated by the legislative authority of a county to carry out administrative and oversight responsibilities of the county chemical dependency program.

"Criminal background check" means a search by the Washington state patrol for any record of convictions or civil adjudication related to crimes against children or other persons, including developmentally disabled and vulnerable adults, per RCW 43.43.830 through 43.43.842 relating to the Washington state patrol.

"Critical incidents" includes:

- (1) Death of a patient;
- (2) Serious injury;
- (3) Sexual assault of patients, staff members, or public citizens on the facility premises;
- (4) Abuse or neglect of an adolescent or vulnerable adult patient by another patient or agency staff member on facility premises;
- (5) A natural disaster presenting a threat to facility operation or patient safety;
- (6) A bomb threat; a break in or theft of patient identifying information;
- (7) Suicide attempt at the facility.

"CSAT" means the Federal Center For Substance Abuse Treatment, a Substance Abuse Service Center of the

Substance Abuse and Mental Health Services Administration.

"Danger to self or others," for purposes of WAC 388-805-520, means a youth who resides in a chemical dependency treatment agency and creates a risk of serious harm to the health, safety, or welfare to self or others. Behaviors considered a danger to self or others include:

- (1) Suicide threat or attempt;
- (2) Assault or threat of assault; or
- (3) Attempt to run from treatment, potentially resulting in a dangerous or life-threatening situation.

"Department" means the Washington state department of social and health services.

"Determination of need" means a process used by the department for opiate substitution treatment program slots within a county area as described in WAC 388-805-040.

"Detoxification" or **"detox"** means care and treatment of a person while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Disability, a person with" means a person whom:

- (1) Has a physical or mental impairment that substantially limits one or more major life activities of the person;
- (2) Has a record of such an impairment; or
- (3) Is regarded as having such an impairment.

"Discrete treatment service" means a chemical dependency treatment service that:

- (1) Provides distinct chemical dependency supervision and treatment separate from any other services provided within the facility;
- (2) Provides a separate treatment area for ensuring confidentiality of chemical dependency treatment services; and
- (3) Has separate accounting records and documents identifying the provider's funding sources and expenditures of all funds received for the provision of chemical dependency treatment services.

"Domestic violence" means:

- (1) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members;
- (2) Sexual assault of one family or household member by another;
- (3) Stalking as defined in RCW 9A.46.110 of one family or household member by another family or household member; or
- (4) As defined in RCW 10.99.020, 26.50.010, or other Washington state statutes.

"Drug addiction" means a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. Drug addiction is characterized by impaired control over use of drugs, preoccupation with drugs, use of a drug despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

"Essential requirement" means a critical element of chemical dependency treatment services that must be present in order to provide effective treatment.

"Established ratio" means using 0.7 percent (.007) of a designated county's adult population to determine an estimate for the number of potential patients with an opiate diagnosis

in need of treatment services as described in WAC 388-805-040.

"Faith-based organization" means an agency or organization such as a church, religiously affiliated entity, or religious organization.

"First steps" means a program available across the state for low-income pregnant women and their infants. First steps provides maternity care for pregnant and postpartum women and health care for infants and young children.

"Governing body" means the legal entity responsible for the operation of the chemical dependency treatment service.

"HIV/AIDS brief risk intervention (BRI)" means an individual face-to-face interview with a patient, to help that person assess personal risk for HIV/AIDS infection and discuss methods to reduce infection transmission.

"HIV/AIDS education" means education, in addition to the brief risk intervention, designed to provide a person with information regarding HIV/AIDS risk factors, HIV antibody testing, HIV infection prevention techniques, the impact of alcohol and other drug use on risks and the disease process, and trends in the spread of the disease.

"Medical practitioner" means a physician, advanced registered nurse practitioner (ARNP), or certified physician's assistant. ARNPs and midwives with prescriptive authority may perform practitioner functions related only to indicated specialty services.

"Off-site treatment" means provision of chemical dependency treatment by a certified provider at a location where treatment is not the primary purpose of the site; such as in schools, hospitals, or correctional facilities.

"Opiate substitution treatment program" means an organization that administers or dispenses an approved medication as specified in 212 CFR Part 291 for treatment or detoxification of opiate dependence. The agency is:

- (1) Certified as an opioid treatment program by the Federal Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration;
- (2) Licensed by the Federal Drug Enforcement Administration;
- (3) Registered by the state board of pharmacy;
- (4) Accredited by an opioid treatment program accreditation body approved by the Federal Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration; and
- (5) Certified as an opiate substitution treatment program by the department.

"Outcomes evaluation" means a system for determining the effectiveness of results achieved by patients during or following service delivery, and patient satisfaction with those results for the purpose of program improvement.

"Patient" is a person receiving chemical dependency treatment services from a certified program.

"Patient contact" means time spent with a patient to do assessments, individual or group counseling, or education.

"Patient placement criteria (PPC)" means admission, continued service, and discharge criteria found in the patient placement criteria for the treatment of substance-related disorders as published by the American Society of Addiction Medicine (ASAM).

"Probation assessment officer (PAO)" means a person employed at a certified district or municipal court probation assessment service that meets the PAO requirements of WAC 388-805-220.

"Probation assessment service" means a certified assessment service offered by a misdemeanor probation department or unit within a county or municipality.

"Progress notes" are a permanent record of ongoing assessments of a patient's participation in and response to treatment, and progress in recovery.

"Qualified personnel" means trained, qualified staff, consultants, trainees, and volunteers who meet appropriate legal, licensing, certification, and registration requirements.

"Registered counselor" means a person registered by the state department of health as required by chapter 18.19 RCW.

"Relocation" means change in location from one office space to a new office space, or moving from one office building to another.

"Remodeling" means expansion of existing office space to additional office space at the same address, or remodeling of interior walls and space within existing office space.

"SAMHSA" means the Federal Substance Abuse and Mental Health Services Administration.

"Self-help group" means community based support groups that address chemical dependency.

"Service provider" or **"provider"** means a legally operated entity certified by the department to provide chemical dependency services. The components of a service provider are:

- (1) Legal entity/owner;
- (2) Facility; and
- (3) Staff and services.

"Sexual abuse" means:

- (1) Sexual assault;
- (2) Incest; or
- (3) Sexual exploitation.

"Sexual harassment" means unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

(1) Submission to such conduct is made either explicitly or implicitly a term or condition of employment or treatment; or

(2) Such conduct interferes with work performance or creates an intimidating, hostile, or offensive work or treatment environment.

"Substance abuse" means a recurring pattern of alcohol or other drug use that substantially impairs a person's functioning in one or more important life areas, such as familial, vocational, psychological, physical, or social.

"Summary suspension" means an immediate suspension of certification, per RCW 34.05.422(4), by the department pending administrative proceedings for suspension, revocation, or other actions deemed necessary by the department.

"Supervision" means:

(1) Regular monitoring of the administrative, clinical, or clerical work performance of a staff member, trainee, student, volunteer, or employee on contract by a person with the authority to give directions and require change; and

(2) **"Direct supervision"** means the supervisor is on the premises and available for immediate consultation.

"Suspend" means termination of the department's certification of a provider's treatment services for a specified period or until specific conditions have been met and the department notifies the provider of reinstatement.

"TARGET" means the treatment and assessment report generation tool.

"Treatment plan review" means a review of active problems on the patient's individualized treatment plan, the need to address new problems, and patient placement.

"Treatment services" means the broad range of emergency, detoxification, residential, and outpatient services and care. Treatment services include diagnostic evaluation, chemical dependency education, individual and group counseling, medical, psychiatric, psychological, and social services, vocational rehabilitation and career counseling that may be extended to alcoholics and other drug addicts and their families, persons incapacitated by alcohol or other drugs, and intoxicated persons.

"Urinalysis" means analysis of a patient's urine sample for the presence of alcohol or controlled substances by a licensed laboratory or a provider who is exempted from licensure by the department of health:

(1) **"Negative urine"** is a urine sample in which the lab does not detect specific levels of alcohol or other specified drugs; and

(2) **"Positive urine"** is a urine sample in which the lab confirms specific levels of alcohol or other specified drugs.

"Vulnerable adult" means a person who lacks the functional, mental, or physical ability to care for oneself.

"Young adult" means an adult who is eighteen, nineteen, or twenty years old.

"Youth" means a person seventeen years of age or younger.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-005, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-005, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-005, filed 11/21/00, effective 1/1/01.]

SECTION II—APPLICATION FOR CERTIFICATION

WAC 388-805-010 What chemical dependency services are certified by the department? (1) The department certifies the following types of chemical dependency services:

(a) **Detoxification services**, which assist patients in withdrawing from alcohol and other drugs including:

(i) **Acute detox**, which provides medical care and physician supervision for withdrawal from alcohol or other drugs; and

(ii) **Subacute detox**, which is nonmedical detoxification or patient self-administration of withdrawal medications ordered by a physician, provided in a home-like environment.

(b) **Residential treatment services**, which provide chemical dependency treatment for patients and include room and board in a twenty-four-hour-a-day supervised facility, including:

(i) **Intensive inpatient**, a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts, and their families;

(ii) **Recovery house**, a program of care and treatment with social, vocational, and recreational activities to aid in patient adjustment to abstinence and to aid in job training, employment, or other types of community activities; and

(iii) **Long-term treatment**, a program of treatment with personal care services for chronically impaired alcoholics and addicts with impaired self-maintenance capabilities. These patients need personal guidance to maintain abstinence and good health.

(c) **Outpatient treatment services**, which provide chemical dependency treatment to patients less than twenty-four hours a day, including:

(i) **Intensive outpatient**, a concentrated program of individual and group counseling, education, and activities for detoxified alcoholics and addicts and their families;

(ii) **Outpatient**, individual and group treatment services of varying duration and intensity according to a prescribed plan; and

(iii) **Opiate substitution outpatient treatment**, which meets both outpatient and opiate substitution treatment program service requirements.

(d) **Assessment services**, which include:

(i) **ADATSA assessments**, alcohol and other drug assessments of patients seeking financial assistance from the department due to the incapacity of chemical dependency. Services include assessment, referral, case monitoring, and assistance with employment; and

(ii) **DUI assessments**, diagnostic services requested by the courts to determine a person's involvement with alcohol and other drugs and to recommend a course of action.

(e) **Information and assistance services**, which include:

(i) **Alcohol and drug information school**, an education program about the use and abuse of alcohol and other drugs, for persons referred by the courts and others, who may have been assessed and do not present a significant chemical dependency problem, to help those persons make informed decisions about the use of alcohol and other drugs;

(ii) **Information and crisis services**, response to persons having chemical dependency needs, by phone or in person;

(iii) **Emergency service patrol**, assistance provided to intoxicated persons in the streets and other public places;

(2) The department may certify a provider for more than one of the services listed under subsection (1) of this section when the provider complies with the specific requirements of the selected services.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-010, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-010, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-010, filed 11/21/00, effective 1/1/01.]

WAC 388-805-015 How do I apply for certification as a chemical dependency service provider? (1) A potential new chemical dependency service provider, referred to as

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applicant, seeking certification for one or more services, as described under WAC 388-805-010, must:

(a) Request from the department an application packet of information on how to become a certified chemical dependency service provider; and

(b) Obtain a license as a residential treatment facility from the department of health, if planning to offer residential services.

(2) The applicant must submit a completed application to the department that includes:

(a) If the applicant is a sole provider: The name and address of the applicant, and a statement of sole proprietorship;

(b) If the applicant is a partnership: The name and address of every partner, and a copy of the written partnership agreement;

(c) If the applicant is a limited liability company: The name and addresses of its officers, and any owner of five percent or more of the organizational assets, and a copy of the certificate of formation issued by the state of Washington, secretary of state;

(d) If the applicant is a corporation: The names and addresses of its officers, board of directors and trustees, and any owner of five percent or more of the organizational assets, and a copy of the corporate articles of incorporation and bylaws;

(e) A copy of the master business license authorizing the organization to do business in Washington state;

(f) The social security number or Federal Employer Identification Number for the governing organization or person;

(g) The name of the individual administrator under whose management or supervision the services will be provided;

(h) A copy of the report of findings from a criminal background check of any owner of five percent or more of the organizational assets and the administrator;

(i) Additional disclosure statements or background inquiries if the department has reason to believe that offenses, specified under RCW 43.43.830, have occurred since completion of the original application;

(j) The physical location of the facility where services will be provided including, in the case of a location known only by postal route and box numbers, and the street address;

(k) A plan of the premises assuring the chemical dependency treatment service is discrete from other programs, indicating capacities of the location for the proposed uses;

(l) Floor plan showing use of each room and location of:

(i) Windows and doors;

(ii) Restrooms;

(iii) Floor to ceiling walls;

(iv) Areas serving as confidential counseling rooms;

(v) Other therapy and recreation areas and rooms;

(vi) Confidential patient records storage; and

(vii) Sleeping rooms, if a residential facility.

(m) A completed facility accessibility self-evaluation form;

(n) Policy and procedure manuals specific to the agency at the proposed site, and meet the manual requirements described later in this regulation, including the:

(i) Administrative manual;

- (ii) Personnel manual; and
- (iii) Clinical manual.
- (o) Sample patient records for each treatment service applied for; and
- (p) Evidence of sufficient qualified staff to deliver services.
- (3) In addition to the requirements in this section, a faith-based organization may implement the requirements of the federal Public Health Act, Sections 581-584 and Section 1955 of 24 U.S.C. 290 and 42 U.S.C. 300x-65.
- (4) The agency owner or legal representative must:
 - (a) Sign the completed application form and submit the original to the department;
 - (b) Send a copy of the completed application form to the county coordinator in the county where services will be provided;
 - (c) Submit the application fee with the application materials; and
 - (d) Report any changes occurring during the certification process.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-015, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-015, filed 11/21/00, effective 1/1/01.]

WAC 388-805-020 How do I apply for certification of a branch agency or added service? (1) A certified chemical dependency service provider applying for a branch site or an additional certified service must request an abbreviated application packet from the department.

- (2) The applicant must submit an abbreviated application, including:
 - (a) The name of the individual administrator providing management or supervision of the services;
 - (b) A written declaration that a current copy of the agency policy and procedure manual will be maintained at the branch site and that the manual has been revised to accommodate the differences in business and clinical practices at that site;
 - (c) An organization chart, showing the relationship of the branch to the main organization, job titles, and lines of authority;
 - (d) Evidence of sufficient qualified staff to deliver services at the branch site; and
 - (e) Evidence of meeting the requirements of:
 - (i) WAC 388-805-015 (1)(b);
 - (ii) WAC 388-805-015 (2)(h) through (2)(l) and (m); and
 - (iii) WAC 388-805-015(3).

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-020, filed 11/21/00, effective 1/1/01.]

WAC 388-805-030 What are the requirements for opiate substitution treatment program certification? Certification as an opiate substitution treatment program is contingent on the concurrent approval by applicable state regulatory authorities; certification as an opioid treatment program by the Federal CSAT SAMHSA; accreditation by an opioid treatment program accreditation body approved by the Federal CSAT SAMHSA [SAMHSA]; and licensure by the Federal Drug Enforcement Administration. In addition to WAC 388-805-015 or 388-805-020 requirements, a potential opiate

substitution treatment program provider must submit to the department:

(1) Documentation the provider has communicated with the county legislative authority and if applicable, the city legislative authority or tribal legislative authority, in order to secure a location for the new opiate substitution treatment program that meets county, tribal or city land use ordinances.

(2) A completed community relations plan developed in consultation with the legislative authority or their designee to minimize the impact of the opiate substitution treatment programs upon the business and residential neighborhoods in which the program is located. The plan must include documentation of strategies used to:

- (a) Obtain stakeholder input regarding the proposed location;
- (b) Address any concerns identified by stakeholders; and
- (c) Develop an ongoing community relations plan to address new concerns expressed by stakeholders as they arise.

(3) A copy of the application for a registration certificate from the Washington state board of pharmacy.

(4) A copy of the application for licensure to the Federal Drug Enforcement Administration.

(5) A copy of the application for certification to the Federal CSAT SAMHSA.

(6) A copy of the application for accreditation by an accreditation body approved as an opioid treatment program accreditation body by the Federal CSAT SAMHSA.

(7) Policies and procedures identified under WAC 388-805-700 through 388-805-750.

(8) Documentation that transportation systems will provide reasonable opportunities to persons in need of treatment to access the services of the program.

(9) At least three letters of support from the administrator or their designee of other health care providers within the existing health care system in the area the applicant proposes to establish a new opiate substitution treatment program. The letters must demonstrate a relationship to the service area's existing health care system.

(10) A declaration to limit the number of individual program participants to three hundred fifty as specified in RCW 70.96A.410 (1)(e).

(11) For new applicants, who operate opiate substitution treatment programs in another state, copies of national and state certification/accreditation documentation, and copies of all survey reports written by national and/or state certification or accreditation organizations for each site they have operated an opiate substitution program in over the past six years.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-030, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-030, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-030, filed 11/21/00, effective 1/1/01.]

WAC 388-805-035 What are the responsibilities for the department when an applicant applies for approval of an opiate substitution treatment program? For purposes of this section, "area" means the county in which an opiate substitution treatment program applicant proposes to locate a certified program, and counties adjacent or near to the county

in which the program is proposed to be located. When making a decision on an application for certification of a program, the department must:

(1) Consult with the county legislative authority in the area in which an applicant proposes to locate a program and the city legislative authority or tribal legislative authority applicable to the site in which an applicant proposes to locate a program. The department will request the county and city or tribal legislative authority to notify the department of any applicable requirements or other issues that the department should consider in order to fulfill the requirements of WAC 388-805-030(7), or 388-805-040 (1) through (5);

(2) Not discriminate in its certification decision on the basis of the corporate structure of the applicant;

(3) Consider the size of the population in need of treatment in the area in which the program would be located and certify only applicants whose programs meet the necessary treatment needs of the population;

(4) Determine there is a need in the community for opiate substitution treatment and not certify more programs than justified by the need in that community as described in WAC 388-805-040;

(5) Consider whether the applicant has the capability, or has in the past demonstrated the capability to provide appropriate treatment services to assist persons in meeting legislative goals of abstinence from opiates and opiate substitutes, obtaining mental health treatment, improving economic independence, and reducing adverse consequences associated with illegal use of controlled substances;

(6) Hold at least one public hearing in the county in which the facility is proposed to be located and one public hearing in the area in which the facility is proposed to be located. After consultation with the county legislative authority, the department may have the public hearing in the adjacent county with the largest population, the adjacent county with the largest underserved population, or the county nearest to the proposed location. The hearing must be held at a time and location most likely to permit the largest number of interested persons to attend and present testimony. The department must notify appropriate media outlets of the time, date, and location of the hearing at least three weeks in advance of the hearing.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-035, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-035, filed 9/23/03, effective 10/25/03.]

WAC 388-805-040 How does the department determine there is a need in the community for opiate substitution treatment? The department will determine whether or not there is a demonstrated need in the community for opiate substitution treatment from information provided to the department by the applicant and through department consultation with the city or tribal and county legislative authority, and other appropriate community resources. A "determination of need" for a proposed program will include a review and evaluation of the following criteria:

(1) For the number of potential patients in an area, the department will consider the size of the population in need of treatment in the area in which the program would be located

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using adult population statistics from the most recent area population trend reports. The department will use the established ratio of .7 percent of the adult population as an estimate for the number of potential patients with an opiate diagnosis in need of treatment services.

(2) For the number of anticipated program slots in an area, the department will multiply the sum of the established ratio of .7 percent of the adult population in subsection (1) of this section by thirty-five percent to determine an estimate of the anticipated need for the number of opiate substitution treatment program slots in the area in which the program would be located.

(3) Demographic and trend data from the area in which the program would be located including the most recent department county trend data, TARGET admission data for opiate substitution treatment from the county, hospital and emergency department admission data from the county, needle exchange data from the county, and other relevant reports and data from county health organizations demonstrating the need for opiate substitution treatment program services.

(4) Availability of other opiate substitution treatment programs near the area of the applicant's proposed program. The department will determine the number of patients, capacity, and accessibility of existing opiate substitution treatment programs near the area of the applicant's proposed program and whether existing programs have the capacity to assume additional patients for treatment services.

(5) Whether the population served or to be served has need for the proposed program and whether other existing services and facilities of the type proposed are available or accessible to meet that need. The assessment will include, but not limited to, consideration of the following:

(a) The extent to which the proposed program meets the need of the population presently served;

(b) The extent to which the underserved need will be met adequately by the proposed program; and

(c) The impact of the service on the ability of low-income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups to obtain needed health care.

(6) The department will review agency policies and procedures that describe the cost of services to patients, sliding fee scales, and charity care policies, procedures, and goals.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-040, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-040, filed 9/23/03, effective 10/25/03.]

WAC 388-805-060 How does the department conduct an examination of nonresidential facilities? The department must conduct an on-site examination of each new nonresidential applicant's facility or branch facility. The department must determine if the applicant's facility is:

(1) Substantially as described.

(2) Suitable for the purposes intended.

(3) Not a personal residence.

(4) Approved as meeting all building and safety requirements.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-060, filed 11/21/00, effective 1/1/01.]

WAC 388-805-065 How does the department determine disqualification or denial of an application? The department must consider the ability of each person named in the application to operate in accord with this chapter before the department grants or renews certification of a chemical dependency service.

(1) The department must deny an applicant's certification when any of the following conditions occurred and was not satisfactorily resolved, or when any owner or administrator:

(a) Had a license or certification for a chemical dependency treatment service or health care agency denied, revoked, or suspended;

(b) Was convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse;

(c) Obtained or attempted to obtain a health provider license, certification, or registration by fraudulent means or misrepresentation;

(d) Committed, permitted, aided, or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180;

(e) Demonstrated cruelty, abuse, negligence, misconduct, or indifference to the welfare of a patient or displayed acts of discrimination;

(f) Misappropriated patient property or resources;

(g) Failed to meet financial obligations or contracted service commitments that affect patient care;

(h) Has a history of noncompliance with state or federal regulations in an agency with which the applicant has been affiliated;

(i) Knowingly, or with reason to know, made a false statement of fact or failed to submit necessary information in:

(i) The application or materials attached; and

(ii) Any matter under department investigation.

(j) Refused to allow the department access to records, files, books, or portions of the premises relating to operation of the chemical dependency service;

(k) Willfully interfered with the preservation of material information or attempted to impede the work of an authorized department representative;

(l) Is in violation of any provision of chapter 70.96A RCW; or

(m) Does not meet criminal background check requirements.

(2) The department may deny certification when an applicant:

(a) Fails to provide satisfactory application materials; or

(b) Advertises itself as certified when certification has not been granted, or has been revoked or canceled.

(3) The department may deny an application for certification of an opiate substitution treatment program when:

(a) There is not a demonstrated need in the community for opiate substitution treatment and/or there is not a demonstrated need for more program slots justified by the need in that community;

(b) There is sufficient availability, accessibility, and capacity of other certified programs near the area in which the applicant proposes to locate the program;

(c) The applicant has not demonstrated in the past, the capability to provide the appropriate services to assist the persons who will utilize the program in meeting goals established by the legislature, including:

- (i) Abstinence from opiates and opiate substitutes,
- (ii) Obtaining mental health treatment,
- (iii) Improving economic independence, and
- (iv) Reducing adverse consequences associated with illegal use of controlled substances.

(4) The applicant may appeal department decisions in accord with chapter 34.05 RCW, the Washington Administrative Procedure Act and chapter 388-02 WAC.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-065, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-065, filed 11/21/00, effective 1/1/01.]

WAC 388-805-070 What happens after I make application for certification? (1) The department may grant an applicant initial certification after a review of application materials and an on-site visit confirms the applicant has the capacity to operate in compliance with this chapter.

(2) A provider's failure to meet and maintain conditions of the initial certification may result in suspension of certification.

(3) An initial certificate of approval may be issued for up to one year.

(4) The provider must post the certificate in a conspicuous place on the premises.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-070, filed 11/21/00, effective 1/1/01.]

WAC 388-805-075 How do I apply for an exemption? (1) The department may grant an exemption from compliance with specific requirements in this WAC chapter if the exemption does not violate:

(a) An existing federal or state law; or

(b) An existing tribal law.

(2) Providers must submit a signed letter requesting the exemption to the Supervisor, Certification Section, Division of Alcohol and Substance Abuse, P.O. Box 45330, Olympia, WA 98504-5330. The provider must assure the exemption request does not:

(a) Jeopardize the safety, health, or treatment of patients; and

(b) Impede fair competition of another service provider.

(3) The department must approve or deny all exemption requests in writing.

(4) The department and the provider must maintain a copy of the decision.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-075, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-075, filed 11/21/00, effective 1/1/01.]

SECTION III—CERTIFICATION FEES

WAC 388-805-080 What are the fee requirements for certification? (1) The department must set fees to be charged for certification.

(2) Providers must pay certification fees:

(a) At the time of application. One-half of the application fee may be refunded if an application is withdrawn before certification or denial; and

(b) Within thirty days of receiving an invoice.

(3) Payment must be made by check, draft, or money order made payable to the department of social and health services.

(4) Fees will not be refunded when certification is denied, revoked, or suspended.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-080, filed 11/21/00, effective 1/1/01.]

WAC 388-805-085 What are the fees for agency certification? (1) Application fees:

- | | |
|---|-------|
| (a) New agency | \$500 |
| (b) Branch agency | \$500 |
| (c) Application for adding one or more services | \$200 |
| (d) Change in ownership | \$500 |

(2) Initial and annual certification fees:

- | | |
|---|-----------------------|
| (a) For detoxification and residential services: | \$26 per licensed bed |
| (b) For nonresidential services: | |
| (i) Large size agencies: 3,000 or more patients served per year | \$1,125 per year |
| (ii) Medium size agencies: 1,000-2,999 patients served per year | \$750 per year |
| (iii) Small size agencies: 0-999 patients served per year | \$375 per year |
| (c) For agencies certified through deeming per WAC 388-805-115 | \$200 per year |

(3) Each year providers must complete a declaration form provided by the department indicating the number of patients served annually, the provider's national accreditation status, and other information necessary for establishing fees and updating certification information.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-085, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-085, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-085, filed 11/21/00, effective 1/1/01.]

WAC 388-805-090 May certification fees be waived?

(1) Certification fees may be waived when:

- (a) The fees would not be in the interest of public health and safety; or
- (b) The fees would be to the financial disadvantage of the state; or
- (c) The department determines that the cost of processing the application is so small that it warrants granting an application fee waiver.

(2) Providers may submit a letter requesting a waiver of fees to the Supervisor, Certification Section, Division of Alcohol and Substance Abuse, P.O. Box 45330, Olympia, Washington, 98504-5330.

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(3) Fee waivers may be granted to qualified providers who receive funding from tribal, federal, state or county government resources as follows:

(a) For residential providers: The twenty-six dollar per bed annual fee will be assessed only for those beds not funded by a governmental source;

(b) For nonresidential providers: The amount of the fee waiver must be determined by the percent of the provider's revenues that come from governmental sources, according to the following schedule:

Percent Government Revenues	90-100%	75-89%	50-74%	0-49%
Small agency	No fee	\$90	\$185	\$375
Medium agency	No fee	\$185	\$375	\$750
Large agency	No fee	\$285	\$565	\$1,125

(4) Requests for fee waiver must be mailed to the department and include the following:

- (a) The reason for the request;
- (b) For residential providers:
 - (i) Documentation of the number of beds currently licensed by the department of health;
 - (ii) Documentation showing the number of beds funded by a government entity including, tribal, federal, state or county government sources.
- (c) For nonresidential providers:
 - (i) Documentation of the number of patients served during the previous twelve-month period;
 - (ii) Documentation showing the amount of government revenues received during the previous twelve-month period;
 - (iii) Documentation showing the amount of private revenues received during the previous twelve-month period.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-090, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-090, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-090, filed 11/21/00, effective 1/1/01.]

WAC 388-805-095 How long are certificates effective? Certificates are effective for one year from the date of issuance unless:

- (1) The department has taken action for noncompliance under WAC 388-805-065, 388-805-125, or 388-805-130; or
- (2) The provider does not pay required fees.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-095, filed 11/21/00, effective 1/1/01.]

SECTION IV—MAINTAINING CERTIFICATION

WAC 388-805-100 What do I need to do to maintain agency certification? (1) A service provider's continued certification and renewal is contingent upon:

- (a) Completion of an annual declaration of certification; and
 - (b) Payment of certification fees, if applicable.
- (2) Providing the essential requirements for chemical dependency treatment, including the following elements:
- (a) Treatment process:

- (i) Assessments, as described in WAC 388-805-310;
- (ii) Treatment planning, as described in WAC 388-805-315 (2)(a) and 388-805-325(11);
- (iii) Documenting patient progress, as described in WAC 388-805-315 (1)(b) and 388-805-325(13);
- (iv) Treatment plan reviews and updates, as described in WAC 388-805-315 (2)(a), 388-805-325(11) and 388-805-325 (13)(c);
- (v) Patient compliance reports, as described in WAC 388-805-315 (4)(b), 388-805-325(17), and 388-805-330;
- (vi) Continuing care, and discharge planning, as described in WAC 388-805-315 (2)(c) and (d) and (7)(a), and 388-805-325 (18) and (19); and
- (vii) Conducting individual and group counseling, as described in WAC 388-805-315 (2)(b) and 388-805-325(13).

(b) Staffing: Provide sufficient qualified personnel for the care of patients as described in WAC 388-805-140(5) and 388-805-145(5);

(c) Facility:

(i) Provide sufficient facilities, equipment, and supplies for the care and safety of patients as described in WAC 388-805-140 (5) and (6);

(ii) If a residential provider, be licensed by the department of health as described by WAC 388-805-015 (1)(b).

(3) Findings during periodic on-site surveys and complaint investigations to determine the provider's compliance with this chapter. During on-site surveys and complaint investigations, provider representatives must cooperate with department representatives to:

(a) Examine any part of the facility at reasonable times and as needed;

(b) Review and evaluate records, including patient clinical records, personnel files, policies, procedures, fiscal records, data, and other documents as the department requires to determine compliance; and

(c) Conduct individual interviews with patients and staff members.

(4) The provider must post the notice of a scheduled department on-site survey in a conspicuous place accessible to patients and staff.

(5) The provider must correct compliance deficiencies found at such surveys immediately or as agreed by a plan of correction approved by the department.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-100, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-100, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-100, filed 11/21/00, effective 1/1/01.]

WAC 388-805-105 What do I need to do for a change in ownership? (1) When a certified chemical dependency service provider plans a change in ownership, the current service provider must submit a change in ownership application form sixty or more days before the proposed date of ownership change.

(2) The current provider must include the following information with the application:

(a) Name and address of each new prospective owner of five percent or more of the organizational assets as required by WAC 388-805-015 (2)(a) through (d);

(b) Current and proposed name (if applicable) of the affected;

(c) Date of the proposed transaction;

(d) A copy of the transfer agreement between the outgoing and incoming owner(s);

(e) If a corporation, the names and addresses of the proposed responsible officers or partners;

(f) A statement regarding the disposition and management of patient records, as described under 42 CFR, Part 2 and WAC 388-805-320; and

(g) A copy of the report of findings from a criminal background check of any new owner of five percent or more of the organizational assets and new administrator when applicable.

(3) The department must determine which, if any, WAC 388-805-015 or 388-805-020 requirements apply to the potential new service provider, depending on the extent of ownership and operational changes.

(4) The department may grant certification to the new owner when the new owner:

(a) Successfully completes the application process; and

(b) Ensures continuation of compliance with rules of this chapter and implementation of plans of correction for deficiencies relating to this chapter, when applicable.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-105, filed 11/21/00, effective 1/1/01.]

WAC 388-805-110 What do I do to relocate or remodel a facility? (1) When a certified chemical dependency service provider plans to relocate or change the physical structure of a facility in a manner that affects patient care, the provider must:

(a) Submit a completed agency relocation approval request form, or a request for approval in writing if remodeling, sixty or more days before the proposed date of relocation or change.

(a) Submit a completed agency relocation approval request form, or a request for approval in writing if remodeling, sixty or more days before the proposed date of relocation or change.

(b) Submit a sample floor plan that includes information identified under WAC 388-805-015 (2)(f) through (k).

(c) Submit a completed facility accessibility self-evaluation form.

(d) Provide for department examination of nonresidential premises before approval, as described under WAC 388-805-060.

(e) Contact the department of health for approval before relocation or remodel if a residential treatment facility.

(2) Opiate substitution treatment provider must complete WAC 388-805-030, 388-805-035, and 388-805-040 requirements for a facility relocation.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-110, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-110, filed 11/21/00, effective 1/1/01.]

WAC 388-805-115 How does the department deem national accreditation? (1) The department must deem accreditation by a national chemical dependency accreditation body, recognized by the department, if the treatment provider was initially certified by the department and when:

(a) A major portion of the national accreditation body requirements meet or exceed chapter 388-805 WAC requirements;

(b) The national accreditation time intervals meet or exceed state expectations;

(c) The provider notifies the department of scheduled on-site surveys;

(d) The provider promptly sends a copy of survey findings, corrective action plans, and follow-up responses to the department; and

(e) WAC 388-805-001 through 388-805-135 continue to apply at all times.

(2) The department may apply an abbreviated department survey, which includes requirements specific to Washington state at its regular certification intervals.

(3) The department must act upon:

(a) Complaints received; and

(b) Deficiencies cited by the national accreditation body for which there is no evidence of correction.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-115, filed 11/21/00, effective 1/1/01.]

WAC 388-805-120 How does the department assess penalties? (1) When the department determines that a service provider fails to comply with provider entry requirements or ongoing requirements of this chapter, the department may:

(a) Assess fees to cover costs of added certification activities;

(b) Cease referrals of new patients who are recipients of state or federal funds; and

(c) Notify the county alcohol and drug coordinator and local media of ceased referrals, involuntary cancellations, suspensions, revocations, or nonrenewal of certification.

(2) When the department determines a service provider knowingly failed to report, as ordered by the court pursuant to chapter 46.61 RCW, a patient's noncompliance with treatment, the department must assess the provider a fine of two hundred fifty dollars for each incident of nonreporting.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-120, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-120, filed 11/21/00, effective 1/1/01.]

WAC 388-805-125 How does the department cancel certification? The department may cancel a provider's certification if the provider:

(1) Ceases to provide services for which the provider is certified.

(2) Voluntarily cancels certification.

(3) Fails to submit required certification fees.

(4) Changes ownership without prior notification and approval.

(5) Relocates without prior notification and approval.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-125, filed 11/21/00, effective 1/1/01.]

WAC 388-805-130 How does the department suspend or revoke certification? (1) The department must suspend or revoke a provider's certification when a disqualifying situation described under WAC 388-805-065 applies to a current service provider.

(2) The department must revoke a provider's certification when the provider knowingly failed to report, as ordered by the court pursuant to chapter 46.61 RCW, within a continu-

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ous twelve-month period, three incidents of patient noncompliance with treatment ordered by the court.

(3) The department may suspend or revoke a provider's certification when any of the following provider deficiencies or circumstances occur:

(a) A provider fails to provide the essential requirements of chemical dependency treatment as described in WAC 388-805-100(2), and one or more of the following conditions occur:

(i) Violation of a rule threatens or results in harm to a patient;

(ii) A reasonably prudent provider should have been aware of a condition resulting in significant violation of a law or rule;

(iii) A provider failed to investigate or take corrective or preventive action to deal with a suspected or identified patient care problem;

(iv) Noncompliance occurs repeatedly in the same or similar areas;

(v) There is an inability to attain compliance with laws or rules within a reasonable period of time.

(b) The provider fails to submit an acceptable and timely plan of correction for cited deficiencies; or

(c) The provider fails to correct cited deficiencies.

(4) The department may suspend certification upon receipt of a providers written request. Providers requesting voluntary suspension must submit a written request for reinstatement of certification within one year from the effective date of the suspension. The department will review the request for reinstatement, determine if the provider is able to operate in compliance with certification requirements, and notify the provider of the results of the review for reinstatement.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-130, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-130, filed 11/21/00, effective 1/1/01.]

WAC 388-805-135 What is the prehearing, hearing and appeals process? (1) In case of involuntary certification cancellation, suspension, or revocation of the certification, or a penalty for noncompliance, the department must:

(a) Notify the service provider and the county coordinator of any action to be taken; and

(b) Inform the provider of prehearing and dispute conferences, hearing, and appeal rights under chapter 388-02 WAC.

(2) The department may order a summary suspension of the provider's certification pending completion of the appeal process when the preservation of public health, safety, or welfare requires emergency action.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-135, filed 11/21/00, effective 1/1/01.]

SECTION V—ORGANIZATIONAL STANDARDS

WAC 388-805-140 What are the requirements for a provider's governing body? The provider's governing body, legally responsible for the conduct and quality of services provided, must:

(1) Appoint an administrator responsible for the day-to-day operation of the program.

(2) Maintain a current job description for the administrator including the administrator's authority and duties.

(3) Establish the philosophy and overall objectives for the treatment services.

(4) Notify the department within thirty days, of changes of the agency administrator.

(5) Provide personnel, facilities, equipment, and supplies necessary for the safety and care of patients.

(6) If a nonresidential provider, ensure:

(a) Safety of patients and staff; and

(b) Maintenance and operation of the facility.

(7) Review and approve written administrative, personnel, and clinical policies and procedures required under WAC 388-805-150, 388-805-200, and 388-805-300.

(8) Ensure the administration and operation of the agency is in compliance with:

(a) Chapter 388-805 WAC requirements;

(b) Applicable federal, state, tribal, and local laws and rules; and

(c) Applicable federal, state, tribal, and local licenses, permits, and approvals.

(9) The governing body of a certified opiate substitution treatment program must ensure that treatment is provided to patients in compliance with 42 Code of Federal Regulations, Part 8.12.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-140, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-140, filed 11/21/00, effective 1/1/01.]

WAC 388-805-145 What are the key responsibilities required of an agency administrator? (1) The administrator is responsible for the day-to-day operation of the certified treatment service, including:

(a) All administrative matters;

(b) Patient care services; and

(c) Meeting all applicable rules and ethical standards.

(2) When the administrator is not on duty or on call, a staff person must be delegated the authority and responsibility to act in the administrator's behalf.

(3) The administrator must ensure administrative, personnel, and clinical policy and procedure manuals:

(a) Are developed and adhered to; and

(b) Are reviewed and revised as necessary, and at least annually.

(4) The administrator must employ sufficient qualified personnel to provide adequate chemical dependency treatment, facility security, patient safety and other special needs of patients.

(5) The administrator must ensure all persons providing counseling services are registered, certified or licensed by the department of health.

(6) The administrator must ensure full-time chemical dependency professionals (CDPs), CDP trainees, or other licensed or registered counselors in training to become a CDP do not exceed one hundred twenty hours of patient contact per month.

(7) The administrator must assign the responsibilities for a clinical supervisor to at least one person within the organization.

(8) The administrator of a certified opiate substitution treatment program must ensure that the number of patients will not exceed three hundred and fifty unless authorized by the county in which the program is located.

(9) The administrator or program sponsor of a certified opiate substitution treatment program must ensure that treatment is provided to patients in compliance with 42 Code of Federal Regulations, Part 8.12.

(10) The administrator or program sponsor of a certified opiate substitution treatment program shall formally designate a medical director who shall assume responsibility for:

(a) All medical services performed;

(b) Ensuring the program is in compliance with all applicable Federal, State and local laws and regulations.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-145, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-145, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-145, filed 11/21/00, effective 1/1/01.]

WAC 388-805-150 What must be included in an agency administrative manual? Each service provider must have and adhere to an administrative manual that contains at a minimum:

(1) The organization's:

(a) Articles and certificate of incorporation if the owner is a corporation;

(b) Partnership agreement if the owner is a partnership;

or

(c) Statement of sole proprietorship.

(2) The agency's bylaws if the owner is a corporation.

(3) Copies of a current master license and state business licenses or a current declaration statement that they are updated as required.

(4) The provider's philosophy on and objectives of chemical dependency treatment with a goal of total abstinence, consistent with RCW 70.96A.011.

(5) A policy and procedures describing how services will be made sensitive to the needs of each patient, including assurance that:

(a) Certified interpreters or other acceptable alternatives are available for persons with limited English-speaking proficiency and persons having a sensory impairment; and

(b) Assistance will be provided to persons with disabilities in case of an emergency.

(6) A policy addressing special needs and protection for youth and young adults, and for determining whether a youth or young adult can fully participate in treatment, before admission of:

(a) A youth to a treatment service caring for adults; or

(b) A young adult to a treatment service caring for youth.

(7) An organization chart specifying:

(a) The governing body;

(b) Each staff position by job title, including volunteers, students, and persons on contract; and

(c) The number of full- or part-time persons for each position.

(8) A delegation of authority policy.

(9) A copy of current fee schedules.

(10) A policy and procedures implementing state and federal regulations on patient confidentiality, including provision of a summary of 42 CFR Part 2.22 (a)(1) and (2) to each patient.

(11) A policy and procedures for reporting suspected child abuse and neglect.

(12) A policy and procedures for reporting the death of a patient to the division of alcohol and substance abuse within one business day when:

(a) The patient is in residence; or

(b) An outpatient dies on the premises.

(13) Patient grievance policy and procedures.

(14) A policy and procedures on reporting of critical incidents and actions taken to the division of alcohol and substance abuse within two business days when an unexpected event occurs.

(15) A smoking policy consistent with the Washington Clean Indoor Air Act, chapter 70.160 RCW.

(16) For a residential provider, a facility security policy and procedures, including:

(a) Preventing entry of unauthorized visitors; and

(b) Use of passes for leaves of patients.

(17) For a nonresidential provider, an evacuation plan for use in the event of a disaster, addressing:

(a) Communication methods for patients, staff, and visitors including persons with a visual or hearing impairment or limitation;

(b) Evacuation of mobility-impaired persons;

(c) Evacuation of children if child care is offered;

(d) Different types of disasters;

(e) Placement of posters showing routes of exit; and

(f) The need to mention evacuation routes at public meetings.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-150, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-150, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-150, filed 11/21/00, effective 1/1/01.]

WAC 388-805-155 What are the requirements for provider facilities? (1) The administrator must ensure the treatment service site:

(a) Is accessible to a person with a disability;

(b) Has a reception area separate from living and therapy areas;

(c) Has adequate private space for personal consultation with a patient, staff charting, and therapeutic and social activities, as appropriate;

(d) Has secure storage of active and closed confidential patient records; and

(e) Has one private room available if youth are admitted to a detox or residential facility.

(2) The administrator of a nonresidential facility must ensure:

(a) Evidence of a current fire inspection approval;

(b) Facilities and furnishings are kept clean, in good repair;

(c) Adequate lighting, heating, and ventilation; and

(d) Separate and secure storage of toxic substances, which are used only by staff or supervised persons.

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[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-155, filed 11/21/00, effective 1/1/01.]

SECTION VI—HUMAN RESOURCE MANAGEMENT

WAC 388-805-200 What must be included in an agency personnel manual? The administrator must have and adhere to a personnel manual, which contains policies and procedures describing how the agency:

(1) Meets the personnel requirements of WAC 388-805-210 through 388-805-260.

(2) Conducts criminal background checks on its employees in order to comply with the rules specified in RCW 43.43.830 through 43.43.842.

(3) Provides for a drug free work place which includes:

(a) A philosophy of nontolerance of illegal drug-related activity;

(b) Agency standards of prohibited conduct; and

(c) Actions to be taken in the event a staff member misuses alcohol or other drugs.

(4) If a nonresidential provider, provides for prevention and control of communicable disease, including specific training and procedures on:

(a) Bloodborne pathogens, including HIV/AIDS and Hepatitis B;

(b) Tuberculosis; and

(c) Other communicable diseases.

(5) Provides staff orientation prior to assigning unsupervised duties, including orientation to:

(a) The administrative, personnel and clinical manuals;

(b) Staff ethical standards and conduct, including reporting of unprofessional conduct to appropriate authorities;

(c) Staff and patient grievance procedures; and

(d) The facility evacuation plan.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-200, filed 11/21/00, effective 1/1/01.]

WAC 388-805-205 What are agency personnel file requirements? (1) The administrator must ensure that there is a current personnel file for each employee, trainee, student, and volunteer, and for each contract staff person who provides or supervises patient care.

(2) The administrator must designate a person to be responsible for management of personnel files.

(3) Each person's file must contain:

(a) A copy of the results of a tuberculin skin test or evidence the person has completed a course of treatment approved by a physician or local health officer if the results are positive;

(b) Documentation of training on bloodborne pathogens, including HIV/AIDS and hepatitis B for all employees, volunteers, students, and treatment consultants on contract;

(i) At the time of staff's initial assignment to tasks where occupational exposure may take place;

(ii) Annually thereafter for bloodborne pathogens;

(c) A signed and dated commitment to maintain patient confidentiality in accordance with state and federal confidentiality requirements; and

(d) A record of an orientation to the agency as described in WAC 388-805-200(5).

(4) For residential facilities, documentation of current cardiopulmonary resuscitation (CPR) and first-aid training for at least one person on each shift.

(5) Documentation of health department training and approval for any staff administering or reading a TB test.

(6) Employees who have been patients of the agency must have personnel records:

- (a) Separate from clinical records; and
- (b) Have no indication of current or previous patient status.

(7) In addition, each patient care staff member's personnel file must contain:

(a) Verification of qualifications for their assigned position including:

(i) For a chemical dependency professional (CDP): A copy of the person's valid CDP certification issued by the department of health (DOH);

(ii) For approved supervisors: Documentation to substantiate the person meets the qualifications of an approved supervisor as defined in WAC 246-811-010;

(iii) For each person engaged in the treatment of chemical dependency, including counselors, physicians, nurses, and other registered, certified, or licensed health care professionals, evidence they comply with the credentialing requirements of their respective professions;

(iv) For probation assessment officers (PAO): Documentation that the person has met the education and experience requirements described in WAC 388-805-220;

(v) For probation assessment officer trainees:

(A) Documentation that the person meets the qualification requirements described in WAC 388-805-225; and

(B) Documentation of the PAO trainee's supervised experience as described in WAC 388-805-230 including an individual education and experience plan and documentation of progress toward completing the plan.

(vi) For information school instructors:

(A) A copy of a certificate of completion of an alcohol and other drug information school instructor's training course approved by the department; and

(B) Documentation of continuing education as specified in WAC 388-805-250.

(b) A copy of a current job description, signed and dated by the employee and supervisor which includes:

- (i) Job title;
- (ii) Minimum qualifications for the position;
- (iii) Summary of duties and responsibilities;
- (iv) For contract staff, formal agreements or personnel contracts, which describe the nature and extent of patient care services, may be substituted for job descriptions.

(c) A written performance evaluation for each year of employment:

- (i) Conducted by the immediate supervisor of each staff member; and
- (ii) Signed and dated by the employee and supervisor.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-205, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-205, filed 11/21/00, effective 1/1/01.]

WAC 388-805-210 What are the requirements for approved supervisors of persons who are in training to become a chemical dependency professional? (1) When an administrator decides to provide training opportunities for persons seeking to become a chemical dependency professional (CDP), the administrator must assign an approved supervisor, as defined in WAC 388-805-005, to each chemical dependency professional trainee (CDPT), or other licensed or registered counselor.

(2) Approved supervisors must provide the CDPT or other licensed or registered counselor assigned to them with documentation substantiating their qualifications as an approved supervisor before the initiation of training.

(3) Approved supervisors must decrease the hours of patient contact allowed under WAC 388-805-145(6) by twenty percent for each full-time CDPT or other licensed or registered counselor supervised.

(4) Approved supervisors are responsible for all patients assigned to the CDPT or other licensed or registered counselor under their supervision.

(5) An approved supervisor must provide supervision to a CDPT or other licensed or registered counselor as required by WAC 246-811-048.

(6) CDPs must review and coauthenticate all clinical documentation of CDPTs or other licensed or registered counselors.

(7) Approved supervisors must supervise, assess and document the progress the CDP trainees or other licensed or registered counselors under their supervision are making toward meeting the requirements described in WAC 246-811-030 and 246-811-047. This documentation must be provided to CDP trainees or other licensed or registered counselors upon request.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-210, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-210, filed 11/21/00, effective 1/1/01.]

WAC 388-805-220 What are the requirements to be a probation assessment officer? A probation assessment officer (PAO) must:

(1) Be employed as a probation officer at a misdemeanor probation department or unit within a county or municipality;

(2) Be certified as a chemical dependency professional, or

(3) Have obtained a bachelor's or graduate degree in a social or health sciences field and have completed twelve quarter or eight semester credits from an accredited college or university in courses that include the following topics:

(a) Understanding addiction and the disease of chemical dependency;

(b) Pharmacological actions of alcohol and other drugs;

(c) Substance abuse and addiction treatment methods;

(d) Understanding addiction placement, continuing care, and discharge criteria, including ASAM PPC criteria;

(e) Cultural diversity including people with disabilities and it's implication for treatment;

(f) Chemical dependency clinical evaluation (screening and referral to include comorbidity);

(g) HIV/AIDS brief risk intervention for the chemically dependent;

(h) Chemical dependency confidentiality;

(i) Chemical dependency rules and regulations.

(4) In addition, a PAO must complete:

(a) Two thousand hours of supervised experience as a PAO trainee in a state-certified DUI assessment service program if a PAO possesses a baccalaureate degree;

(b) One thousand five hundred hours of experience as a PAO trainee in a state-certified DUI assessment service program if a PAO possesses a masters or higher degree.

(5) PAOs, must complete fifteen clock hours each year or thirty clock hours every two years of continuing education in chemical dependency subject areas which will enhance competency as a PAO beginning on January 1 of the year following the year of initial qualification.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-220, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-220, filed 11/21/00, effective 1/1/01.]

WAC 388-805-225 What are the requirements to be a probation assessment officer trainee? A probation assessment officer (PAO) trainee must:

(1) Be employed as a probation officer at a misdemeanor probation department or unit within a county or municipality; and

(2) Be directly supervised and tutored by a PAO.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-225, filed 11/21/00, effective 1/1/01.]

WAC 388-805-230 What are the requirements for supervising probation assessment officer trainees? (1) Probation assessment officers (PAO) are responsible for all offenders assigned to PAO trainees under their supervision.

(2) PAO trainee supervisors must:

(a) Review and coauthenticate all trainee assessments entered in each offender's assessment record;

(b) Assist the trainee to develop and maintain an individualized education and experience plan (IEEP) designed to assist the trainee in obtaining the education and experience necessary to become a PAO;

(c) Provide the trainee orientation to the various laws and regulations that apply to the delivery of chemical dependency assessment and treatment services;

(d) Instruct the trainee in assessment methods and the transdisciplinary foundations described in the addiction counseling competencies;

(e) Observe the trainee conducting assessments; and

(f) Document quarterly evaluations of the progress of each trainee.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-230, filed 11/21/00, effective 1/1/01.]

WAC 388-805-240 What are the requirements for student practice in treatment agencies? (1) The treatment provider must have a written agreement with each educational institution using the treatment agency as a setting for student practice.

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(2) The written agreement must describe the nature and scope of student activity at the treatment setting and the plan for supervision of student activities.

(3) Each student and academic supervisor must sign a confidentiality statement, which the provider must retain.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-240, filed 11/21/00, effective 1/1/01.]

WAC 388-805-250 What are the requirements to be an information school instructor? (1) An information school instructor must have a certificate of completion of an alcohol and other drug information school instructor's training course approved by the department if not a chemical dependency professional (CDP).

(2) To remain qualified, the information school instructor must maintain information school instructor status by completing fifteen clock hours of continuing education if not a CDP:

(a) During each two-year period beginning January of the year following initial qualification; and

(b) In subject areas that increase knowledge and skills in training, teaching techniques, curriculum planning and development, presentation of educational material, laws and rules, and developments in the chemical dependency field.

[Statutory Authority: RCW 70.96A.090 and Chapter 70.96A RCW; chapter 242, Laws of 2001; 42 C.F.R. Part 8. 03-20-020, § 388-805-250, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-250, filed 11/21/00, effective 1/1/01.]

WAC 388-805-260 What are the requirements for using volunteers in a treatment agency? (1) Each volunteer assisting a provider must be oriented as required under WAC 388-805-200(5).

(2) A volunteer must meet the qualifications of the position to which the person is assigned.

(3) A volunteer may provide counseling services when the person meets the requirements for a chemical dependency professional trainee or is a chemical dependency professional.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-260, filed 11/21/00, effective 1/1/01.]

SECTION VII—PROFESSIONAL PRACTICES

WAC 388-805-300 What must be included in the agency clinical manual? Each chemical dependency service provider must have and adhere to a clinical manual containing patient care policies and procedures, including:

(1) How the provider meets WAC 388-805-305 through 388-805-350 requirements.

(2) How the provider will meet applicable certified service standards for the level of program service requirements:

Allowance of up to twenty percent of education time to consist of film or video presentations.

(3) Identification of resources and referral options so staff can make referrals required by law and as indicated by patient needs.

(4) Assurance that there is an identified clinical supervisor who:

(a) Is a chemical dependency professional (CDP);

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(b) Reviews a sample of patient records of each CDP quarterly; and

(c) Ensures implementation of assessment, treatment, continuing care, transfer and discharge plans in accord with WAC 388-805-315.

(5) Patient admission, continued service, and discharge criteria using PPC.

(6) Policies and procedures to implement the following requirements:

(a) The administrator must not admit or retain a person unless the person's treatment needs can be met;

(b) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must assess and refer each patient to the appropriate treatment service; and

(c) A person needing detoxification must immediately be referred to a detoxification provider, unless the person needs acute care in a hospital.

(7) Additional requirements for opiate substitution treatment programs:

(a) A program physician must ensure that a person is currently addicted to an opioid drug and that the person became addicted at least one year before admission to treatment;

(b) A program physician must ensure that each patient voluntarily chooses maintenance treatment and provides informed written consent to treatment;

(c) A program physician must ensure that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient;

(d) A person under eighteen years of age needing opiate substitution treatment is required to have had two documented attempts at short-term detoxification or drug-free treatment within a twelve-month period. A waiting period of no less than seven days is required between the first and second short-term detoxification treatment;

(e) No person under eighteen years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to treatment;

(f) A program physician may waive the requirement of a one year history of addiction under subsection (7)(a) of this section, for patients released from penal institutions (within six months after release), for pregnant patients (program physician must certify pregnancy), and for previously treated patients (up to two years after discharge);

(g) Documentation in each patient's record that the service provider made a good faith effort to review if the patient is enrolled in any other opiate substitution treatment service;

(h) When the medical director or program physician of an opiate substitution treatment program provider in which the patient is enrolled determines that exceptional circumstances exist, the patient may be granted permission to seek concurrent treatment at another opiate substitution treatment program provider. The justification for finding exceptional circumstances for double enrollment must be documented in the patient's record at both treatment program providers.

(8) Tuberculosis screening for prevention and control of TB in all detox, residential, and outpatient programs, including:

(a) Obtaining a history of preventive or curative therapy;

(b) Screening and related procedures for coordinating with the local health department; and

(c) Implementing TB control as provided by the department of health TB control program.

(9) HIV/AIDS information, brief risk intervention, and referral.

(10) Limitation of group counseling sessions to twelve or fewer patients.

(11) Counseling sessions with nine to twelve youths to include a second adult staff member.

(12) Provision of education to each patient on:

(a) Alcohol, other drugs, and chemical dependency;

(b) Relapse prevention; and

(c) HIV/AIDS, hepatitis, and TB.

(13) Provision of education or information to each patient on:

(a) The impact of chemical use during pregnancy, risks to the fetus, and the importance of informing medical practitioners of chemical use during pregnancy;

(b) Emotional, physical, and sexual abuse; and

(c) Nicotine addiction.

(14) An outline of each lecture and education session included in the service, sufficient in detail for another trained staff person to deliver the session in the absence of the regular instructor.

(15) Assigning of work to a patient by a CDP when the assignment:

(a) Is part of the treatment program; and

(b) Has therapeutic value.

(16) Use of self-help groups.

(17) Patient rules and responsibilities, including disciplinary sanctions for noncomplying patients.

(18) If youth are admitted, a policy and procedure for assessing the need for referral to child welfare services.

(19) Implementation of the deferred prosecution program.

(20) Reporting status of persons convicted under chapter 46.61 RCW to the department of licensing.

(21) Asking at intake or next counseling session if the patient has been court ordered to chemical dependency or mental health treatment and is under supervision by the department of corrections, and documenting the patient's response in the clinical record.

(22) For patients that are court ordered to receive chemical dependency or mental health treatment and under department of corrections supervision, the provider must request:

(a) Authorizations to share information with the department of corrections, the county designated chemical dependency specialist and any other court ordered treatment provider; or

(b) A copy of the court order that exempts the patient from the reporting requirements with the department of corrections and mental health provider.

(c) If a patient refuses to sign a release, document attempt in the patient record.

(23) Nonresidential providers must have policies and procedures on:

(a) Medical emergencies;

(b) Suicidal and mentally ill patients;

(c) Laboratory tests, including UA's and drug testing;

(d) Services and resources for pregnant women;

(i) A pregnant woman who is not seen by a private physician must be referred to a physician or the local first steps

maternity care program for determination of prenatal care needs; and

(ii) Services include discussion of pregnancy specific issues and resources.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-300, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-300, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-300, filed 11/21/00, effective 1/1/01.]

WAC 388-805-305 What are patients' rights requirements in certified agencies? (1) Each service provider must ensure each patient:

(a) Is admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientation, age, or disability, except for bona fide program criteria;

(b) Is reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;

(c) Is treated in a manner sensitive to individual needs and which promotes dignity and self-respect;

(d) Is protected from invasion of privacy except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;

(e) Has all clinical and personal information treated in accord with state and federal confidentiality regulations;

(f) Has the opportunity to review their own treatment records in the presence of the administrator or designee;

(g) Has the opportunity to have clinical contact with a same gender counselor, if requested and determined appropriate by the supervisor, either at the agency or by referral;

(h) Is fully informed regarding fees charged, including fees for copying records to verify treatment and methods of payment available;

(i) Is provided reasonable opportunity to practice the religion of their choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. The patient has the right to refuse participation in any religious practice;

(j) Is allowed necessary communication:

(i) Between a minor and a custodial parent or legal guardian;

(ii) With an attorney; and

(iii) In an emergency.

(k) Is protected from abuse by staff at all times, or from other patients who are on agency premises, including:

(i) Sexual abuse or harassment;

(ii) Sexual or financial exploitation;

(iii) Racism or racial harassment; and

(iv) Physical abuse or punishment.

(l) Is fully informed and receives a copy of counselor disclosure requirements established under RCW 18.19.060;

(m) Receives a copy of patient grievance procedures upon request; and

(n) In the event of an agency closure or treatment service cancellation, each patient must be:

(i) Given thirty days notice;

(ii) Assisted with relocation;

(iii) Given refunds to which the person is entitled; and

(iv) Advised how to access records to which the person is entitled.

(2) A faith-based service provider must ensure the right of patients to receive treatment without religious coercion by ensuring that:

(a) Patients must not be discriminated against when seeking services;

(b) Patients must have the right to decide whether or not to take part in inherently religious activities; and

(c) Patients have the right to receive a referral to another service provider if they object to a religious provider.

(3) A service provider must obtain patient consent for each release of information to any other person or entity. This consent for release of information must include:

(a) Name of the consenting patient;

(b) Name or designation of the provider authorized to make the disclosure;

(c) Name of the person or organization to whom the information is to be released;

(d) Nature of the information to be released, as limited as possible;

(e) Purpose of the disclosure, as specific as possible;

(f) Specification of the date or event on which the consent expires;

(g) Statement that the consent can be revoked at any time, except to the extent that action has been taken in reliance on it;

(h) Signature of the patient or parent, guardian, or authorized representative, when required, and the date; and

(i) A statement prohibiting further disclosure unless expressly permitted by the written consent of the person to whom it pertains.

(4) A service provider must notify patients that outside persons or organizations which provide services to the agency are required by written agreement to protect patient confidentiality

(5) A service provider must notify an ADATSA recipient of the recipient's additional rights as required by WAC 388-800-0090.

(6) The administrator must ensure a copy of patients' rights is given to each patient receiving services, both at admission and in case of disciplinary discharge.

(7) The administrator must post a copy of patients' rights in a conspicuous place in the facility accessible to patients and staff.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-305, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-305, filed 11/21/00, effective 1/1/01.]

WAC 388-805-310 What are the requirements for chemical dependency assessments? A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must conduct and document an assessment of each patient's involvement with alcohol and other drugs. The CDP's assessment must include:

(1) A face-to-face diagnostic interview with each patient to obtain, review, evaluate, and document the following:

(a) A history of the patient's involvement with alcohol and other drugs, including:

(i) The type of substances used;

- (ii) The route of administration; and
- (iii) Amount, frequency, and duration of use.
- (b) History of alcohol or other drug treatment or education;
- (c) The patient's self-assessment of use of alcohol and other drugs;
- (d) A relapse history; and
- (e) A legal history.
- (2) If the patient is in need of treatment, a CDP or CDP trainee under supervision of a CDP must evaluate the assessment using PPC dimensions for the patient placement decision.
- (3) If an assessment is conducted on a youth, and the patient is in need of treatment, the CDP, or CDP trainee under supervision of a CDP, must also obtain the following information:
 - (a) Parental and sibling use of drugs;
 - (b) History of school assessments for learning disabilities or other problems, which may affect ability to understand written materials;
 - (c) Past and present parent/guardian custodial status, including running away and out-of-home placements;
 - (d) History of emotional or psychological problems;
 - (e) History of child or adolescent developmental problems; and
 - (f) Ability of parents/guardians to participate in treatment.
- (4) Documentation of the information collected, including:
 - (a) A diagnostic assessment statement including sufficient data to determine a patient diagnosis supported by criteria of substance abuse or substance dependence;
 - (b) A written summary of the data gathered in subsections (1), (2), and (3) of this section that supports the treatment recommendation;
 - (c) A statement regarding provision of an HIV/AIDS brief risk intervention, and referrals made; and
 - (d) Evidence the patient:
 - (i) Was notified of the assessment results; and
 - (ii) Documentation of treatment options provided, and the patient's choice; or
 - (iii) If the patient was not notified of the results and advised of referral options, the reason must be documented.
- (5) Completion and submission of all reports required by the courts, department of corrections, department of licensing, and department of social and health services in a timely manner.
- (6) Referral of an adult or minor who requires assessment for involuntary chemical dependency treatment to the county-designated chemical dependency specialist.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-310, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-310, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-310, filed 11/21/00, effective 1/1/01.]

WAC 388-805-315 What are the requirements for treatment, continuing care, transfer, and discharge plans? (1) A chemical dependency professional (CDP), or a

CDP trainee under supervision of a CDP, must be responsible for the overall treatment plan for each patient, including:

- (a) Patient involvement in treatment planning;
- (b) Documentation of progress toward patient attainment of goals; and
- (c) Completeness of patient records.

(2) A CDP or a CDP trainee under supervision of a CDP must:

- (a) Develop the individualized treatment plan based upon the assessment and update the treatment plan based upon achievement of goals, or when new problems are identified;

- (b) Conduct individual and group counseling;
- (c) Develop the continuing care plan; and
- (d) Complete the discharge summary.

(3) A CDP, or CDP trainee under supervision of a CDP, must also include in the treatment plan for youth problems identified in specific youth assessment, including any referrals to school and community support services.

(4) A CDP, or CDP trainee under supervision of a CDP, must follow up when a patient misses an appointment to:

- (a) Try to motivate the patient to stay in treatment; and
- (b) Report a noncompliant patient to the committing authority as appropriate.

(5) A CDP, or CDP trainee under supervision of a CDP, must involve each patient's family or other support persons, when the patient gives written consent:

- (a) In the treatment program; and
- (b) In self-help groups.

(6) When transferring a patient from one certified treatment service to another within the same agency, at the same location, a CDP, or a CDP trainee under supervision of a CDP, must:

- (a) Update the patient assessment and treatment plan; and

(b) Provide a summary report of the patient's treatment and progress, in the patient's record.

(7) A CDP, or CDP trainee under supervision of a CDP, must meet with each patient at the time of discharge from any treatment agency, unless in detox or when a patient leaves treatment without notice, to:

- (a) Finalize a continuing care plan to assist in determining appropriate recommendation for care;

(b) Assist the patient in making contact with necessary agencies or services; and

- (c) Provide the patient a copy of the plan.

(8) When transferring a patient to another treatment provider, the current provider must forward copies of the following information to the receiving provider when a release of confidential information is signed by the patient:

- (a) Patient demographic information;
- (b) Diagnostic assessment statement and other assessment information, including:

- (i) Documentation of the HIV/AIDS intervention;
- (ii) TB test result;
- (iii) A record of the patient's detox and treatment history;
- (iv) The reason for the transfer; and
- (v) Court mandated, department of correction supervision status or agency recommended follow-up treatment.

(c) Discharge summary; and

(d) The plan for continuing care or treatment.

(9) A CDP, or CDP trainee under supervision of a CDP, must complete a discharge summary, within seven days of each patient's discharge from the agency, which includes:

- (a) The date of discharge or transfer; and
- (b) A summary of the patient's progress toward each treatment goal, except in detox.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-315, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-315, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-315, filed 11/21/00, effective 1/1/01.]

WAC 388-805-320 What are the requirements for a patient record system? Each service provider must have a comprehensive patient record system maintained in accord with recognized principles of health record management. The provider must ensure:

- (1) A designated individual is responsible for the record system;
- (2) A secure storage system which:
 - (a) Promotes confidentiality of and limits access to both active and inactive records; and
 - (b) Protects active and inactive files from damage during storage.
- (3) Patient record policies and procedures on:
 - (a) Who has access to records;
 - (b) Content of active and inactive patient records;
 - (c) A systematic method of identifying and filing individual patient records so each can be readily retrieved;
 - (d) Assurance that each patient record is complete and authenticated by the person providing the observation, evaluation, or service;
 - (e) Retention of patient records for a minimum of six years after the discharge or transfer of the patient; and
 - (f) Destruction of patient records.
- (4) In addition to subsection (1) through (3) of this section, an opiate substitution treatment program provider must ensure that the patient record system comply with all federal and state reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction.
- (5) In addition to subsection (1) through (3) of this section, providers maintaining electronic patient records must:
 - (a) Make records available in paper form upon request:
 - (i) For review by the department;
 - (ii) By patients requesting record review as authorized by WAC 388-805-305 (1)(f).
 - (b) Provide secure, limited access through means that prevent modification or deletion after initial preparation;
 - (c) Provide for back up of records in the event of equipment, media or human error;
 - (d) Provide for protection from unauthorized access, including network and internet access.
- (6) In case of an agency closure, the provider closing its treatment agency must arrange for the continued management of all patient records. The closing provider must notify the department in writing of the mailing and street address where records will be stored and specify the person managing the records. The closing provider may:

(a) Continue to manage the records and give assurance they will respond to authorized requests for copies of patient records within a reasonable period of time;

(b) Transfer records of patients who have given written consent to another certified provider;

(c) Enter into a qualified service organization agreement with a certified provider to store and manage records, when the outgoing provider will no longer be a chemical dependency treatment provider; or

(d) In the event none of the arrangements listed in (a) through (c) of this subsection can be made, the closing provider must arrange for transfer of patient records to the department.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-320, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-320, filed 11/21/00, effective 1/1/01.]

WAC 388-805-325 What are the requirements for patient record content? The service provider must ensure patient record content includes:

- (1) Demographic information;
- (2) A chemical dependency assessment and history of involvement with alcohol and other drugs;
- (3) Documentation of the patient's response when asked if the patient is under:
 - (a) Department of corrections supervision; and
 - (b) Civil or criminal court ordered mental health or chemical dependency treatment; or
 - (c) A copy of the court order exempting patient from reporting requirements.
- (4) Documentation the patient was informed of the diagnostic assessment and options for referral or the reason not informed;
- (5) Documentation the patient was informed of federal confidentiality requirements and received a copy of the patient notice required under 42 CFR, Part 2 and 45 CFR, Part 160 through 164;
- (6) Documentation the patient was informed of treatment service rules, translated when needed, signed and dated by the patient before beginning treatment;
- (7) Voluntary consent to treatment signed and dated by the patient, parent or legal guardian, except as authorized by law for protective custody, involuntary treatment, or the department of corrections;
- (8) Documentation the patient received counselor disclosure information, acknowledged by the provider and patient by signature and date;
- (9) Documentation of the patient's tuberculosis test and results;
- (10) Documentation the patient received the HIV/AIDS brief risk intervention;
- (11) Initial and updated individual treatment plans, including results of the initial assessment and periodic reviews, addressing:
 - (a) Patient biopsychosocial problems;
 - (b) Treatment goals;
 - (c) Estimated dates or conditions for completion of each treatment goal;
 - (d) Approaches to resolve the problems;

- (e) Identification of persons responsible for implementing the approaches;
- (f) Medical orders, if appropriate.
- (12) Documentation of referrals made for specialized care or services;
- (13) At least weekly individualized documentation of ongoing services in residential services, and as required in intensive outpatient and outpatient services, including:
 - (a) Date, duration, and content of counseling and other treatment sessions;
 - (b) Ongoing assessments of each patient's participation in and response to treatment and other activities;
 - (c) Progress notes as events occur, and treatment plan reviews as specified under each treatment service of chapter 388-805 WAC; and
 - (d) Documentation of missed appointments.
- (14) Medication records, if applicable;
- (15) Laboratory reports, if applicable;
- (16) Properly completed authorizations for release of information;
- (17) Copies of all correspondence related to the patient, including any court orders and reports of noncompliance;
- (18) A copy of the continuing care plan signed and dated by the CDP and the patient; and
- (19) The discharge summary.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-325, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-325, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-325, filed 11/21/00, effective 1/1/01.]

WAC 388-805-330 What are the requirements for reporting patient noncompliance? The following standards define patient noncompliance behaviors and set minimum time lines for reporting these behaviors to the appropriate court, community corrections officer, or county designated chemical dependency specialist.

(1) Reporting patient noncompliance is contingent upon obtaining a properly completed authorization to release confidential information form meeting the requirements of 42 CFR Part 2 and 45 CFR Parts 160 and 164 or through a court order authorizing the disclosure pursuant to 42 CFR Part 2, Section 2.63 through 2.67.

(2) Chemical dependency service providers failing to report patient noncompliance with court ordered or deferred prosecution treatment requirements may be considered in violation of chapter 46.61 RCW, RCW 70.96A.142 or chapter 10.05 RCW reporting requirements and be subject to penalties specified in WAC 388-805-120, 388-805-125, and 388-805-130.

(3) For patients under the department of corrections supervision and court ordered to treatment, the provider must notify the designated chemical dependency specialist within three working days from obtaining information of any violation of the terms of the court order for purposes of revocation of the patient's conditional release.

(4) For emergent noncompliance: The following noncompliance is considered emergent noncompliance and must be reported to the appropriate court within three working days from obtaining the information:

(a) Patient failure to maintain abstinence from alcohol and other nonprescribed drugs as verified by patient self-report, identified third party report confirmed by the agency, or blood alcohol content or other laboratory test;

(b) Patient reports a subsequent alcohol/drug related arrest;

(c) Patient leaves program against program advice or is discharged for rule violation.

(5) For nonemergent noncompliance: The following noncompliance is considered nonemergent noncompliance and must be reported to the appropriate court as required by subsection (6) and (7) of this section:

(a) Patient has unexcused absences or failure to report. Agencies must report all patient unexcused absences, including failure to attend self-help groups. Report failure of patient to provide agency with documentation of attendance at self-help groups if under a deferred prosecution order or required by the treatment plan. In providing this report, include the agency's recommendation for action.

(b) Patient failure to make acceptable progress in any part of the treatment plan. Report details of the patient's noncompliance behavior along with a recommendation for action.

(6) If a court accepts monthly progress reports, nonemergent noncompliance may be reported in monthly progress reports, which must be mailed to the court within ten working days from the end of each reporting period.

(7) If a court does not wish to receive monthly reports and only requests notification of noncompliance or other significant changes in patient status, the reports should be transmitted as soon as possible, but in no event longer than ten working days from the date of the noncompliance.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-330, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-330, filed 11/21/00, effective 1/1/01.]

SECTION VIII—OUTCOMES EVALUATION

WAC 388-805-350 What are the requirements for outcomes evaluation? Each service provider must develop and implement policies and procedures for outcomes evaluation, to monitor and evaluate program effectiveness and patient satisfaction for the purpose of program improvement.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-350, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-350, filed 11/21/00, effective 1/1/01.]

SECTION IX—PROGRAM SERVICE STANDARDS

WAC 388-805-400 What are the requirements for detoxification providers? Detoxification services include acute and subacute services. To be certified to offer detoxification services, a provider must:

(1) Meet WAC 388-805-001 through 388-805-320, 388-805-330, and 388-805-350 requirements; and

(2) Meet relevant requirements of chapter 246-337 WAC.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-400, filed 9/23/03, effective

10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-400, filed 11/21/00, effective 1/1/01.]

WAC 388-805-410 What are the requirements for detox staffing and services? (1) The service provider must ensure staffing as follows:

(a) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, to assess, counsel, and attempt to motivate each patient for referral;

(b) Other staff as necessary to provide services needed by each patient;

(c) All personnel providing patient care, except licensed staff and CDPs, must complete a minimum of forty hours of documented training before assignment of patient care duties. The personnel training must include:

(i) Chemical dependency;

(ii) HIV/AIDS and hepatitis B education;

(iii) TB prevention and control; and

(iv) Detox screening, admission, and signs of trauma.

(d) All personnel providing patient care must have current training in:

(i) Cardio-pulmonary resuscitation (CPR); and

(ii) First aid.

(2) The service provider must ensure detoxification services include:

(a) A staff member who demonstrates knowledge about addiction, and is skilled in observation and eliciting information, will perform a screening of each person prior to admission;

(b) Counseling of each patient by a CDP, or CDP trainee under supervision of a CDP, at least once:

(i) Regarding the patient's chemical dependency; and

(ii) Attempting to motivate each person to accept referral into a continuum of care for chemical dependency treatment.

(c) Sleeping arrangements that permit observation of patients;

(d) Separate sleeping rooms for youth and adults; and

(e) Referral of each patient to other appropriate treatment services.

(3) The service provider must ensure detoxification patient records include:

(a) Demographic information;

(b) Documentation the patient was informed of federal confidentiality requirements and received a copy of the patient notice required under 42 CFR, Part 2;

(c) Documentation the patient was informed of treatment service rules, translated when needed, signed and dated by the patient before beginning treatment;

(d) Voluntary consent to treatment signed and dated by the patient, parent or legal guardian, except as authorized by law for protective custody and involuntary treatment;

(e) Documentation the patient receive counselor disclosure information, acknowledged by the provider and patient by signature and date;

(f) Documentation the patient received the HIV/AIDS brief risk intervention;

(g) Progress notes each shift and as events occur;

(h) Medication records, if applicable;

(i) Laboratory reports, if applicable;

(j) Properly completed authorizations for release of information; and

(k) The discharge summary, which includes the patient's physical condition.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-410, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-410, filed 11/21/00, effective 1/1/01.]

WAC 388-805-500 What are the requirements for residential providers? To be certified to offer intensive inpatient, recovery, or long-term residential services, a provider must meet the requirements of:

(1) WAC 388-805-001 through 388-805-350;

(2) WAC 388-805-510 through 388-805-550 as applicable; and

(3) Chapter 246-337 WAC as required for department of health licensing.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-500, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-500, filed 11/21/00, effective 1/1/01.]

WAC 388-805-510 What are the requirements for residential providers admitting youth? A residential service provider admitting youth must ensure:

(1) A youth will be admitted only with the written permission of a parent or legal guardian. In cases where the youth meets the requirements of child in need of services (CHINS) the youth may sign themselves into treatment.

(2) The youth must agree to, and both the youth and parent or legal guardian must sign the following when possible:

(a) Statement of patient rights and responsibilities;

(b) Treatment or behavioral contracts; and

(c) Any consent or release form.

(3) Youth chemical dependency treatment must include:

(a) Group meetings to promote personal growth; and

(b) Recreational, leisure, and other therapy and related activities.

(4) A certified teacher or tutor must provide each youth one or more hours per day, five days each week, of supervised academic tutoring or instruction when the youth is unable to attend school for an estimated period of four weeks or more. The provider must:

(a) Document the patient's most recent academic placement and achievement level; and

(b) Obtain schoolwork, where applicable, from the patient's home school or provide schoolwork and assignments consistent with the person's academic level and functioning.

(5) Adult staff must lead or supervise seven or more hours of structured recreation each week.

(6) Staff must conduct room checks frequently and regularly when patients are in their rooms.

(7) A person fifteen years of age or younger must not room with a person eighteen years of age or older.

(8) Sufficient numbers of adult staff, whose primary task is supervision of patients, must be trained and available at all times to ensure appropriate supervision, patient safety, and compliance with WAC 388-805-520.

(9) In co-ed treatment services, there must be at least one adult staff person of each gender present or on call at all times.

(10) There must be at least one chemical dependency professional (CDP) for every ten youth patients.

(11) Staff must document attempts to notify the parent or legal guardian within two hours of any change in the status of a youth.

(12) For routine discharge, each youth must be discharged to the care of the youth's legal custodian.

(13) For emergency discharge and when the custodian is not available, the provider must contact the appropriate authority.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-510, filed 11/21/00, effective 1/1/01.]

WAC 388-805-520 What are the requirements for youth behavior management? (1) Upon application for a youth's admission, a service provider must:

(a) Advise the youth's parent and other referring persons of the programmatic and physical plant capabilities and constraints in regard to providing treatment with or without a youth's consent;

(b) Obtain the parent's or other referring person's agreement to participate in the treatment process as appropriate and possible; and

(c) Obtain the parent's or other referring person's agreement to return and take custody of the youth as necessary and appropriate on discharge or transfer.

(2) The administrator must ensure policies and procedures are written and implemented which detail least to increasingly restrictive practices used by the provider to stabilize and protect youth who are a danger to self or others, including:

(a) Obtaining signed behavioral contracts from the youth, at admission and updated as necessary;

(b) Acknowledging positive behavior and fostering dignity and self respect;

(c) Supporting self-control and the rights of others;

(d) Increased individual counseling;

(e) Increased staff monitoring;

(f) Verbal deescalation;

(g) Use of unlocked room for voluntary containment or time-out;

(h) Use of therapeutic physical intervention techniques during a time limited immediate crisis to prevent or limit free body movement that may cause harm to the person or others; and

(i) Emergency procedures, including notification of the parent, guardian or other referring person, and, when appropriate, law enforcement.

(3) The provider must ensure staff is trained in safe and therapeutic techniques for dealing with a youth's behavioral and emotional crises, including:

(a) Verbal deescalation;

(b) Crisis intervention;

(c) Anger management;

(d) Suicide assessment and intervention;

(e) Conflict management and problem solving skills;

(f) Management of assaultive behavior;

(g) Proper use of therapeutic physical intervention techniques; and

(h) Emergency procedures.

(4) To reduce the possibility of a youth's unauthorized exit from the residential treatment site, the provider may have:

(a) An unlocked room for voluntary containment or time-out;

(b) A secure perimeter, such as a nonscalable fence with locked gates; and

(c) Locked windows and exterior doors.

(5) Providers using holding mechanisms in subsection (4) of this section must meet current Uniform Building Code requirements, which include fire safety and special egress control devices, such as alarms and automatic releases.

(6) When less restrictive measures are not sufficient to de-escalate a behavioral crisis, clinical staff may use, for voluntary containment or time-out of a youth, a quiet unlocked room which has a window for observation and:

(a) The clinical supervisor or designated alternate must be notified immediately of the staff person's use of a quiet room for a youth, and must determine its appropriateness;

(b) A chemical dependency professional (CDP) or designated clinical alternate must consult with the youth immediately and at least every ten minutes, for counseling, assistance, and to maintain direct communication; and

(c) The clinical supervisor or designated alternate must evaluate the youth and determine the need for mental health consultation.

(7) Youth who demonstrate continuing refusal to participate in treatment or continuing to exhibit behaviors that present health and safety risks to self, other patients, or staff may be discharged or transferred to more appropriate care after:

(a) Interventions appropriate to the situation from those listed in subsection (2) of this section have been attempted without success;

(b) The person has been informed of the consequences and return options;

(c) The parents, guardian, or other referring person has been notified of the emergency and need to transfer or discharge the person; and

(d) Arrangements are made for the physical transfer of the person into the custody of the youth's parent, guardian, or other appropriate person or program.

(8) Involved staff must document the circumstances surrounding each incident requiring intervention in the youth's record and include:

(a) The precipitating circumstances;

(b) Measures taken to resolve the incident;

(c) Final resolution; and

(d) Record of notification of appropriate others.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-520, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-520, filed 11/21/00, effective 1/1/01.]

WAC 388-805-530 What are the requirements for intensive inpatient services? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

(a) Complete the initial treatment plan within five days of admission;

(b) Conduct at least one face-to-face individual chemical dependency counseling session with each patient each week;

(c) Provide a minimum of ten hours of chemical dependency counseling with each patient each week;

(d) Document a treatment plan review, at least weekly, which updates patient status, progress toward goals; and

(e) Refer each patient for ongoing treatment or support, as necessary, upon completion of treatment.

(2) The provider must ensure a minimum of twenty hours of treatment services for each patient each week; up to ten hours may be education.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-530, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-530, filed 11/21/00, effective 1/1/01.]

WAC 388-805-540 What are the requirements for recovery house services? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must provide a minimum of five hours of treatment, for each patient each week, consisting of:

(a) Education regarding drug-free and sober living; and

(b) Individual or group counseling.

(2) A CDP, or CDP trainee under supervision of a CDP, must document a treatment plan review at least monthly; and

(3) Staff must assist patients with general reentry living skills and, for youth, continuation of educational or vocational training.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-540, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-540, filed 11/21/00, effective 1/1/01.]

WAC 388-805-550 What are the requirements for long-term treatment services? Each chemical dependency service provider must ensure each patient receives:

(1) Education regarding alcohol, other drugs, and other additions, at least two hours each week.

(2) Individual or group counseling by a chemical dependency professional (CDP), or CDP trainee under supervision of a CDP, a minimum of two hours each week.

(3) Education on social and coping skills.

(4) Social and recreational activities.

(5) Assistance in seeking employment, when appropriate.

(6) Document a treatment plan review at least monthly.

(7) Assistance with reentry living skills.

(8) A living arrangement plan.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-550, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-550, filed 11/21/00, effective 1/1/01.]

WAC 388-805-600 What are the requirements for outpatient providers? To be certified to provide intensive or other outpatient services, a chemical dependency service provider must meet the requirements of:

(1) WAC 388-805-001 through 388-805-350;

(2) WAC 388-805-610 through 388-805-630, as applicable; and

(3) WAC 388-805-700 through 388-805-750, if offering opiate substitution treatment program services.

(2007 Ed.)

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-600, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-600, filed 11/21/00, effective 1/1/01.]

WAC 388-805-610 What are the requirements for intensive outpatient treatment services? (1) Patients admitted to intensive outpatient treatment under a deferred prosecution order pursuant to chapter 10.05 RCW, must complete intensive treatment as described in subsection (2) of this section. Any exceptions to this requirement must be approved, in writing, by the court having jurisdiction in the case.

(2) Each chemical dependency service provider must ensure intensive outpatient services are designed to deliver:

(a) A minimum of seventy-two hours of treatment services within a maximum of twelve weeks,

(b) The first four weeks of treatment must consist of:

(i) At least three sessions each week;

(ii) Each group session must last at least one hour; and

(iii) Each session must be on separate days of the week.

(c) Individual chemical dependency counseling sessions with each patient at least once a month, or more if clinically indicated;

(d) Education totaling not more than fifty percent of patient treatment services regarding alcohol, other drugs, relapse prevention, HIV/AIDS, hepatitis B, hepatitis C, and TB prevention, and other air/bloodborne pathogens;

(e) Self-help group attendance in addition to the seventy-two hours;

(f) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must conduct and document a review of each patient's treatment plan in individual chemical dependency counseling sessions, if appropriate, to assess adequacy and attainment of goals;

(g) Upon completion of intensive outpatient treatment, a CDP, or a CDP trainee under the supervision of a CDP, must refer each patient for ongoing treatment or support, as necessary.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-610, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-610, filed 11/21/00, effective 1/1/01.]

WAC 388-805-620 What are the requirements for outpatient services? A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

(1) Complete admission assessments within ten calendar days of admission, or by the second visit, unless participation in this outpatient treatment service is part of the same provider's continuum of care.

(2) Conduct group or individual chemical dependency counseling sessions for each patient, each month, according to an individual treatment plan.

(3) Conduct and document a treatment plan review for each patient:

(a) Once a month for the first three months; and

(b) Quarterly thereafter or sooner if required by other laws.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-620, filed 5/17/06, effective 6/17/06. Statutory Authority:

RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-620, filed 11/21/00, effective 1/1/01.]

WAC 388-805-625 What are the requirements for outpatient services for persons subject to RCW 46.61-.5056? (1) Patients admitted to outpatient treatment subject to RCW 46.61.5056, must complete outpatient treatment as described in subsection (2) of this section.

(2) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must:

- (a) For the first sixty days of treatment:
 - (i) Conduct group or individual chemical dependency counseling sessions for each patient, each week, according to an individual treatment plan.
 - (ii) Conduct at least one individual chemical dependency counseling session of no less than thirty minutes duration excluding a chemical dependency assessment for each patient, according to an individual treatment plan.
 - (iii) Conduct alcohol and drug basic education for each patient.
 - (iv) Document patient participation in self-help groups described in WAC 388-805-300(16) for patients with a diagnosis of substance dependence.
 - (v) For patients with a diagnosis of substance dependence who received intensive inpatient chemical dependency treatment services, the balance of the sixty-day time period will consist, at a minimum, of weekly outpatient counseling sessions according to an individual treatment plan.

(b) For the next one hundred twenty days of treatment:

- (i) Conduct group or individual chemical dependency counseling sessions for each patient, every two weeks, according to an individual treatment plan.
- (ii) Conduct at least one individual chemical dependency counseling session of no less than thirty minutes duration every sixty days for each patient, according to an individual treatment plan.

(c) Upon completion of one hundred eighty days of intensive treatment, a CDP, or a CDP trainee under the supervision of a CDP, must refer each patient for ongoing treatment or support, as necessary, using PPC.

(3) For patients who are assessed with insufficient evidence of substance dependence or substance abuse, a CDP must refer the patient to alcohol/drug information school.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-625, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-625, filed 9/23/03, effective 10/25/03.]

WAC 388-805-630 What are the requirements for outpatient services in a school setting? Any certified chemical dependency service provider may offer school-based services by:

- (1) Meeting WAC 388-805-640 requirements; and
- (2) Ensuring counseling is provided by a chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-630, filed 11/21/00, effective 1/1/01.]

[Title 388 WAC—p. 1220]

WAC 388-805-640 What are the requirements for providing off-site chemical dependency treatment services? (1) If a certified service provider wishes to offer treatment services, for which the provider is certified, at a site where patients are located primarily for purposes other than chemical dependency treatment, the administrator must:

- (a) Ensure off-site treatment services will be provided:
 - (i) In a private, confidential setting that is discrete from other services provided within the off-site location; and
 - (ii) By a chemical dependency professional (CDP) or CDP trainee under supervision of a CDP;
- (b) Revise agency policy and procedures manuals to include:
 - (i) A description of how confidentiality will be maintained at each off-site location, including how confidential information and patient records will be transported between the certified facility and the off-site location;
 - (ii) A description of how services will be offered in a manner that promotes patient and staff member safety; and
 - (iii) Relevant administrative, personnel, and clinical practices.
- (c) Maintain a current list of all locations where off-site services are provided including the name, address (except patient in-home services), primary purpose of the off-site location, level of services provided, and date off-site services began at the off-site location.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-640, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-640, filed 11/21/00, effective 1/1/01.]

WAC 388-805-700 What are the requirements for opiate substitution treatment program providers? An opiate substitution treatment program provider must meet requirements of:

- (1) WAC 388-805-001 through 388-805-350;
- (2) WAC 388-805-620;
- (3) WAC 388-805-700 through 388-805-750; and
- (4) 42 Code of Federal Regulations, Part 8.12.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-700, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-700, filed 11/21/00, effective 1/1/01.]

WAC 388-805-710 What are the requirements for opiate substitution medical management? (1) The medical director must assume responsibility for administering all medical services performed by the opiate substitution treatment program.

(2) The medical director must be responsible for ensuring that the opiate substitution treatment program is in compliance with all applicable federal, state, and local laws and regulations.

(3) A program physician or authorized health care professional under supervision of a program physician, must provide oversight for determination of opiate physical addiction and conducting a complete, fully documented physical evaluation for each patient before admission.

(4) A medical examination must be conducted on each patient:

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(a) By a program physician or other medical practitioner; and

(b) Within fourteen days of admission.

(5) Prior to initial prescribed dosage of opiate substitution medication, a program physician must ensure that all pregnant patients are provided written and verbal:

(a) Current health information concerning the possible addiction, health risks and benefits opiate substitution medication may have on them and their fetus;

(b) Current health information concerning the risks of not initiating opiate substitution medication may have on them and their fetus and;

(c) Referral options to address neonatal abstinence syndrome for their baby.

(6) Following the patient's initial dose of opiate substitution treatment, the physician must establish adequacy of dose, considering:

(a) Signs and symptoms of withdrawal;

(b) Patient comfort; and

(c) Side effects from over medication.

(7) Prior to the beginning of detox, a program physician must approve an individual detoxification schedule for each patient being detoxified.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-710, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-710, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-710, filed 11/21/00, effective 1/1/01.]

WAC 388-805-715 What are the requirements for opiate substitution medication management? (1) An opiate substitution treatment program must use only those opioid agonist treatment medications that are approved by the Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) for use in the treatment of opioid addiction.

(2) In addition, an opiate substitution treatment program who is fully compliant with the protocol of an investigational use of a drug and other conditions set forth in the application may administer a drug that has been authorized by the Food and Drug Administration under an investigational new drug application under section 505(i) of the Federal Food, Drug, and Cosmetic Act for investigational use in the treatment of opioid addiction. Currently the following opioid agonist treatment medications will be considered to be approved by the Food and Drug Administration for use in the treatment of opioid addiction:

(a) Methadone;

(b) Levomethadyl acetate (LAAM); and

(c) Buprenorphine distributed as subutex and suboxone.

(3) An opiate substitution treatment program must maintain current procedures that are adequate to ensure that the following dosage form and initial dosing requirements are met:

(a) Methadone must be administered or dispensed only in oral form and must be formulated in such a way as to reduce its potential for parenteral abuse;

(b) For each new patient enrolled in a program, the initial dose of methadone must not exceed thirty milligrams and the total dose for the first day must not exceed forty milligrams,

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unless the program physician documents in the patient's record that forty milligrams did not suppress opiate abstinence symptoms.

(4) An opiate substitution treatment program must maintain current procedures adequate to ensure that each opioid agonist treatment medication used by the program is administered and dispensed in accordance with its approved product labeling. Dosing and administration decisions must be made by a program physician familiar with the most up-to-date product labeling. These procedures must ensure that any significant deviations from the approved labeling, including deviations with regard to dose, frequency, or the conditions of use described in the approved labeling, are specifically documented in the patient's record.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-715, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-715, filed 9/23/03, effective 10/25/03.]

WAC 388-805-720 What are the requirements for drug testing in opiate substitution treatment? (1) The provider must obtain a specimen sample from each patient for drug testing:

(a) At least eight times per year; and

(b) Randomly, without notice to the patient.

(2) Staff must observe the collection of each specimen sample and use proper chain of custody techniques when handling each sample;

(3) When a patient refuses to provide a specimen sample or initial the log of sample numbers, staff must consider the specimen positive; and

(4) Staff must document a positive specimen and discuss the findings with the patient at the next scheduled counseling session.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-720, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-720, filed 11/21/00, effective 1/1/01.]

WAC 388-805-730 What are the requirements for opiate substitution treatment dispensaries? (1) Each opiate substitution treatment provider must comply with applicable portions of 21 CFR, Part 1301 requirements, as now or later amended.

(2) The administrator must ensure written policies and procedures to verify the identity of patients.

(3) Dispensary staff must maintain a file with a photograph of each patient. Dispensary staff must ensure pictures are updated when:

(a) The patient's physical appearance changes significantly; or

(b) Every two years, whichever comes first.

(4) In addition to notifying the Federal CSAT, SAMHSA and the Federal Drug Enforcement Administration, the administrator must immediately notify the department and the state board of pharmacy of any theft or significant loss of a controlled substance.

(5) The administrator must have a written diversion control plan that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use and that assigns specific responsibility to the

medical and administrative staff members for carrying out the diversion control measures and functions described in the plan.

[Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-730, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-730, filed 11/21/00, effective 1/1/01.]

WAC 388-805-740 What are the requirements for opiate substitution treatment counseling? (1) A chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, must provide individual or group counseling sessions once each:

(a) Week, for the first ninety days, for a new patient or a patient readmitted more than ninety days since the person's most recent discharge from opiate substitution treatment;

(b) Week, for the first month, for a patient readmitted within ninety days of the most recent discharge from opiate substitution treatment; and

(c) Month, for a patient transferring from another opiate substitution treatment program where the patient stayed for ninety or more days.

(2) Conduct a treatment plan review once every six months after the second year of continued enrollment in treatment.

(3) A CDP, or a CDP trainee under supervision of a CDP, must provide counseling in a location that is physically separate from other activities.

(4) A pregnant woman and any other patient who requests, must receive at least one-half hour of counseling and education each month on:

(a) Matters relating to pregnancy and street drugs;

(b) Pregnancy spacing and planning; and

(c) The effects of opiate substitution treatment on the woman and fetus, when opiate substitution treatment occurs during pregnancy.

(5) Staff must provide at least one-half hour of counseling on family planning with each patient through either individual or group counseling.

(6) The administrator must ensure there is one staff member who has training in family planning, prenatal health care, and parenting skills.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-740, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-740, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-740, filed 11/21/00, effective 1/1/01.]

WAC 388-805-750 What are the requirements for opiate substitution treatment take-home medications? (1) An opiate substitution treatment provider may authorize take-home medications for a patient when:

(a) The medication is for a Sunday or legal holiday, as identified under RCW 1.16.050; or

(b) Travel to the facility presents a safety risk for patients or staff due to inclement weather.

(2) A service provider may permit take-home medications on other days for a stabilized patient who:

(a) Has received opiate substitution treatment medication for a minimum of ninety days; and

(b) Had negative urines for the last sixty days.

(3) The provider must meet 42 CFR, Part 8.12 (i)(1-5) requirements.

(4) The provider may arrange for opiate substitution treatment medication to be administered by licensed staff or self-administered by a pregnant woman receiving treatment at a certified residential treatment agency when:

(a) The woman had been receiving treatment medication for ninety or more days; and

(b) The woman's use of treatment medication can be supervised.

(5) All exceptions to take-home requirements must be authorized by the state methadone authority.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-750, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-750, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-750, filed 11/21/00, effective 1/1/01.]

WAC 388-805-800 What are the requirements for ADATSA assessment services? (1) An agency certified to conduct ADATSA assessments must conduct the assessment for each eligible patient and be governed by the requirements under:

(a) WAC 388-805-001 through 388-805-310;

(b) WAC 388-805-020 and 388-805-325 (1), (2), (3), (4), (5), (9), (15), (16), 388-805-330; and 388-805-350; and

(c) Chapter 388-800 WAC.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-800, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-800, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-800, filed 11/21/00, effective 1/1/01.]

WAC 388-805-810 What are the requirements for DUI assessment providers? (1) If located in a district or municipal probation department, each DUI service provider must meet the requirements of:

(a) WAC 388-805-001 through 388-805-135,

(b) WAC 388-805-145 (4), (5), and (6);

(c) WAC 388-805-150, the administrative manual, subsections (4), (7) through (11), (13), and (14);

(d) WAC 388-805-155, facilities, subsections (1)(b), (c), (d), and (2)(b);

(e) WAC 388-805-200 (1), (4), and (5);

(f) WAC 388-805-205 (1), (2), (3)(a) through (d), (4), (6), and (7);

(g) WAC 388-805-220, 388-805-225, and 388-805-230;

(h) WAC 388-805-260, volunteers;

(i) WAC 388-805-300, clinical manual, subsections (1), (2), (3), (9), (20), (21), and (22);

(j) WAC 388-805-305, patients' rights;

(k) WAC 388-805-310, assessments;

(l) WAC 388-805-320, patient record system, subsections (3)(a) through (f), and (5);

(m) WAC 388-805-325, record content, subsections (1), (2), (3), (4), (5), (7), (8), (10), (15), (16), and (17); and

(n) WAC 388-805-350, outcomes evaluation;

(o) WAC 388-805-815, DUI assessment services.

(2) If located in another certified chemical dependency treatment facility, the DUI service provider must meet the requirements of:

(a) WAC 388-805-001 through 388-805-260; 388-805-305 and 388-805-310;

(b) WAC 388-805-300, 388-805-320, 388-805-325 as noted in subsection (1) of this section, 388-805-350; and

(c) WAC 388-805-815.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-810, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-810, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-810, filed 11/21/00, effective 1/1/01.]

WAC 388-805-815 What are the requirements for DUI assessment services? (1) The administrator must limit patients to persons who have been arrested for a violation of driving while under the influence of intoxicating liquor or other drugs or in physical control of a vehicle as defined under chapter 46.61 RCW;

(2) A chemical dependency professional (CDP), or a CDP trainee under the supervision of a CDP, or a probation assessment officer must conduct each patient assessment and ensure the assessment includes, in addition to the requirements under WAC 388-805-310:

(a) Evaluation of the patient's blood alcohol level and other drug levels at the time of arrest, if available; and

(b) Assessment of the patient's self-reported driving record and the abstract of the patient's legal driving record.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-815, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-815, filed 11/21/00, effective 1/1/01.]

WAC 388-805-820 What are the requirements for alcohol and other drug information school? (1) Alcohol and other drug information school providers must be governed under:

(a) WAC 388-805-001 through 388-805-135; and

(b) This section.

(2) The provider must:

(a) Inform each student of fees at the time of enrollment; and

(b) Ensure adequate and comfortable seating in well-lit and ventilated rooms.

(3) A certified information school instructor or a chemical dependency professional must teach the course and:

(a) Advise each student there is no assumption the student is an alcoholic or drug addict, and this is not a therapy session;

(b) Discuss the class rules;

(c) Review the course objectives;

(d) Follow curriculum contained in "Alcohol and Other Drugs Information School Training Curriculum," published in 2001, or later amended;

(e) Ensure not less than eight and not more than fifteen hours of class room instruction;

(f) Administer the posttest from the above reference to each enrolled student after the course is completed;

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(g) Ensure individual student records include:

(i) Intake form;

(ii) Hours and date or dates in attendance;

(iii) Source of referral;

(iv) Copies of all reports, letters, certificates, and other correspondence;

(v) A record of any referrals made; and

(vi) A copy of the scored posttest.

(h) Complete and submit reports required by the courts and the department of licensing, in a timely manner.

[Statutory Authority: RCW 70.96A.090, 70.96A.142, 70.96A.157, chapter 70.96A RCW, 2004 c 166, 2005 c 70 and 504, 42 C.F.R. Parts 2 and 8. 06-11-096, § 388-805-820, filed 5/17/06, effective 6/17/06. Statutory Authority: RCW 70.96A.090, chapter 70.96A RCW, 2001 c 242, 42 C.F.R. Part 8. 03-20-020, § 388-805-820, filed 9/23/03, effective 10/25/03. Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-820, filed 11/21/00, effective 1/1/01.]

WAC 388-805-830 What are the requirements for information and crisis services? (1) Information and crisis service providers must be governed under:

(a) WAC 388-805-001 through 388-805-135; and

(b) This section.

(2) The information and crisis service administrator must:

(a) Ensure a chemical dependency professional (CDP), or a CDP trainee under supervision of a CDP, is available or on staff;

(b) Maintain a current directory of certified chemical dependency service providers in the state;

(c) Maintain a current list of local resources for legal, employment, education, interpreter, and social and health services;

(d) Have services available twenty-four hours a day, seven days a week;

(e) Ensure all staff completes forty hours of training that covers the following areas before assigning unsupervised duties:

(i) Chemical dependency crisis intervention techniques;

(ii) Alcoholism and drug abuse; and

(iii) Prevention and control of TB and bloodborne pathogens.

(f) Have policies and procedures for provision of emergency services, by phone or in person, to a person incapacitated by alcohol or other drugs, or to the person's family, such as:

(i) General assessments;

(ii) Interviews for diagnostic or therapeutic purposes;

(iii) Crisis counseling; and

(iv) Referral.

(g) Maintain records of each patient contact, including:

(i) The presenting problem;

(ii) The outcome;

(iii) A record of any referral made;

(iv) The signature of the person handling the case; and

(v) The name, age, sex, and race of the patient.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-830, filed 11/21/00, effective 1/1/01.]

WAC 388-805-840 What are the requirements for emergency service patrol? (1) The emergency service patrol provider must ensure staff providing the service:

(a) Have proof of a valid Washington state driver's license;

(b) Possess annually updated verification of first-aid and cardiopulmonary resuscitation training;

(c) Have completed forty hours of training in chemical dependency crisis intervention techniques, and alcoholism and drug abuse, to improve skills in handling crisis situations; and

(d) Have training on communicable diseases, including:

(i) TB prevention and control; and

(ii) Bloodborne pathogens such as HIV/AIDS and hepatitis.

(2) Emergency service patrol staff must:

(a) Respond to calls from police, merchants, and other persons for assistance with an intoxicated person in a public place;

(b) Patrol assigned areas and give assistance to a person intoxicated in a public place; and

(c) Conduct a preliminary assessment of a person's condition relating to the state of inebriation and presence of a physical condition needing medical attention:

(i) When a person is intoxicated, but subdued and willing, transport the person home, to a certified treatment provider, or a health care facility;

(ii) When a person is incapacitated, unconscious, or has threatened or inflicted harm on another person, staff must make reasonable efforts to:

(A) Take the person into protective custody; and

(B) Transport the person to an appropriate treatment or health care facility.

(3) Emergency service patrol staff must maintain a log including:

(a) The time and origin of each call received for assistance;

(b) The time of arrival at the scene;

(c) The location of the person at the time of the assist;

(d) The name and sex of the person transported;

(e) The destination of the transport and time of arrival; and

(f) In case of nonpickup of a person, a notation must be made about why the pickup did not occur.

[Statutory Authority: RCW 70.96A.090 and chapter 70.96A RCW. 00-23-107, § 388-805-840, filed 11/21/00, effective 1/1/01.]

Chapter 388-810 WAC

ADMINISTRATION OF COUNTY CHEMICAL DEPENDENCY PREVENTION, TREATMENT, AND SUPPORT PROGRAM

(Formerly chapter 440-25 WAC)

WAC

388-810-005	What is the purpose of this chapter?
388-810-010	What definitions apply to this chapter?
388-810-020	What are the qualifications to be a county chemical dependency program coordinator?
388-810-030	What are the qualifications to be a county-designated chemical dependency specialist?
388-810-040	Who determines the service priorities for the county chemical dependency prevention, treatment, and support program?
388-810-050	How are available funds allocated for the county chemical dependency program?

388-810-060	How much money can a county claim for the administration of its chemical dependency prevention, treatment, and support program?
388-810-070	How will funds be made available to the county?
388-810-080	May a county subcontract for chemical dependency prevention, treatment, and support services?
388-810-090	How does a county request an exemption?

WAC 388-810-005 What is the purpose of this chapter? The purpose of this chapter is to describe the planning, contracting, and provision of chemical dependency prevention, treatment, and support services through counties (see chapter 70.96A RCW).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-005, filed 9/20/99, effective 10/21/99.]

WAC 388-810-010 What definitions apply to this chapter?

"County" means each county or two or more counties acting jointly.

"County chemical dependency program coordinator" means a person appointed by the county legislative authority as the chief executive officer responsible for carrying out the duties under chapter 70.96A RCW.

"County chemical dependency prevention, treatment, and support program" means services and activities funded by the department through a negotiated contract between a county and the department.

"Department" means the department of social and health services (DSHS).

"Designated chemical dependency specialist" means a person designated by the county chemical dependency program coordinator to perform the involuntary commitment duties under chapter 70.96A RCW.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-010, filed 9/20/99, effective 10/21/99.]

WAC 388-810-020 What are the qualifications to be a county chemical dependency program coordinator? A county chemical dependency program coordinator must have training and experience in:

(1) Chemical dependency prevention, intervention, and treatment strategies used in combating chemical dependency; and

(2) Administration of social and/or human services programs, sufficient to perform the following duties:

(a) Providing general supervision over the county chemical dependency prevention, treatment, and support program;

(b) Preparing plans and applications for funds to support the county chemical dependency prevention, treatment, and support program;

(c) Monitoring the delivery of services to assure conformance with plans and contracts;

(d) Providing staff support to the county alcoholism and other drug addiction board;

(e) Selecting the county designated chemical dependency specialist(s) to perform the intervention, involuntary detention and commitment duties as described under RCW 70.96A.120 and 70.96A.140; and

(f) Advising DSHS, county courts, law enforcement agencies, hospitals, chemical dependency programs, and other local health care and service agencies in the county as

to who has been designated as the chemical dependency specialist(s).

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-020, filed 9/20/99, effective 10/21/99.]

WAC 388-810-030 What are the qualifications to be a county-designated chemical dependency specialist? A county-designated chemical dependency specialist must:

(1) Be certified as a chemical dependency professional (CDP) by the department of health under chapter 18.205 RCW, or meet or exceed the requirements to be eligible to be certified as a CDP as described in chapter 246-811 WAC;

(2) Demonstrate knowledge of the laws regarding the involuntary commitment of chemically dependent adolescents and adults; and

(3) Demonstrate knowledge and skills in differential assessment of mentally ill and chemically dependant clients.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-030, filed 9/20/99, effective 10/21/99.]

WAC 388-810-040 Who determines the service priorities for the county chemical dependency prevention, treatment, and support program? (1) DSHS determines the service priorities for services funded by the department.

(2) DSHS must inform the county of the service priorities during the contract negotiation process.

(3) Counties must follow DSHS's service priorities when delivering chemical dependency program services supported by department funds.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-040, filed 9/20/99, effective 10/21/99.]

WAC 388-810-050 How are available funds allocated for the county chemical dependency program? (1) For the purposes of this section, "county" means the legal subdivision of the state, regardless of any agreement between two counties.

(2) The department shall allocate the funds available to the counties through funding formulas jointly developed with representatives of the counties, to carry out the intent of the federal and state legislated appropriations including any budget provisos.

(3) For information on current funding formulas, contact: Chief Financial Officer, Division of Alcohol and Substance Abuse, P.O. Box 45330, Olympia, Washington 98504-5330, Telephone: (360) 438-8088.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-050, filed 9/20/99, effective 10/21/99.]

WAC 388-810-060 How much money can a county claim for the administration of its chemical dependency prevention, treatment, and support program? A county may not use more than ten percent of the chemical dependency prevention, treatment, and support program funds managed by the county for administering the program.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-060, filed 9/20/99, effective 10/21/99.]

WAC 388-810-070 How will funds be made available to the county? (1) DSHS and each county negotiates and

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executes a county contract before the department reimburses the county for chemical dependency prevention, treatment, and support program services.

(2) DSHS may authorize the county to continue providing services according to a previous county contract and reimburse at the average level of the previous contract, in order to continue services until the department executes a new contract.

(3) DSHS may make advance payments to a county, if the payments facilitate sound program management.

(4) DSHS may require fiscal and program reports.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-070, filed 9/20/99, effective 10/21/99.]

WAC 388-810-080 May a county subcontract for chemical dependency prevention, treatment, and support services? A county may subcontract for services specified in the contract.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-080, filed 9/20/99, effective 10/21/99.]

WAC 388-810-090 How does a county request an exemption? (1) A county may request an exemption to these rules by sending a written request to the department.

(2) DSHS may grant an exemption if the department's assessment of the exemption request:

(a) Ensures the exemption does not undermine the legislative intent of chapter 70.96A RCW; and

(b) Shows that granting the exemption does not adversely affect the quality of the services, supervision, health, and safety of department customers.

[Statutory Authority: RCW 70.96A.040, 70.96A.090 and 70.96A.180. 99-19-105, § 388-810-090, filed 9/20/99, effective 10/21/99.]

Chapter 388-818 WAC

DEAF AND HARD OF HEARING SERVICES

WAC

PURPOSE

388-818-0010	What is the purpose of this chapter?
388-818-0020	What does the office of the deaf and hard of hearing do?
388-818-0030	What does the telecommunications access service do?

DEFINITIONS

388-818-0040	What definitions apply to this chapter?
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SOCIAL SERVICES FOR CLIENTS WITH HEARING LOSS

388-818-0050	What social services relating to hearing loss are available to the public?
388-818-0060	Who are qualified service providers?

TELECOMMUNICATIONS EQUIPMENT

388-818-0070	Is telecommunications equipment available for clients?
388-818-0080	What items are not included with telecommunications equipment?

TELECOMMUNICATIONS EQUIPMENT—APPLICATION PROCESS

388-818-0090	Who is eligible to apply for telecommunications equipment from TAS?
388-818-0100	Who must certify an applicant's eligibility for telecommunications equipment from TAS?
388-818-0110	How do applicants request specialized telecommunications equipment?
388-818-0120	What types of income are included when requesting equipment from TAS?
388-818-0130	How are applicants notified about decisions for telecommunications equipment?

388-818-0140	What are reasons for denying telecommunications equipment?		2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
TELECOMMUNICATIONS EQUIPMENT—APPLICATION RENEWAL			
388-818-0150	When may clients renew their applications for telecommunications equipment?	388-818-003	Services. [99-20-022, recodified as § 388-818-003, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-003, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
388-818-0160	How do clients renew their application for telecommunications equipment?		
TELECOMMUNICATIONS EQUIPMENT—NONPROFIT ORGANIZATIONS			
388-818-0170	Are nonprofit organizations eligible for telecommunications equipment?	388-818-005	Definitions. [99-20-022, recodified as § 388-818-005, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-005, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
388-818-0180	What process do nonprofit organizations follow to receive telecommunications equipment from TAS?		
TELECOMMUNICATIONS EQUIPMENT—PURCHASE AND LOAN			
388-818-0190	How much does an applicant have to pay for telecommunications equipment?		
388-818-0200	How does an applicant request a waiver (exception) of equipment cost?	388-818-010	Eligibility requirements. [99-20-022, recodified as § 388-818-010, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-010, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-010, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
388-818-0210	What conditions must be met for a client to receive purchased telecommunication equipment?		
388-818-0220	When is telecommunications equipment owned by the client?		
388-818-0230	May clients return purchased telecommunications equipment?		
388-818-0240	When may telecommunications equipment be loaned to an applicant?	388-818-020	Approval of application for initial device or request for replacement device. [99-20-022, recodified as § 388-818-020, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-020, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-020, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
388-818-0250	What are the conditions for loaning telecommunications equipment?		
388-818-0260	When does state-loaned equipment have to be returned to TAS?		
388-818-0270	May a person take loaned telecommunications equipment outside the state?		
TELECOMMUNICATIONS EQUIPMENT—TRAINING			
388-818-0280	Will training be provided on the use and care of telecommunications equipment?		
388-818-0290	What services do trainers provide to clients?	388-818-030	Denial of initial application or request for replacement device. [99-20-022, recodified as § 388-818-030, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-030, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
TELECOMMUNICATION EQUIPMENT—REPLACEMENT			
388-818-0300	When may telecommunications equipment be replaced?		
388-818-0310	When may requests for replacement telecommunications equipment be denied?		
TELECOMMUNICATION EQUIPMENT—RECONDITIONED			
388-818-0320	Who may receive reconditioned telecommunications equipment?	388-818-040	Application renewal process. [99-20-022, recodified as § 388-818-040, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-040, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
GRIEVANCE			
388-818-0330	May an applicant disagree with a DSHS decision about telecommunications equipment?		
GRIEVANCE—RELAY SERVICES			
388-818-0340	What is a relay complaint?	388-818-050	Notice of approval or denial. [99-20-022, recodified as § 388-818-050, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-050, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
388-818-0350	What may a client do when dissatisfied with relay services?		
388-818-0360	May a client file a formal complaint about the relay service?		
388-818-0370	When is customer service available for clients?		
388-818-0380	May clients file their complaint about relay services with the FCC?		
388-818-0390	May the FCC file a complaint?	388-818-060	Review by department. [99-20-022, recodified as § 388-818-060, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-060, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
388-818-0400	What documents must ODHHS keep for complaints?		
DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER			
388-818-001	Scope. [99-20-022, recodified as § 388-818-001, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-001, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.	388-818-070	Distribution. [99-20-022, recodified as § 388-818-070, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-070, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
388-818-002	Regional centers. [99-20-022, recodified as § 388-818-002, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-002, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed	388-818-080	Training. [99-20-022, recodified as § 388-818-080, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042

- (Order 3691), § 388-43-080, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
- 388-818-090 Ownership and liability. [99-20-022, recodified as § 388-818-090, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-090, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
- 388-818-110 Telecommunications relay service. [99-20-022, recodified as § 388-818-110, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.720, 43.20A.725 and 43.20A.730. 94-02-042 (Order 3691), § 388-43-110, filed 12/30/93, effective 1/30/94.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.
- 388-818-130 Uses for returned equipment. [99-20-022, recodified as § 388-818-130, filed 9/28/99, effective 9/28/99. Statutory Authority: RCW 43.20A.725 and 43.20A.730. 95-03-049 (Order 3825), § 388-43-130, filed 1/11/95, effective 2/11/95.] Repealed by 03-05-100, filed 2/19/03, effective 3/22/03. Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. Formerly chapter 388-43 WAC.

PURPOSE

WAC 388-818-0010 What is the purpose of this chapter? (1) The purpose of this chapter is to provide regulations about social and telecommunications access services for people with hearing loss and speech impairments.

(2) These services are provided:

- (a) Under contract with qualified service providers; or
- (b) Directly through the office of the deaf and hard of hearing (ODHH) at the department of social and health services (DSHS).

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0010, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0020 What does the office of the deaf and hard of hearing do? (1) The office of the deaf and hard of hearing (ODHH) within DSHS provides the following services to DSHS staff:

- (a) Provides information about hearing loss;
- (b) Offers technical assistance and workshops about deafness; and
- (c) Identifies ways for DSHS staff to get sign language interpreter services for their clients who have hearing loss.

(2) ODHH administers and monitors contracts with qualified service providers. These service providers offer community-based social services for clients who have hearing loss.

(3) ODHH manages the telecommunications access service program.

(4) ODHH contracts to provide telecommunications relay services (TRS).

(5) ODHH facilitates the DSHS-telecommunications relay services (TRS) advisory committee on deafness.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0020, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0030 What does the telecommunications access service do? Telecommunications access service (TAS), a program within ODHH:

(2007 Ed.)

(1) Provides eligible clients with initial or replacement equipment, based on the availability of equipment and/or funds;

(2) Maintains and oversees the statewide program for distributing telecommunications equipment;

(3) Maintains and oversees the contract for TRS; and

(4) May contract with qualified service providers for other telecommunications options as technology advances.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0030, filed 2/19/03, effective 3/22/03.]

DEFINITIONS

WAC 388-818-0040 What definitions apply to this chapter? "Amplified telephone" means an electrical device that increases the volume or tone of sounds being received during a telephone call.

"Applicant" means a client who applies for specialized telecommunications equipment.

"Audiologist" means a person who has a certificate of clinical competence in audiology from the American Speech, Hearing, and Language Association and is licensed to practice in the state of Washington.

"Client" means a person who is deaf, hard of hearing, speech impaired, or deaf-blind and may receive services from ODHH.

"Deaf" means a condition where a person's hearing ability is absent or mostly absent.

"Deaf-blind" means a person with both hearing loss and visual impairments.

"DSHS or department" means the department of social and health services.

"Federal poverty guidelines" means the poverty level established by the **"Poverty Income Guideline"** updated annually in the Federal Register.

"Hearing loss" means any form of hearing impairment, from mild to profound.

"Mobility impairment" for the purpose of this chapter means restricted upper body movement, which limits the ability to hold or dial a standard telephone to communicate. Individuals must also have a hearing loss or speech impairment.

"ODHH" means the office of the deaf and hard of hearing in the department of social and health services.

"Qualified service provider" means an agency or a business that provides social services to individuals with hearing loss or speech impairments. A qualified service provider may also be a **"qualified trainer."**

"Qualified trainer" means a person under contract with TAS who is knowledgeable in the use of telecommunications equipment.

"Relay service" is defined under **"telecommunications relay service (TRS)."**

"School-age" means between four and seventeen years of age.

"Sliding fee scale" means a range used to determine an applicant's participation in the cost of equipment.

"Speech impairment" means inability to speak or a speech disability.

"TAS" means the telecommunications access service program administered by the office of the deaf and hard of

hearing. The program provides equipment and services to help people with hearing loss and speech impairments have equal access to telecommunications.

"Telecommunications equipment" means any specialized device determined by TAS in ODHH to help a person with a hearing loss or speech impairment to communicate effectively. Examples include: Amplified telephone, TTY, signaling devices, software, digital equipment, and accessories. (See WAC 388-818-0070.)

"Telecommunications relay service (TRS)" means wire or radio service that enables a person with hearing loss or speech impairment to communicate with a person who uses a voice telephone. This service has communication assistants who transfer telephone conversations from one format to another (such as spoken words to text) to facilitate communication between two or more people.

"TTY" means teletypewriter or text telephone.

"TTY with Braille" means a teletypewriter with Braille keyboard and display.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0040, filed 2/19/03, effective 3/22/03.]

SOCIAL SERVICES FOR CLIENTS WITH HEARING LOSS

WAC 388-818-0050 What social services relating to hearing loss are available to the public? (1) These social services relating to hearing loss are offered by qualified service providers and ODHH staff throughout the state:

- (a) Information and referral about issues related to hearing loss;
 - (b) Advocacy on behalf of people with hearing loss;
 - (c) Training on deaf awareness and daily living issues experienced by people with hearing loss;
 - (d) Social gathering opportunities for groups, organizations, and clubs related to people with hearing loss; and
 - (e) Services related to telecommunications equipment, distribution of equipment, and training on the use and care of equipment.
- (2) Qualified service providers offer these services to:
- (a) Washington residents with hearing loss;
 - (b) The general public for information about hearing loss; and
 - (c) Telephone users who need their conversations relayed, or transferred from one format to another (such as spoken words to text).

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0050, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0060 Who are qualified service providers? Qualified service providers are organizations or businesses that contract with ODHH to provide social services related to hearing loss. Examples of qualified service providers include: Regional deaf and hard of hearing centers, relay service providers, and trainers for telecommunication equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0060, filed 2/19/03, effective 3/22/03.]

[Title 388 WAC—p. 1228]

TELECOMMUNICATIONS EQUIPMENT

WAC 388-818-0070 Is telecommunications equipment available for clients? (1) Clients may request telecommunications equipment from TAS.

(2) For clients to receive equipment, TAS staff must approve equipment requests.

(3) To be approved, telecommunications equipment must help people with hearing loss or speech impairments to:

- (a) Have independent use of telecommunications equipment; and
- (b) Gain equal access to telecommunications services that people with normal hearing and speech have.
- (4) Specialized equipment may include: Text, amplification, video, and hands-free equipment as well as ring signaling devices.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0070, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0080 What items are not included with telecommunications equipment? In the use of telecommunications equipment, neither TAS nor contracted qualified service providers offer:

- (1) Replacement batteries for any telecommunications equipment, except for deaf-blind equipment;
- (2) Replacement paper for TTYs;
- (3) Replacement light bulbs for signal equipment; or
- (4) Payment of the client's telephone bill.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0080, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT—APPLICATION PROCESS

WAC 388-818-0090 Who is eligible to apply for telecommunications equipment from TAS? (1) Washington state residents may apply to receive telecommunications equipment from TAS if they:

- (a) Are at least school aged; and
- (b) Are certified as having hearing loss or speech impairments.
- (2) Nonprofit organizations may apply to receive telecommunications equipment, as specified under WAC 388-818-0180.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0090, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0100 Who must certify an applicant's eligibility for telecommunications equipment from TAS? (1) A professional must certify that applicants have hearing loss and/or speech impairments and are eligible to receive telecommunications equipment from TAS.

- (2) These professionals include:
 - (a) A person who is licensed or certified by the department of health to provide health care in the state of Washington;
 - (b) An audiologist or hearing aid fitter/dispenser in Washington;
 - (c) A vocational rehabilitation counselor;

(2007 Ed.)

(d) A deaf specialist or coordinator at one of the community service centers for the deaf and hard of hearing in the state;

(e) A deaf-blind specialist or coordinator at an organization that serves deaf-blind people;

(f) A certified speech pathologist practicing in the state of Washington;

(g) A licensed occupational therapist;

(h) Staff from a qualified state agency as determined and specified by the TRS advisory committee on deafness; or

(i) Any in-state nonprofit organization serving the hearing or speech impaired.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0100, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0110 How do applicants request specialized telecommunications equipment? (1) To request specialized telecommunications equipment, an applicant must send a completed "Application for Telecommunications Equipment" form (DSHS 14-264) to TAS. To request an application, contact ODHH at 1-800-422-7930 V/TTY.

(2) The application form must be signed by an approved professional who certifies applicant's eligibility. (See WAC 388-818-0100.)

(3) If the applicant is seventeen or under, his or her parent/legal guardian must sign the application form.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0110, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0120 What types of income are included when requesting equipment from TAS? To meet income standards for telecommunications equipment from TAS, an applicant's income includes any of the following:

(1) Earned income, such as wages and tips;

(2) Social Security benefits;

(3) Unearned income, such as interest, dividends, and pensions;

(4) Family's share of income from corporations, partnerships, estates, and trusts; and

(5) Gains from the sale or exchange (including barter) of real estate, securities, coins, gold, silver, gems, or other property.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0120, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0130 How are applicants notified about decisions for telecommunications equipment? (1) When approving an application for telecommunications equipment, TAS staff must inform the applicant in writing about:

(a) The receipt of the applicant's completed application form;

(b) Any cost that applicants will incur for equipment; and

(c) The time frame when the applicant may expect a qualified trainer to set up the equipment and provide training.

(2) When denying an application for telecommunications equipment, TAS must inform the applicant in writing about:

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(a) The receipt of the applicant's completed application form;

(b) The reasons for the denial; and

(c) Any applicable procedures for appeal, as well as the circumstances under which the applicant may reapply. (See WAC 388-818-0150.)

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0130, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0140 What are reasons for denying telecommunications equipment? (1) For an initial application for services, TAS must deny an application for telecommunications equipment if an applicant:

(a) Does not meet the eligibility requirements of WAC 388-818-0090; or

(b) Has received similar equipment from TAS within the last three years.

(2) For an application requesting replacement of telecommunications equipment, TAS must deny the request if the client has done any of the following:

(a) Abused, misused, or repaired without approval any previously issued equipment;

(b) Failed to file with the police a report of stolen equipment within fifteen working days of discovering a theft;

(c) Failed to file with the police or the fire department a report of fire having damaged the equipment within fifteen working days of the incident of the fire;

(d) Lost, pawned, or sold the equipment; or

(e) Failed to obtain approval from DSHS before moving or traveling out of state with state-loaned equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0140, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT— APPLICATION RENEWAL

WAC 388-818-0150 When may clients renew their applications for telecommunications equipment? Clients may renew their applications for telecommunications equipment when:

(1) Additional telecommunication equipment is necessary to meet the client's needs; or

(2) Equipment no longer works and it's been more than three years since he or she first received equipment.

Note: If less than three years have passed since a client first received equipment, refer to WAC 388-818-0300 for replacement criteria.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0150, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0160 How do clients renew their application for telecommunications equipment? When renewing an application for telecommunications equipment, a client must:

(1) Complete a new application, including recent information on total annual family income and family size; and

(2) Go through the same procedures as first-time applicants (outlined in WAC 388-818-0090 through 388-818-0130).

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0160, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT— NONPROFIT ORGANIZATIONS

WAC 388-818-0170 Are nonprofit organizations eligible for telecommunications equipment? (1) A nonprofit organization may be eligible for telecommunications equipment when these two criteria are met:

(a) Only nonprofit organizations under section 501 (c)(3) of the internal revenue code, are eligible for any equipment from TAS; and

(b) Nonprofit organizations must serve people with hearing loss, deaf-blindness, and/or speech impairments.

(2) A qualified nonprofit organization is eligible to receive:

(a) Reconditioned telecommunications equipment from ODHH; or

(b) New equipment when it is in the best interest of both ODHH and the individuals served by the nonprofit organization.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0170, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0180 What process do nonprofit organizations follow to receive telecommunications equipment from TAS? (1) To apply for reconditioned equipment, a nonprofit organization must provide to TAS the following:

(a) A completed application form, "Nonprofit Organization Application for Reconditioned Equipment" (DSHS 14-440), which can be obtained by calling ODHH at 1-800-422-7930;

(b) A letter explaining the services provided by the organization to people with hearing loss and speech impairments in their communities;

(c) A copy of a certificate of incorporation as a nonprofit organization under section 501 (c)(3) of the internal revenue code; and

(d) A copy of the organization's bylaws.

(2) TAS staff notifies the nonprofit organization of acceptance or denial.

(3) TAS staff sends the equipment to an approved nonprofit organization.

(4) The nonprofit organizations are responsible for care and maintenance of this equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0180, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT— PURCHASE AND LOAN

WAC 388-818-0190 How much does an applicant have to pay for telecommunications equipment? (1) TAS staff must consider family size and household income in determining how much the applicant must pay for telecommunications equipment. Financial responsibility ranges from no cost to one hundred percent of actual cost based on federal poverty guidelines.

(2) Exception: If the normal cost that TAS assesses for equipment is still beyond the applicant's ability to pay, the cost may be partly or totally waived (excused) if:

(a) The eligible person requires TTY with Braille equipment or any other equipment of comparable cost; or

[Title 388 WAC—p. 1230]

(b) The cost of the equipment would create an undue hardship on the eligible person.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0190, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0200 How does an applicant request a waiver (exception) of equipment cost? (1) To request a waiver (exception) of equipment cost, an applicant must write a letter to the ODHH director explaining the reasons for inability to pay for equipment. Letters can be mailed to: ODHH, Attn: Director, P.O. Box 45301, Olympia WA 98504-5301.

(2) ODHH notifies the applicant in writing of the final decision for the waiver request.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0200, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0210 What conditions must be met for a client to receive purchased telecommunication equipment? For a client to receive purchased telecommunications equipment, these two conditions must be met:

(1) TAS must receive full payment before an eligible client receives telecommunications equipment; and

(2) The applicant or the applicant's parent/legal guardian must provide a signed "Statement of Rights and Responsibilities" form to TAS upon receiving the equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0210, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0220 When is telecommunications equipment owned by the client? Telecommunications equipment is owned by the client when the client or the parent/legal guardian:

(1) Pay any portion of the equipment's cost; and

(2) Sign a "Statement of Rights and Responsibilities" form upon receiving the equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0220, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0230 May clients return purchased telecommunications equipment? (1) A client may return purchased telecommunications equipment to TAS within thirty days after receiving the equipment.

(2) A client must receive a financial refund for the equipment if it was returned:

(a) In clean and good condition;

(b) In its original packaging; and

(c) Within the required time frame.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0230, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0240 When may telecommunications equipment be loaned to an applicant? ODHH may loan telecommunications equipment to an eligible person if:

(1) TAS determines that a client may get equipment at no cost;

(2) A "Conditions of Acceptance" form is signed by the client or the parent/legal guardian upon receiving the equipment.

(3) The applicant has not violated the requirements in WAC 388-818-0140(2).

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0240, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0250 What are the conditions for loaning telecommunications equipment? (1) When loaning telecommunications equipment, ODHHS must ensure that the client understands that the equipment remains the sole property of Washington state.

(2) A client, or the client's parent/legal guardian is liable for any damage to or loss of telecommunications equipment issued by TAS.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0250, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0260 When does state-loaned equipment have to be returned to TAS? A client or the client's parent/legal guardian must return state-loaned telecommunications equipment to TAS when the client:

- (1) Moves from a permanent Washington state residence to a location outside of Washington;
- (2) No longer needs the equipment;
- (3) Has been notified by TAS to return the equipment; or
- (4) Has received new state-loaned equipment.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0260, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0270 May a person take loaned telecommunications equipment outside the state? (1) People must get written permission from TAS before moving their loaned telecommunications equipment from Washington state for over ninety days.

(2) TAS may grant the client permission to move telecommunications equipment from the state if it is in the best interest of the client and DSHS.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0270, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATIONS EQUIPMENT— TRAINING

WAC 388-818-0280 Will training be provided on the use and care of telecommunications equipment? (1) ODHHS contracts with qualified people or agencies to train individuals on ways to use and care for telecommunications equipment provided by TAS.

(2) ODHHS must ensure reasonable accessibility to training for people with hearing loss or speech impairment.

(3) ODHHS staff determine who receives training on proper equipment use and care from qualified trainers. Individuals receiving training may include:

- (a) Clients;
- (b) Parents/legal guardians; and
- (c) Staff or volunteers of profit and nonprofit organizations.

(4) When applicants are age seventeen or younger, their parents/legal guardians must attend all training sessions on appropriate equipment use and care.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0280, filed 2/19/03, effective 3/22/03.]

(2007 Ed.)

WAC 388-818-0290 What services do trainers provide to clients? (1) Qualified trainers must determine the training needs of individuals and the type of training that would be most effective.

(2) A qualified trainer must:

(a) Conduct individual and group training sessions for the applicants in the use and care of the equipment;

(b) Provide training and presentations to individuals, agencies and organizations, as requested by ODHHS staff; and

(c) Distribute and set up telecommunications equipment for applicants.

(3) When delivering telecommunications equipment, a qualified trainer may decide that the purchased equipment does not meet the client's needs. In this case, the trainer may recommend other equipment to the client. If accepting other equipment, the client must take financial responsibility for any cost difference by signing an "Acceptance of Financial Responsibility" form.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0290, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATION EQUIPMENT— REPLACEMENT

WAC 388-818-0300 When may telecommunications equipment be replaced? (1) TAS may replace telecommunications equipment without a client renewing the application for equipment if:

- (a) The equipment is no longer working; and
- (b) Less than three years have passed since the client's initial application date for equipment.

(2) Clients may renew their application with TAS to replace telecommunications equipment if:

- (a) The equipment is no longer working; and
- (b) Three years have passed from the last time they applied and received their equipment. (See WAC 388-818-0160 for the renewal process.)

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0300, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0310 When may requests for replacement telecommunications equipment be denied? TAS may deny a request for replacement telecommunications equipment if previously issued equipment:

- (1) Was neglected, misused, or abused;
- (2) Was not reported as stolen or burned to either police or fire department within fifteen working days; or
- (3) Was lost, sold, traded, or pawned.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0310, filed 2/19/03, effective 3/22/03.]

TELECOMMUNICATION EQUIPMENT— RECONDITIONED

WAC 388-818-0320 Who may receive reconditioned telecommunications equipment? TAS may recondition telecommunications equipment and give it to any of the following agencies, nonprofit organizations or individuals:

- (1) State agencies;
- (2) Tribal community centers;

(3) Nonprofit organizations that are registered under section 501 (c)(3) of the internal revenue code and serve people who have hearing loss, deaf-blindness or speech impairment (see WAC 388-818-0180 for application details); and

(4) Nonpaying clients.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0320, filed 2/19/03, effective 3/22/03.]

GRIEVANCE

WAC 388-818-0330 May an applicant disagree with a DSHS decision about telecommunications equipment?

(1) When TAS denies an application for original or replacement equipment, an applicant or client may request that ODHH review this decision.

(2) For a review of a TAS decision, the applicant or client must:

(a) Submit a request in writing to ODHH, specifying the reason for the request; and

(b) Ensure that ODHH receives this request within forty days of the date of the denial notice.

(3) Within thirty days after receiving the request for review, ODHH staff must inform the applicant or client in writing of the decision of the request. The decision of ODHH is final.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0330, filed 2/19/03, effective 3/22/03.]

GRIEVANCE—RELAY SERVICES

WAC 388-818-0340 What is a relay complaint? (1) A client may make a complaint about an unsatisfactory experience while using the relay services during a telephone call. Complaints may be about:

(a) Communications assistant (CA) or video interpreter (VI) performance, such as typing speed, accuracy of relaying a message's intent, clarity of signs, and spelling accuracy;

(b) Service quality, such as timeliness of response and connection; and/or

(c) Technical issues during a call made through the relay service, such as disconnection of call, video picture quality, or text garbling.

(2) The main purpose of a relay complaint is to:

(a) Improve the quality of relay service; and

(b) Monitor relay agent or interpreter performance and the accuracy of relaying information between calling parties.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0340, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0350 What may a client do when dissatisfied with relay services? (1) ODHH must ensure that clients have access to customer services for the relay service provider or an opportunity to resolve quality of service issues with TRS regarding:

(a) Any problems with the relay service; and/or

(b) Dissatisfaction with explanations given for any relay service problems.

(2) To assist dissatisfied clients, the ODHH compliance officer must provide names and telephone numbers for customer support.

[Title 388 WAC—p. 1232]

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0350, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0360 May a client file a formal complaint about the relay service? (1) A client may file a formal complaint about the relay service:

(a) To obtain a complaint form about the relay service, a client may contact ODHH (at 1-800-422-7930) to request that a form be mailed.

(b) The client may also contact the ODHH compliance officer or relay provider customer service representative for assistance in completing the form.

(c) Completed complaint forms may be mailed, faxed, or e-mailed to ODHH.

(2) ODHH must investigate and resolve the complaint within one hundred eighty days, as required by the Federal Communications Commission (FCC).

(a) Complaints related to service issues are resolved by the relay service provider and the compliance officer.

(b) Technical complaints are referred to relay service provider technical personnel for resolution.

(c) Any corrective action must be taken as soon as possible.

(d) The ODHH compliance officer must notify the client about the result of the investigation, including any actions taken.

(3) If the client is satisfied with the results of the investigation, the ODHH compliance officer must document and close the case.

(4) If the client is dissatisfied with the results of the investigation, the compliance officer and relay service provider may discuss further options to resolve the complaint and corrective actions.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0360, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0370 When is customer service available for clients? The relay service provider and ODHH must ensure that customer service is available during regular work days (Monday through Friday excluding state holidays) to:

(1) Address client complaints or inquiries; and

(2) Respond to FCC staff members when requested.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0370, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0380 May clients file their complaint about relay services with the FCC? (1) A client who continues to be dissatisfied with responses from the formal complaint process at ODHH may file a complaint with the Federal Communications Commission (FCC).

(2) The ODHH compliance officer must give the client the toll-free telephone number and address of the FCC for further review of the complaint.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0380, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0390 May the FCC file a complaint? (1) The FCC may file a complaint to ODHH or the relay service provider.

(2) Within one hundred eighty days of receiving the complaint, ODHH must:

(2007 Ed.)

(a) Report the results of the complaint investigation to the FCC; or

(b) Keep the FCC informed about ongoing progress of actions toward resolution.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0390, filed 2/19/03, effective 3/22/03.]

WAC 388-818-0400 What documents must ODHH keep for complaints? (1) ODHH must keep a record of all complaints about the quality of relay services.

(2) The complaint document must show at least:

(a) The name, phone number and address of the complainant;

(b) The nature and date of the complaint;

(c) Actions taken; and

(d) The final disposition of the complaint.

(3) These records must be maintained in a suitable place, readily available for FCC review.

(4) ODHH and the relay service provider must retain correspondence and records of complaints for a minimum of two years.

[Statutory Authority: RCW 43.20A.725, 43.20A.720, 2001 c 210. 03-05-100, § 388-818-0400, filed 2/19/03, effective 3/22/03.]

Chapter 388-823 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES INTAKE AND DETERMINATION OF DEVELOPMENTAL DISABILITIES

WAC

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APPLYING FOR A DETERMINATION OF A DEVELOPMENTAL DISABILITY

WAC 388-823-0010 Definitions. The following definitions apply to this chapter:

"Client" means a person with a developmental disability as defined in chapter 388-823 WAC who is currently eligible and active with the division of developmental disabilities.

"DAS" means differential ability scales, which is a cognitive abilities battery for children and adolescents at least age two years, six months but under age eighteen.

"DDD" means the division of developmental disabilities, a division within the aging and disability services administration, department of social and health services.

"Department" means the department of social and health services.

"Division" means the division of developmental disabilities.

"Eligible" means you have a developmental disability that meets all of the requirements in this chapter for a specific condition.

"Expiration date" means a specific date that your eligibility as a client of DDD and all services paid by DDD will stop.

"FSIQ" means the full scale intelligence quotient which is a broad measure of intelligence achieved through one of the standardized intelligence tests included in these rules. Any standard error of measurement value will not be taken into consideration when making a determination for DDD eligibility.

"ICAP" means the inventory for client and agency planning. This is a standardized assessment of functional ability. The adaptive behavior section of the ICAP assesses daily living skills and the applicant awareness of when to perform these skills. The goal is to get a snapshot of his/her ability.

"IMR" means an institution for the mentally retarded, per chapter 388-835 WAC or chapter 388-837 WAC.

"K-ABC" means Kaufman assessment battery for children, which is a clinical instrument for assessing intellectual development. It is an individually administered test of intelligence and achievement for children at least age two years, six months but under age twelve years, six months. The K-ABC comprises four global scales, each yielding standard scores. A special nonverbal scale is provided for children at least age four years but under age twelve years, six months.

"Leiter-R" means Leiter international performance scale - revised, which is an untimed, individually administered test of nonverbal cognitive ability for individuals at least age two years but under age twenty-one years.

"Review" means DDD must redetermine that you still have a developmental disability according to the rules that are in place at the time of the review.

"RHC" means one of five residential habilitation centers operated by the division: Lakeland Village, Yakima Valley School, Fircrest, Rainier School, and Francis Haddon Morgan Center.

"SIB-R" means the scale of independent behavior-revised which is an adaptive behavior assessment derived from quality standardization and norming. It can be administered as a questionnaire or as a carefully structured interview, with special materials to aid the interview process.

"SOLA" means a state operated living alternative residential service for adults operated by the division.

"Stanford-Binet" is a battery of fifteen subtests measuring intelligence for individuals at least age two years but under age twenty-three years.

"Termination" means an action taken by DDD that stops your DDD eligibility and services paid by DDD.

"VABS" means Vineland adaptive behavior scales, which is an assessment to measure adaptive behavior in children from birth but under age eighteen years, nine months and in adults with low functioning in four separate domains: Communication, daily living skills, socialization, and motor skills.

"Wechsler" means the Wechsler intelligence scale, which is an individually administered 11-subtest measure of an individual's capacity for intelligent behavior. The Wechsler has both a verbal scale and a performance scale. The Wechsler is used with individuals at least age three years but under age seventy-four years. The verbal scale can be used alone with individuals who have visual or motor impairments, and the performance scale can be used alone with individuals who cannot adequately understand or produce spoken language. There are three Wechsler intelligence scales, dependent upon the age of the individual:

- The Wechsler preschool and primary scale of intelligence - revised (WPPSI-R), for children at least age three years but under age seven years;
- The Wechsler intelligence scale for children - third edition, (WISC-III), for children at least age six years but under age sixteen years; and
- The Wechsler adult intelligence scale - revised (WAIS-R), for individuals at least age sixteen years but under age seventy-four years.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters

71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0010, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0020 How do I become a client of the division of developmental disabilities? You become a client of the division of developmental disabilities (DDD) if you apply for eligibility with DDD and DDD determines that you have a "developmental disability" as defined in this chapter.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0020, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0030 Will I receive paid services if DDD decides that I have a developmental disability? If DDD determines that you have a developmental disability, your access to paid services as a DDD client depends on:

(1) Your meeting eligibility requirements for the specific service;

(2) An assessed need for the service; and

(3) Available funding for the service. The availability of funding does not apply to Medicaid state plan services or services available under the DDD Medicaid home and community based services waiver.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0030, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0040 What is a developmental disability? (1) A developmental disability is defined in RCW 71A.10.020(3) and must meet all of the following requirements. The developmental disability must currently:

(a) Be attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition found by DDD to be closely related to mental retardation or requiring treatment similar to that required for individuals with mental retardation;

(b) Originate prior to age eighteen;

(c) Be expected to continue indefinitely; and

(d) Result in substantial limitations to an individual's adaptive functioning.

(2) In addition to the requirements listed in (1) above, you must meet the other requirements contained in this chapter.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0040, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0050 Must I be a resident of the state of Washington? When you apply for eligibility with DDD, you must be a resident of the state of Washington. Proof of residency includes:

(1) The receipt of Medicaid or other benefits from the department of social and health services that require residency as a condition of eligibility; or

(2) Documentation that shows you live in the state of Washington, or, if you are a child under the age of eighteen, documentation that shows your parent or legal guardian lives in the state of Washington.

(2007 Ed.)

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0050, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0060 How do I apply to become a client of DDD? (1) You apply to become a client of DDD by calling the regional DDD office or a local DDD office and requesting determination of a developmental disability. The toll free regional numbers are:

Region 1	Spokane	1-800-462-0624
Region 2	Yakima	1-800-822-7840
Region 3	Everett Bellingham Mount Vernon	1-800-788-2053 1-800-239-8285 1-800-491-5266
Region 4	Seattle	1-800-314-3296
Region 5	Tacoma Bremerton	1-800-248-0949 1-800-735-6740
Region 6	Port Angeles Tumwater Vancouver	1-877-601-2760 1-800-339-8227 1-888-877-3490

(2) DDD will make arrangements with you to complete the application for the eligibility determination by mail or over the phone.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0060, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0070 Who can apply for an eligibility determination? (1) The following individuals can apply for a determination of developmental disability:

(a) The parent or legal representative must apply on behalf of a child under the age of eighteen years;

(b) If there is a legal guardian of an applicant age eighteen years or older, the legal guardian must apply on behalf of the adult applicant; or

(c) If there is no legal guardian of an adult applicant age eighteen years or older, the adult applicant can apply on his/her own behalf.

(2) Any person, agency, or advocate may refer an adult for a determination of a developmental disability and assist with the application process. However, since the request for a determination of developmental disability is voluntary, DDD will request the verbal or written consent from the legal guardian of the adult or from the adult applicant if there is no legal guardian.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0070, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0080 Who determines that I have a developmental disability? DDD determines if you have a developmental disability as defined in this chapter after reviewing all documentation received by the division.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0080, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0090 How long will it take to complete a determination of my eligibility? (1) Once DDD receives sufficient documentation to determine you eligible, DDD has thirty days from receipt of the final piece of documentation to make the determination of eligibility.

(2) If DDD has received all requested documentation but it is insufficient to establish eligibility, DDD will make a determination of ineligibility and send you written notice of denial of eligibility.

(3) If DDD has insufficient information to determine you eligible but has not received all of the requested documentation, DDD may deny your eligibility after ninety days from the date of application. Rules governing reapplying for eligibility are in WAC 388-823-1080.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0090, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0100 What is the effective date that I become an eligible client of DDD? (1) If DDD receives sufficient information to substantiate your DDD eligibility, the effective date of your eligibility as a DDD client is the date of receipt of the final piece of documentation.

(2) Paid DDD services cannot begin before the effective date of your DDD eligibility.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0100, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0105 How will DDD notify me of the results of my eligibility determination? DDD will send you written notification of the final determination of your eligibility per WAC 388-825-100.

(1) If you are not eligible, the written notice will explain why you are not eligible, explain your appeal rights to this decision, and provide you with a fair hearing request form.

(2) If you are eligible, the written notice will include:

(a) Your eligibility condition(s);

(b) The effective date of your eligibility;

(c) The expiration date or review date of your eligibility, if applicable; and

(d) The name and phone number of your assigned case manager.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0105, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0110 Who is responsible for obtaining the documentation needed to make this eligibility determination? You are responsible to obtain all of the information needed to document your disability or to provide DDD with the sources for obtaining the documentation.

(1) DDD will assist you in obtaining records but the purchase of diagnostic assessments or intelligence quotient (IQ) testing is your responsibility.

(2) If DDD determines that an Inventory of Client and Agency Planning (ICAP) is required, DDD will administer the ICAP at no expense to you.

[Title 388 WAC—p. 1236]

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0110, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0120 Will my diagnosis of a developmental disability qualify me for DDD eligibility? Eligibility for DDD requires more than a diagnosis of a developmental disability. You must meet all of the elements that define a developmental disability in WAC 388-823-0040 and meet the requirements of a specific eligible condition defined in this chapter.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0120, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0130 Can I be eligible for DDD if my disability occurs on or after my eighteenth birthday? DDD eligibility requires that your disability exist before your eighteenth birthday.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0130, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0140 What if I do not have written evidence that my disability began before my eighteenth birthday? (1) If there is no documentation available to prove that your disability began prior to age eighteen, DDD may accept verbal information from your family or others who knew you prior to the age of eighteen about your early developmental history, educational history, illnesses, injuries or other information sufficient to validate the existence of an eligible condition prior to age eighteen.

(2) DDD will determine if the reported verbal information is adequate for documenting the existence of your condition prior to age eighteen.

(3) Additional evidence of your eligible condition and the resulting substantial limitations to adaptive functioning is still required.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0140, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0150 Which rules define a developmental disability if I am a child under the age of six years? If you are a child under the age of six years, assessment of developmental delays and other age appropriate criteria are used to substantiate an eligible condition and substantial limitations in adaptive functioning as defined in WAC 388-823-0800 through 388-823-0850.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0150, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0160 Which rules define a developmental disability if I am age six through nine? If you are a child age six but under age ten, you can meet the criteria for a developmental disability under either of the two following sets of rules:

(1) Developmental delays per WAC 388-823-0800 through 388-823-0850; or

(2) Developmental disabilities per WAC 388-823-0200 through 388-823-0710.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0160, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0170 Which rules define a developmental disability if I am age ten or older? If you are age ten or older, only the rules in WAC 388-823-0200 through 388-823-0710 apply when deciding if you have a developmental disability.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0170, filed 6/1/05, effective 7/2/05.]

DETERMINATION OF A DEVELOPMENTAL DISABILITY MENTAL RETARDATION

WAC 388-823-0200 What evidence do I need to substantiate "mental retardation" as an eligible condition? Evidence that you have an eligible condition under "mental retardation" requires a diagnosis of mental retardation by a licensed psychologist, or a finding of mental retardation by a certified school psychologist or a diagnosis of Down syndrome by a licensed physician.

(1) This diagnosis is based on documentation of a life-long condition originating before age eighteen.

(2) The condition results in significantly below average intellectual and adaptive skills functioning that will not improve with treatment, instruction or skill acquisition.

(3) A diagnosis or finding of mental retardation by the examining psychologist must include an evaluation of adaptive functioning that includes the use of a standardized adaptive behavior scale indicating adaptive functioning that is more than two standard deviations below the mean, in at least two of the following areas: Communication, self care, home living, social/interpersonal skills, use of community resources, self direction, functional academic skills, work, leisure, health, and safety.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0200, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0210 If I have mental retardation, how do I meet the definition of substantial limitations in adaptive functioning? (1) If you meet the definition of mental retardation in WAC 388-823-0200, you must have substantial limitations in adaptive functioning of two standard deviations below the mean and a full-scale intelligence quotient (FSIQ) of more than two standard deviations below the mean.

(2) The substantial limitation in adaptive functioning must reflect your current condition.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters (2007 Ed.)

71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0210, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0215 What evidence do I need of my FSIQ? Evidence of a qualifying FSIQ to meet the definition of substantial limitations for the condition of mental retardation is a FSIQ derived from a Stanford-Binet, Wechsler intelligence scale (Wechsler), differential abilities scale (DAS), Kaufman assessment battery for children (K-ABC), or a Leiter international performance scale-revised (Leiter-R) if you have a significant hearing impairment or English is not your primary language.

(1) The test must be administered by a licensed psychologist or certified school psychologist.

(2) The FSIQ cannot be attributable to mental illness or other psychiatric condition occurring at any age; or other illness or injury occurring after age eighteen:

(a) If you are dually diagnosed with mental retardation and mental illness, other psychiatric condition, or other illness or injury, DDD must make its eligibility decision based solely on the diagnosis of mental retardation, excluding the effects of the mental illness, other psychiatric condition, illness or injury; or

(b) If DDD is unable to make this eligibility decision based solely on the diagnosis of mental retardation due to the existence of mental illness, other psychiatric condition or illness or injury, DDD will deny eligibility.

(3) If you have a significant hearing impairment, the administering professional may estimate an FSIQ score using only the performance IQ score of the appropriate Wechsler or administer the Leiter-R.

(4) If you have a vision impairment that prevents completion of the performance portion of the IQ test, the administering professional may estimate an FSIQ using only the verbal IQ score of the appropriate Wechsler.

(5) The following table shows the standard deviation for each assessment and the qualifying score of more than two standard deviations below the mean.

ASSESSMENT	STANDARD DEVIATION	QUALIFYING SCORE
Stanford-Binet 4th edition	16	67 or less
Stanford-Binet 5th edition	15	69 or less
Wechsler Intelligence Scales (Wechsler)	15	69 or less
Differential Abilities Scale (DAS)	15	69 or less
Kaufman Assessment Battery for Children (K-ABC)	15	69 or less
Leiter International Performance Scale-Revised (Leiter-R) [for persons with significant hearing impairments or when English is not a primary language]	15	69 or less

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters

71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0215, filed 6/1/05, effective 7/2/05.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-823-0220 If I am too intellectually impaired to complete a standardized IQ test, how do I meet the criteria under mental retardation? If in the opinion of the examining psychologist, you are too intellectually impaired to complete all of the subtests necessary to achieve an FSIQ score on an approved standardized IQ test, the examining psychologist may estimate an FSIQ from the available information based on a professional judgment about your intellectual functioning.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0220, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0230 If I have more than one FSIQ score, what criteria will DDD use to select the FSIQ score for determining eligibility? (1) If you have more than one FSIQ, DDD will review the pattern of FSIQ scores.

(a) If there is no significant difference among these, DDD will accept the score the closest to age eighteen.

(b) If there are significant differences among the FSIQ scores, DDD will review the pattern and attempt to determine reasons for the fluctuations to ensure that the FSIQ is resulting from mental retardation and not from mental illness or other psychiatric condition, or illness, or other injury.

(i) If you are age eighteen or older, DDD will use the FSIQ obtained at age thirteen or older, provided the FSIQ is resulting from mental retardation.

(ii) If you are under age eighteen, DDD will use the most current FSIQ, provided the FSIQ is resulting from mental retardation.

(2) DDD will exclude any FSIQ score attributable to a condition or impairment that began on or after your eighteenth birthday.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0230, filed 6/1/05, effective 7/2/05.]

CEREBRAL PALSY

WAC 388-823-0300 What evidence do I need to substantiate "cerebral palsy" as an eligible condition? Evidence that you have an eligible condition under "cerebral palsy" requires a diagnosis by a licensed physician of cerebral palsy, quadriplegia, hemiplegia, or diplegia with symptoms that:

- (1) Existed prior to age three; and
- (2) Impair control of movement.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0300, filed 6/1/05, effective 7/2/05.]

[Title 388 WAC—p. 1238]

WAC 388-823-0310 If I have cerebral palsy, how do I meet the definition of substantial limitations to adaptive functioning? If you have an eligible condition of cerebral palsy, substantial limitations of adaptive functioning is the need for direct physical assistance on a daily basis with two or more of the following activities as a result of your condition:

- (1) Toileting;
- (2) Bathing;
- (3) Eating;
- (4) Dressing;
- (5) Mobility; or
- (6) Communication.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0310, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0320 What evidence do I need of my need for direct physical assistance with activities of daily living? Evidence for direct physical assistance with activities of daily living means:

(1) You need the presence and assistance of another person on a daily basis to be able to communicate and be understood by any other person.

(a) If you are able to communicate through a communication device you will be considered independent in communication.

(b) You must require more than "setting up" of the communication device.

(2) You need direct physical assistance from another person on a daily basis with toileting, bathing, eating, dressing, or mobility.

(a) You require more than "setting up" the task to enable you to perform the task independently.

(b) You must require direct physical assistance for more than transferring in and out of wheelchair, in and out of the bath or shower, and/or on and off of the toilet.

(c) Your ability to be mobile is your ability to move yourself from place to place, not your ability to walk. For instance, if you can transfer in and out of a wheelchair and are independently mobile in a wheelchair, you do not meet the requirement for direct physical assistance with mobility.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0320, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0330 How can I document my need for direct physical assistance? Any of the following can be used as evidence to determine your direct physical assistance needs:

(1) The comprehensive assessment reporting evaluation (CARE) tool or other department assessments that measure direct assistance needs in the areas specified above;

(2) Assessments and reports from educational or health-care professionals that are current and consistent with your current functioning;

(3) In the absence of professional reports or assessments, DDD may document its own observation of your direct assistance needs along with reported information by family and others familiar with you.

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[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0330, filed 6/1/05, effective 7/2/05.]

EPILEPSY

WAC 388-823-0400 What evidence do I need to substantiate "epilepsy" as an eligible condition? Evidence of an eligible condition under "epilepsy" requires a diagnosis of a neurological condition that produces brief disturbances in the normal electrical functions of the brain resulting in seizures.

(1) This condition requires a diagnosis of epilepsy or seizure disorder that originated prior to age eighteen and is expected to continue indefinitely.

(2) The diagnosis must be made by a board certified neurologist and be based on documentation of medical history and neurological testing.

(3) You must provide confirmation from your physician or neurologist that your seizures are currently uncontrolled and ongoing or recurring and cannot be controlled by medication.

(4) DDD will not consider your seizures uncontrolled or ongoing if it is documented or reported that you refuse to take medications.

(5) Your seizures must make you physically incapacitated, requiring direct physical assistance for one or more activities as defined in WAC 388-823-0310 and 388-823-0320 during or following seizures.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0400, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0410 If I have epilepsy, how do I meet the definition of substantial limitations to adaptive functioning? A substantial limitation to adaptive functioning under epilepsy is a functional assessment score of more than two standard deviations below the mean on a Vineland adaptive behavior scales (VABS), scale of independent behavior-revised (SIB-R) or inventory for client and agency planning (ICAP) assessment instrument as described in WAC 388-823-0420.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0410, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0420 What evidence do I need to substantiate adaptive functioning limitations for the eligible conditions of epilepsy, autism and other conditions similar to mental retardation? (1) Evidence of substantial limitations of adaptive functioning for the conditions of epilepsy, autism, and other conditions similar to mental retardation requires a qualifying score completed in the past thirty-six months in a VABS or a SIB-R, or a qualifying score completed in the past twenty-four months in an ICAP.

(a) Professionals who administer and score the VABS must have a background in individual assessment, human development and behavior, and tests and measurements, as well as an understanding of individuals with disabilities.

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(b) Department staff or designee contracted with DDD must administer the ICAP.

(c) DDD will administer or arrange for the administration of the ICAP if VABS or SIB-R results are not submitted.

(d) Qualifying scores for each assessment are as follows:

ASSESSMENT	STANDARD DEVIATION	QUALIFYING SCORE
Vineland Adaptive Behavior Scales (VABS)	15	An adaptive behavior composite score of 69 or less
Scales of Independent Behavior-Revised (SIB-R)	15	A broad independence standard score of 69 or less for the adaptive behaviors
Inventory for Client and Agency Planning (ICAP)	15	Pursuant to WAC 388-823-0900, the broad independence domain score based on the applicant's birth date and the date the test is administered.

(2) If DDD is unable to determine that your current adaptive functioning impairment is the result of your developmental disability because you have an unrelated injury or illness that is impairing your current adaptive functioning:

(a) DDD will not accept the results of a VABS or SIB-R administered after that event and will not administer the ICAP; and

(b) Your eligibility will have to be determined under a different condition that does not require evidence of adaptive functioning per a VABS, SIB-R or ICAP.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0420, filed 6/1/05, effective 7/2/05.]

AUTISM

WAC 388-823-0500 What evidence do I need to substantiate "autism" as an eligible condition? Evidence of an eligible condition under "autism" requires a diagnosis by a qualified professional of autism or autistic disorder per 299.00 in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) that is expected to continue indefinitely, and evidence of onset before age three.

(1) The following professionals are qualified to give this diagnosis:

- (a) Board eligible neurologist;
- (b) Board eligible psychiatrist;
- (c) Licensed psychologist; or
- (d) Board certified developmental and behavioral pediatrician.

(2) The evidence provided by a diagnosing professional in subsection (1) above exhibits a total of six or more of the following diagnostic criteria listed in the current DSM-IV-TR for Autistic Disorder 299.00:

- (a) Two or more qualitative impairments in social interactions;
- (b) One or more qualitative impairments in communication; and
- (c) One or more impairments in restricted repetitive and stereotypical patterns or behavior, interests, and activities.

[Title 388 WAC—p. 1239]

(3) A checklist of diagnostic criteria follows:

DSM-IV-TR Diagnostic Criteria required for Autism	Check if present
1. Qualitative impairment in social interaction	
a. Marked impairment in the use of multiple non-verbal behaviors	
b. Failure to develop peer relationships appropriate to developmental level	
c. A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people	
d. Lack of social or emotional reciprocity	
2. Qualitative impairment in communication	
a. Delay in the development of spoken language without nonverbal compensation	
b. In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others	
c. Stereotyped and repetitive use of language or idiosyncratic use of language	
d. Lack of varied, spontaneous, make-believe play or social imitative play appropriate to developmental level	
3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities	
a. Encompassing preoccupation with stereotyped and restricted patterns of interest that is abnormal in either intensity or focus	
b. Apparently inflexible adherence to specific, nonfunctional routines or rituals	
c. Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)	
d. Persistent occupation with parts of objects	
TOTAL	

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0500, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0510 If I have autism, how do I meet the definition of substantial limitations to adaptive functioning? A substantial limitation of adaptive functioning for the condition of autism is the presence of adaptive functioning impairment as described in WAC 388-823-0515.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0510, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0515 What evidence do I need to substantiate adaptive functioning limitations for the condition of autism? Evidence of the substantial limitations of adaptive functioning for the condition of autism is both (1) and (2) below:

(1) Evidence of delay or abnormal functioning prior to age three years in at least one of the following areas:

- (a) Social interaction;
- (b) Language as used in social interaction;
- (c) Communication; or
- (d) Symbolic or imaginative play.

(2) Eligible scores in adaptive functioning per WAC 388-823-0420 (1)(d) and subject to all of WAC 388-823-0420.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0515, filed 6/1/05, effective 7/2/05.]

[Title 388 WAC—p. 1240]

ANOTHER NEUROLOGICAL CONDITION

WAC 388-823-0600 What evidence do I need to substantiate "another neurological condition" as an eligible condition? Evidence of an eligible condition under "another neurological condition" requires a diagnosis by a licensed physician of an impairment of the central nervous system involving the brain and/or spinal cord that meets all of the following:

- (1) Originated before age eighteen;
- (2) Results in both physical disability and intellectual impairment;
- (3) Is expected to continue indefinitely; and
- (4) Is not attributable to a mental illness or psychiatric disorder.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0600, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0610 If I have another neurological condition, how do I meet the definition of substantial limitations to adaptive functioning? Substantial limitations to adaptive functioning for the condition of another neurological condition require both intellectual impairment and the need for direct physical assistance with activities of daily living per WAC 388-823-0615 (1) and (2) below.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0610, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0615 What evidence do I need to substantiate adaptive functioning limitations for another neurological condition? Evidence of substantial limitations to intellectual functioning for another neurological condition is all of the following:

(1) You must have an FSIQ score of 1.5 or more standard deviations below the mean on one of the following acceptable assessments in addition to the other criteria in this section. The acceptable assessments, the standard deviation and the qualifying scores are contained in the following table:

ASSESSMENT	STANDARD DEVIATION	QUALIFYING SCORE
Stanford-Binet 4th edition	16	76 or less
Stanford-Binet 5th edition	15	78 or less
Wechsler	15	78 or less
Differential Abilities Scale (DAS)	15	78 or less
Kaufman Assessment Battery for Children (K-ABC)	15	78 or less
Leiter-R [for persons with significant hearing impairments or when English is not primary language]	15	78 or less

(2) You must have evidence of need for direct physical assistance on a daily basis with two or more of the following

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activities: Toileting, bathing, eating, dressing, mobility, or communication as a result of your condition as defined in WAC 388-823-0320 and 388-823-0330.

(3) The intellectual impairment and physical assistance needs must be the result of the central nervous system impairment and not due to another condition or diagnosis.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0615, filed 6/1/05, effective 7/2/05.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

"OTHER CONDITION" SIMILAR TO MENTAL RETARDATION

WAC 388-823-0700 How do I meet the definition for an "other condition" similar to mental retardation? You will need evidence in (1) or (2) below to substantiate that you have an "other condition" similar to mental retardation.

(1) You have a diagnosis of a condition or disorder that by definition results in both intellectual and adaptive skills deficits; and

(a) The diagnosis must be made by a licensed physician or licensed psychologist;

(b) The diagnosis must be due to a neurological condition, central nervous system disorder involving the brain or spinal column, or chromosomal disorder;

(c) The diagnosis or condition is not attributable to or is itself a mental illness, or emotional, social or behavior disorder;

(d) The condition must have originated before age eighteen; and

(e) The condition must be expected to continue indefinitely.

(2) You are under the age of eighteen and are eligible for DSHS-paid in-home nursing through the medically intensive program, defined in WAC 388-551-3000.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0700, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0710 What evidence do I need to meet the definition of substantial limitations for an "other condition" similar to mental retardation? (1) Evidence of substantial limitation in both (a) and (b) below is required for an "other condition" similar to mental retardation.

(a) Evidence of intellectual impairment requires documentation of either (i) or (ii) or (iii) below:

(i) An FSIQ of 1.5 or more standard deviations below the mean as described in WAC 388-823-0615(1) for another neurological condition; or

(ii) Significant academic delays resulting in delay of at least twenty-five percent below the chronological age or age equivalent academic functioning in at least two academic areas or grade placement; or

(iii) In the absence of school records to substantiate (ii) above, DDD may review other information about your academic progress sufficient to validate your cognitive deficits.

(b) Unless there is evidence of other conditions or impairments unrelated to the eligible condition currently affecting adaptive functioning, the following evidence will determine if the eligible condition or disorder results in a substantial limitation in adaptive functioning:

(i) A score of more than two standard deviations below the mean on a VABS or SIB-R current within the past three years, or in the absence of a VABS or SIB-R, an ICAP administered by DDD within the past twenty-four months.

(ii) The qualifying scores for these tests are listed in WAC 388-823-0420 (1)(d).

(2) You do not need the additional evidence of your substantial limitations to adaptive functioning in (1)(a) and (b) above if your eligible condition is solely due to your eligibility and participation in the medically intensive program offered through DDD, defined in WAC 388-551-3000.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0710, filed 6/1/05, effective 7/2/05.]

EFFECT OF AGE ON ELIGIBILITY

WAC 388-823-0800 Which eligible developmental disability conditions apply at what age? (1) Children under the age of six must meet the definition of having a developmental disability by meeting the requirements listed in WAC 388-823-0810 through 388-823-0850.

(2) Children at least age six but under the age of ten can meet the definition of developmental disability by:

(a) Meeting the requirements listed in WAC 388-823-0200 through 388-823-0710; or

(b) Meeting the requirements listed in WAC 388-823-0810 through 388-823-0850.

(3) Children age ten and older must meet the requirements in WAC 388-823-0200 through 388-823-0710.

(4) The following chart summarizes the applicable eligibility conditions by age.

Eligible Conditions	Age 0-5	Age 6-9	Age 10-17	Age 18 and older
Developmental Delays	X	X		
Down Syndrome	X	X		
Too severe to be assessed	X	X		
Medically Intensive	X	X	X	
Mental Retardation (MR)		X	X	X
Cerebral Palsy		X	X	X
Epilepsy		X	X	X

Eligible Conditions	Age 0-5	Age 6-9	Age 10-17	Age 18 and older
Autism		X	X	X
Another Neurological		X	X	X
Other condition similar to MR		X	X	X

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0800, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0810 If I am a child under age ten, what evidence do I need to meet the definition for an "other condition" similar to mental retardation? If you are a child under age ten, evidence of one of the following substantiates that you have an eligible "other condition" similar to mental retardation:

(1) Developmental delay measured by developmental assessment tools administered by qualified professionals as described in WAC 388-823-0850.

(2) A diagnosis of Down syndrome by a licensed physician;

(3) A determination of eligibility for the DSHS medically intensive program;

(4) A diagnosis by a licensed physician or licensed psychologist of a condition that is so severe the child is unable to demonstrate the minimal skills required to complete a developmental evaluation or assessment.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0810, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0820 If I am a child under age ten with an eligible condition under the medically intensive program, Down syndrome, or a diagnosed condition that is too severe for developmental testing, how do I meet the definition of substantial limitations to adaptive functioning? You do not need additional evidence of substantial limitations if you are a child under the age of ten with an eligible condition based on the medically intensive program, Down syndrome, or a diagnosed condition that is too severe for developmental testing.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0820, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0830 If I am a child under age ten with an eligible condition based on developmental delays, how do I meet the definition of substantial limitations to adaptive functioning? (1) If you are a child under age ten with an eligible condition based on developmental delays, evidence of substantial handicap requires developmental delays of at least 1.5 standard deviations or twenty-five percent or more of the chronological age in the following developmental areas:

- (a) Physical skills (fine or gross motor);
- (b) Self help/adaptive skills;
- (c) Expressive or receptive communication, including American Sign Language;
- (d) Social/emotional skills; and
- (e) Cognitive, academic, or problem solving skills.

[Title 388 WAC—p. 1242]

(2) The number of areas in which you are required to have delays to meet the evidence is specific to your age.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0830, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0840 If I am a child under age ten, how many areas of developmental delays meet the definition of substantial limitations to adaptive functioning? If you are a child under the age ten, eligible based on developmental delays, the number of delays required for substantial limitations to adaptive functioning is specific to your age.

(1) A child from birth but under age three must have a developmental delay in one or more developmental areas.

(2) A child age three but under age ten must have developmental delays in three or more developmental areas.

AGE	NUMBER OF AREAS OF DELAY
Birth but under age three	One or more
Age three but under age ten	Three or more

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0840, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0850 What developmental evaluations or assessments will be acceptable for determining developmental delay? DDD will accept any standardized developmental evaluation test of procedures to assess developmental delays if:

(1) The results of the evaluation/assessment are reasonably reliable and valid by professional standards.

(a) If you are under age three, there is an evaluation of developmental areas that is current within the past twelve months. Evaluations determine eligibility for services and need to address each of the five developmental areas.

(b) If you are age three or older, there is an assessment of developmental areas. Assessments are more detailed than evaluations and are needed for determining types of services, method, intensity, and funding. Assessments are also the way to document the ongoing status of child's development, progress and recommended steps to meet outcomes.

(2) The evaluation/assessment is administered by one of the following professionals qualified to administer the evaluation or assessment of developmental areas:

- (a) Licensed physician;
- (b) Licensed psychologist or certified school psychologist;
- (c) Speech language pathologist;
- (d) Audiologist;
- (e) Registered occupational therapist;
- (f) Licensed physical therapist;
- (g) Registered nurse;

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- (h) Certified teacher;
- (i) Masters level social worker; or
- (j) Orientation and mobility specialist.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0850, filed 6/1/05, effective 7/2/05.]

INVENTORY FOR CLIENT AND AGENCY PLANNING (ICAP)

WAC 388-823-0900 What are the qualifying scores for inventory of client and agency planning broad independence for each age? When the ICAP is administered to determine eligibility under substantial handicap for a developmental disability, the qualifying score must be at or below the three digit broad independence domain score specific to the age of the applicant at the time of the administration of the ICAP. The score specific to age follows:

AGE	SCORE (at or below)
6	449
7	456
8	463
9	469
10	476
11	482
12	487
13	492
14	497
15	501
16	505
17 and older	509

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0900, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0910 What is the purpose of ICAP?

The purpose of the ICAP is to assess your adaptive skills in the areas of motor skills, personal living skills, social and communication skills, and community living skills.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0910, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0920 What sections of the ICAP does DDD or a designee contracted with DDD complete and score? (1) DDD or a designee contracted with DDD completes the adaptive behavior portion of the ICAP.

(2) There is a computer generated broad independence score of your motor skills, personal living skills, social and communication skills, and community living skills, based on your age.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0920, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0930 How does DDD or a designee contracted with DDD administer the ICAP? (1) DDD or a

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designee contracted with DDD completes the adaptive section of the ICAP by interviewing a qualified respondent who has known you for at least three months and who sees you on a day-to-day basis. You cannot be the respondent for your own ICAP.

(2) DDD or a designee contracted with DDD will choose the respondent and may interview more than one respondent to ensure that information is complete and accurate.

(3) DDD or a designee contracted with DDD will ask you to demonstrate some of the skills in order to evaluate what skills you are able to perform. DDD or a designee contracted with DDD cannot administer the ICAP if no respondent is identified and available.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0930, filed 6/1/05, effective 7/2/05.]

WAC 388-823-0940 What happens if DDD or a designee contracted with DDD cannot identify a qualified respondent? If you and DDD or a designee contracted with DDD cannot identify a qualified respondent for the ICAP, DDD or a designee contracted with DDD will not be able to administer the ICAP or determine you eligible under any conditions that require an ICAP.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-0940, filed 6/1/05, effective 7/2/05.]

ELIGIBILITY EXPIRATION, REVIEWS, AND REAPPLICATION

WAC 388-823-1000 Once I become an eligible DDD client, is there a time limit to my eligibility? While DDD has the authority to review your eligibility at any time, your eligibility as a DDD client will expire or have required reviews as indicated in WAC 388-823-1005 and 388-823-1010.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.-070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1000, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1005 When does my eligibility as a DDD client expire? (1) If you are determined eligible prior to age four, your eligibility expires on your fourth birthday.

(a) DDD will notify you at least ninety days before your eligibility expiration date.

(b) You must reapply for eligibility with DDD.

(2) If you are determined or redetermined eligible at age three but under age ten per WAC 388-823-0810 through 388-823-0850, your eligibility expires on your tenth birthday.

(a) DDD will notify you at least ninety days before your eligibility expiration date.

(b) You must reapply for eligibility with DDD.

(3) If your eligibility determination was prior to July 2005 under developmental delays, Down syndrome, or medically intensive program and you are age four or older as of June 30, 2005, your eligibility expires on your tenth birthday.

(a) DDD will notify you at least ninety days before of your eligibility expiration date.

(b) You must reapply for eligibility with DDD.

(4) If your eligibility determination was made after July 2005 and is solely due to your need for nursing through the medically intensive program, your eligibility expires when you are no longer eligible for the program but no later than your eighteenth birthday.

(a) DDD will notify you at least ninety days before your eighteenth birthday.

(b) You must reapply for eligibility with DDD.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1005, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1010 When will DDD review my eligibility to determine if I continue to have a developmental disability? (1) Your eligibility can be reviewed at any time if your eligibility effective date is prior to July 2005 and you are age ten or older and were eligible under a condition of developmental delay or Down syndrome.

(2) Your eligibility will be reviewed at age seventeen with termination occurring no sooner than your eighteenth birthday if your most current eligibility determination was at sixteen or younger under mental retardation, cerebral palsy, epilepsy, autism, another neurological condition, or other condition similar to mental retardation.

(3) DDD will review your eligibility prior to the initial authorization of any paid service from DDD when you are not currently receiving paid services and:

(a) You are age eighteen or older and your most current eligibility determination is more than twenty-four months old; or

(b) You are age four but under age eighteen and your eligibility was established under the eligible conditions of developmental delay or Down syndrome and your eligibility effective date is prior to July 2005.

(4) DDD will review your eligibility if DDD discovers:

(a) The evidence used to make your most recent eligibility determination completed in 1992 or later appears to be insufficient, in error, or fraudulent; or

(b) New diagnostic information becomes available that does not support your current eligibility and you are under the age of eighteen.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1010, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1015 What is the definition of "DDD paid services" in WAC 388-823-1010(3)? DDD paid services are defined by one or more of the following:

(1) Authorization of a paid service within the last ninety days as evidenced by a social services payment system (SSPS) authorization, a county authorization for day program services, a waiver plan of care approving a DDD paid service, or residence in a SOLA, RHC, or IMR (authorization of a state supplementary payment through SSPS does not meet the definition of a DDD paid service);

(2) Authorization of family support services within the last twelve months.

[Title 388 WAC—p. 1244]

(3) Documentation of DDD approval of your absence from DDD paid services for more than ninety days with available funding for your planned return to services.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1015, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1020 Can DDD terminate my eligibility if I no longer am a resident of the state of Washington? DDD will terminate your eligibility if you lose residency in the state of Washington as defined in WAC 388-823-0050.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1020, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1030 How will I know that my eligibility is expiring or is due for review? If your eligibility has a required expiration or review date, DDD will send you prior written notification with reapplication or review information.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1030, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1040 What happens if I do not reapply for eligibility before my eligibility expiration date? (1) If you fail to reapply before your eligibility expires on your fourth or tenth birthday or if you reapply so near in time to your fourth or tenth birthday that DDD does not have sufficient time to make an eligibility determination by the date of expiration, DDD eligibility will expire and your DDD paid services will stop.

(a) If DDD determines you eligible after your eligibility expires, your eligibility and paid services will be reinstated on the date that DDD determines you eligible pursuant to WAC 388-823-0100.

(b) If DDD determines you eligible after your eligibility expires, your eligibility and paid services will not be retroactive to the expiration date.

(2) This expiration of eligibility takes effect even if DDD is unable to locate you to provide written notification that eligibility is expiring.

(3) There is no appeal right to an expired eligibility determination.

(4) Your appeal rights to the termination of services resulting from a review of your eligibility due to the expiration of your eligibility on your fourth or tenth birthday are in WAC 388-825-120 and 388-825-150(2).

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1040, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1050 What happens if I do not respond to a request for information to review my eligibility? If you do not provide DDD with the information required to review and redetermine your eligibility, DDD will terminate your eligibility and any DDD services you might be receiving.

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[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1050, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1060 How will DDD notify me of its decision? DDD will notify you and your legal representative or one other responsible party in writing of its determination of eligibility, ineligibility, or expiration of eligibility per WAC 388-825-100.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1060, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1070 What are my appeal rights to a department decision that I do not have a developmental disability? Your appeal rights to a department decision that you are not eligible to be a DDD client because you do not have a developmental disability are limited to those described in WAC 388-825-120 through 388-825-165.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1070, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1080 If DDD decides that I do not have a developmental disability, how soon can I reapply for another decision? If DDD decides that you do not have a developmental disability as defined in this chapter, you may reapply only if:

- (1) Your eligibility was terminated because DDD could not locate you and you have subsequently contacted DDD;
- (2) Your eligibility was terminated because you lost residency in the state of Washington and you have reestablished residency;
- (3) You have additional or new information relevant to the determination that DDD did not review for the previous determination of eligibility; or
- (4) DDD denied or terminated your eligibility based solely on your ICAP score and it has been more than twenty-four months since your last ICAP.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1080, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1090 If I am already eligible, how do these new rules affect me? If you are an eligible DDD client on the effective date of these rules, you continue to be an eligible DDD client but you are subject to the expiration and required eligibility reviews per WAC 388-823-1000 through 388-823-1050.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1090, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1095 What are my rights as a DDD client? As a DDD client, you have the following rights:

- (1) The right to be free from any kind of abuse or punishment (verbal, mental, physical, and/or sexual); or being sent to a place by yourself, if you do not choose to be alone;

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(2) The right to appeal any decision by DDD that denies, reduces, or terminates your eligibility, your services or your choice of provider;

(3) The right to receive only those services you agree to;

(4) The right to meet with and talk privately with your friends and family;

(5) The right to personal privacy and confidentiality of your personal and other records;

(6) The right to choose activities, schedules, and health care that meet your needs;

(7) The right to be free from discrimination because of your race, color, creed, national origin, religion, age, disability, marital status, or sexual orientation;

(8) The right to set your own rules in your home and to know what rules your providers have when you are living in their house or working in their facility;

(9) The right to request information regarding services that may be available from DDD;

(10) The right to know what your doctor wants you to do or take and to help plan how that will happen;

(11) The right to be free from unnecessary medication, restraints and restrictions;

(12) The right to vote and help people get elected to office;

(13) The right to complain and not to have someone "get even";

(14) The right to have your provider listen to your concerns including those about the behavior of other people where you live;

(15) The right to receive help from an advocate;

(16) The right to manage your money or choose other persons to assist you;

(17) The right to be part of the community;

(18) The right to make choices about your life;

(19) The right to wear your clothes and hair the way you want;

(20) The right to work and be paid for the work you do; and

(21) The right to decide whether or not to participate in research after the research has been explained to you, and after you or your guardian gives written consent for you to participate in the research;

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1095, filed 6/1/05, effective 7/2/05.]

WAC 388-823-1100 How do I complain to DDD about my services or treatment? If you have a complaint or grievance about your services or treatment, follow these steps in this order:

(1) First, contact your case resource manager or social worker by phone, in writing, e-mail, or in person and explain your problem.

(2) If you are not happy with the results from speaking with your case resource manager or social worker, you may ask to speak with their supervisor.

(3) If steps (1) and (2) do not solve your problem, you submit your complaint in writing to the regional office.

(4) If you do not reach a solution with the regional office, you can request that your complaint be forwarded to the DDD headquarters in Olympia.

[Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW. 05-12-130, § 388-823-1100, filed 6/1/05, effective 7/2/05.]

Chapter 388-824 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES MINI-ASSESSMENT PROCESS

WAC

388-824-0001	What definitions apply to this chapter?
388-824-0010	What is the DDD mini-assessment?
388-824-0015	How do you and/or your respondent(s) obtain information about the mini-assessment?
388-824-0020	What is the purpose of the mini-assessment?
388-824-0025	What domains does the mini-assessment evaluate to identify your relative level of need?
388-824-0030	Does the mini-assessment affect other DDD assessments?
388-824-0040	Who receives a mini-assessment?
388-824-0050	Who does not receive a mini-assessment?
388-824-0055	Who participates in the mini-assessment?
388-824-0060	How does DDD conduct an initial mini-assessment?
388-824-0065	When does DDD conduct a reassessment?
388-824-0070	Does DDD require you to disclose financial information?
388-824-0080	Is the respondent required to provide verification of my family's annual gross income?
388-824-0090	Does reporting your family's annual gross income and number of family dependents affect your eligibility for paid services?
388-824-0100	What does DDD do if the respondent does not provide the requested family income and dependent information?
388-824-0120	What is the difference between a mini-assessment for adults and a mini-assessment for children?
388-824-0140	How does the mini-assessment use information that is scored during the mini-assessment interview?
388-824-0170	What occurs when you are assigned to the "high level of need" group?
388-824-0190	What occurs when you are assigned to the "moderate level of need" group?
388-824-0210	What occurs when you are assigned to the "low level of need" group?
388-824-0220	When will I be reassigned to another level of need group?
388-824-0230	Does the mini-assessment result in paid services?
388-824-0240	How do you know the results of your mini-assessment?
388-824-0260	What is the full assessment referral data base?
388-824-0280	What information does DDD use in deciding whom to refer for a full assessment?
388-824-0290	When does DDD remove my name from the full assessment referral data base?
388-824-0310	When DDD adjusts the mini-assessment algorithm, when does the adjustment become effective?
388-824-0320	Are there appeal rights to the mini-assessment?
388-824-0330	If you request a hearing to review the results of your mini-assessment, which mini-assessment does the administrative law judge review in the hearing?

WAC 388-824-0001 What definitions apply to this chapter? The following definitions apply to this chapter:

"Algorithm" means a numerical formula used by the mini-assessment software application to assign a client to a level of need group.

"CARE" means the comprehensive assessment reporting evaluation as defined in chapter 388-106 WAC.

"Client" means a person with a developmental disability as defined in chapter 388-823 WAC. For purposes of this chapter, the term "client" may include the client's representative.

"Crisis" means a serious and imminent threat exists or will exist without immediate intervention and the client lacks the resources to address the situation. The threat may be:

- (1) To the life, health and/or safety of the client; or
- (2) To the safety of the client's family; or
- (3) To the safety of the community.

"Department" means the Washington state department of social and health services.

"DDD" means the division of developmental disabilities, a division within the aging and disability services administration (ADSA), department of social and health services (DSHS).

"Domain" means a specific area of the client's life. For mini-assessment purposes only, domains are identified in WAC 388-824-0025.

"Full assessment" means an inventory and evaluation of client needs using a department approved tool to determine service eligibility and amount of services that may be authorized.

"Full assessment referral data base" means a report that contains client identification information and mini-assessment results.

"ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded by Title XIX to provide services to individuals diagnosed as having mental retardation or persons with related conditions as defined in chapter 388-825 WAC.

"Information and referral" means a service directing clients to appropriate DSHS and generic community resources based on reported and/or assessed needs. This includes client/family education and problem solving related to reported and/or identified needs. This does not include authorizing a paid service.

"Mini-assessment" means a brief computerized assessment tool using a set of questions and responses scored by an algorithm. A mini-assessment identifies the relative level of need that exists in specific domains of the client's life.

"Paid services" is defined as one or more of the following:

(1) Authorization of a paid service within the last ninety days as evidenced by a social services payment system (SSPS) authorization, a county authorization for day program services, a waiver plan of care approving a DDD paid service, or residence in a SOLA or ICF/MR.

(2) Authorization of family support services within the last twelve months.

(3) Documentation of DDD approval of your absence from DDD paid services for more than ninety days with available funding for your planned return to services.

"Reassessment" means any additional mini-assessment that the client receives after the initial mini-assessment.

"Respondent" means a client's parent(s) or another person who participates in the mini-assessment interview by answering questions and providing information.

"Significant change" means a reported change, for better or worse, in the client's medical condition, caregiver status, or need for support that differs from what was reported in the client's initial mini-assessment.

"SOLA" means a state operated living alternative program for adults that is operated by DDD.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0001, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0010 What is the DDD mini-assessment? (1) The mini-assessment is a brief computerized assessment tool that case managers use to identify the relative level of need that exists in specific domains of your life.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0010, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0015 How do you and/or your respondent(s) obtain information about the mini-assessment? Upon request, your case manager must provide you with a written copy and/or information on how to obtain a copy of the mini-assessment and associated algorithm.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0015, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0020 What is the purpose of the mini-assessment? The purpose of the mini-assessment is to:

- (1) Identify major domains in which needs may exist, as identified in WAC 388-824-0010;
- (2) Identify clients with no current unmet needs;
- (3) Identify clients who are not in crisis and who will receive information and referral services alone;
- (4) Identify clients who need employment or other county services;
- (5) Determine whether a client is in crisis;
- (6) Identify clients who may be eligible for Medicaid personal care;
- (7) Assign clients to one of the following level of need groups for referral to the full assessment referral data base:
 - (a) High level of need;
 - (b) Moderate level of need; or
 - (c) Low level of need; and
- (8) Assist supervisors and case resource managers to make decisions about whom to refer for a full assessment.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0020, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0025 What domains does the mini-assessment evaluate to identify your relative level of need? The mini-assessment evaluates information you report regarding the following specific domains:

- (1) Housing;
- (2) Caregiver/support system;
- (3) Safety;
- (4) Community protection;
- (5) Behavior;
- (6) Financial/subsistence;
- (7) Physical health;
- (8) Mental health;
- (9) Personal care assistance;
- (10) Education;
- (11) Employment;
- (12) Social/community participation;
- (13) Legal;
- (14) Communication;
- (15) Adaptive equipment; and
- (16) Transportation.

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[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0025, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0030 Does the mini-assessment affect other DDD assessments? The mini-assessment does not replace or change other assessments that DDD uses.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0030, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0040 Who receives a mini-assessment? (1) DDD conducts a mini-assessment if you have been determined eligible to be a client of the division of developmental disabilities per WAC 388-823-0020 and meet the requirements of WAC 388-824-0050; or

(2) You are eligible to be a client of DDD per WAC 388-823-0020 and are eligible for the Medicaid categorically needy program (CNP) but you have been determined ineligible for Medicaid personal care by a CARE assessment, or have declined Medicaid personal care services.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0040, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0050 Who does not receive a mini-assessment? DDD does not conduct a mini-assessment in any of these situations:

- (1) Your child is under age of three, since your child:
 - (a) May be eligible for services through the federally funded infant toddler early intervention program; and
 - (b) May be referred for county-funded child development services.
- (2) You are under the age of seventeen years and receiving private duty nursing services as defined by WAC 388-551-3000.
- (3) You have been authorized to receive a state supplementary payment, through SSPS.
- (4) You are currently living in or being discharged from a state-paid residential program or facility.
- (5) You are in crisis and have been referred directly for a full assessment by a supervisor or case resource manager.
- (6) You are receiving paid services as defined in WAC 388-824-0001.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0050, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0055 Who participates in the mini-assessment? You and your respondent(s) participate in the mini-assessment. If you are under age of eighteen or have a legal guardian, the primary respondent(s) will be your parent(s) or legal guardian.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0055, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0060 How does DDD conduct an initial mini-assessment? (1) DDD staff must complete the mini-assessment through a face-to-face interview with you.

(2) The mini-assessment may occur at any site agreed to by you, your respondent(s) and DDD.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0060, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0065 When does DDD conduct a reassessment? A reassessment may occur when:

- (1) A significant change is reported regarding your relative level of need; and
- (2) You and/or your respondent have requested assistance in supporting your reported unmet need to your case resource manager; and
- (3) You meet the criteria defined in WAC 388-824-0040 and 388-824-0050; or
- (4) A supervisor and/or your case resource manager determine that a reassessment is necessary.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0065, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0070 Does DDD require you to disclose financial information? (1) If you are under the age of eighteen and live with your natural, step, or adoptive parent(s), your case resource manager must ask for information regarding:

- (a) Your family's annual gross income; and
 - (b) The number of dependents in your family's household.
- (2) Your case resource manager must ask for this information before completing your mini-assessment.
- (3) If your respondent(s) agree to disclose your family's annual gross income and the number of your family's dependents, your case resource manager must record this information in the CARE tool.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0070, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0080 Is the respondent required to provide verification of my family's annual gross income? Your respondent(s) are not required to provide verification or evidence of your family's annual gross income and/or number of family dependents.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0080, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0090 Does reporting your family's annual gross income and number of family dependents affect your eligibility for paid services? Reporting your family's annual gross income and number of family dependents does not affect your eligibility for paid services except when the legislature establishes, by law, standards for a specific service.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0090, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0100 What does DDD do if the respondent does not provide the requested family income and dependent information? If the respondent does not provide information regarding your family's annual gross income and number of family dependents, the case resource manager must:

- (1) Document that the your respondent(s) have declined to provide information regarding your family's annual gross income information and/or number of family dependents.
- (2) Ask your respondent(s) if they would like information regarding a referral for ICF/MR services per Title 71A RCW, chapter 388-825 WAC and chapter 388-837 WAC.

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- (3) Offer you and/or your respondent(s) an opportunity to complete the mini-assessment.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0100, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0120 What is the difference between a mini-assessment for adults and a mini-assessment for children? The differences between a mini-assessment for adults and children are:

- (1) The requirement to request your family income information and number of family dependents per WAC 388-824-0070; and
- (2) The presentation of different wordings of questions which may activate or inactivate whole questions based on your age.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0120, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0140 How does the mini-assessment use information that is scored during the mini-assessment interview? The mini-assessment uses information reported by you and/or your respondent(s) to evaluate your relative level of need using an algorithm in the software application.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0140, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0170 What occurs when you are assigned to the "high level of need" group? When you are assigned to the "high level of need" group, your case resource manager must do one or more of the following:

- (1) Refer you to the full assessment referral data base for a full assessment.
- (2) Assist you to resolve a crisis, if indicated by the mini-assessment, before initiating a full assessment.
- (3) Offer you necessary information and referral services to address a reported and/or assessed need.
- (4) Provide you and your respondent(s) with information on how to contact your case resource manager should a change in your needs occur.
- (5) Refer you for further case management review if the mini-assessment indicates:
 - (a) You have an unmet need in the community protection domain; or
 - (b) You may be at risk for placement in a more restrictive setting.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0170, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0190 What occurs when you are assigned to the "moderate level of need" group? When you are assigned to the "moderate level of need" group, your case resource manager must do one or more of the following:

- (1) Refer you to the full assessment referral data base for a full assessment.
- (2) Offer you necessary information and referral services to address a reported and/or assessed need.
- (3) Refer you for further case management review if the mini-assessment identifies you to be at risk for placement in a more restrictive residential setting.

(2007 Ed.)

(4) Provide you and your respondent(s) with information on how to contact your case resource manager should a change in your needs occur.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0190, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0210 What occurs when you are assigned to the "low level of need" group? When you are assigned to the "low level of need" group, your case resource manager must do one or more of the following:

(1) Refer you to the full assessment referral data base.
(2) Offer you necessary information and referral services to address a reported and/or assessed need.

(3) Provide you and your respondent(s) with information on how to contact your case resource manager should a change in your needs occur.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0210, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0220 When will I be reassigned to another level of need group? You may be reassigned to another level of need group only if you continue to meet the criteria defined in WAC 388-824-0065 and receive a reassessment that indicates assignment to another level of need group.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0220, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0230 Does the mini-assessment result in paid services? The mini-assessment does not result in you receiving paid services except when the legislature establishes, by law, standards for specific service.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0230, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0240 How do you know the results of your mini-assessment? After the mini-assessment is performed, your case resource manager must discuss the results with you and/or your respondent(s). You and your designated respondent(s) will be notified in writing regarding:

(1) Your assigned level of need group; and
(2) Information on how to contact your case resource manager should a change in your needs occur.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0240, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0260 What is the full assessment referral data base? The full assessment referral data base is a report that assists supervisors and case resource managers to make decisions about whom to refer for a full assessment. It contains the following information:

(1) Your name, date of birth, and phone number.
(2) The date your mini-assessment was performed.
(3) Information about whether the mini-assessment indicated that you may be in crisis.
(4) Information regarding your relative level of need to include:
(a) Your assigned level of need group; and
(b) Your mini-assessment score.

(2007 Ed.)

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0260, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0280 What information does DDD use in deciding whom to refer for a full assessment? DDD refers you from the full assessment referral data base for a full assessment on the basis of:

(1) Your mini-assessment score;
(2) Your identified level of unmet need;
(3) DDD's capacity for completing full assessments; and
(4) Available funding to provide an approved service to meet the identified level of unmet need.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0280, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0290 When does DDD remove my name from the full assessment referral data base? DDD removes your name from the full assessment referral data base after:

(1) You have received a full assessment;
(2) DDD determines that you no longer meet the criteria for a mini-assessment per WAC 388-824-0050; or
(3) DDD determines that you are receiving a paid service and/or no longer eligible to be a client of the division of developmental disabilities per chapter 388-823 WAC.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0290, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0310 When DDD adjusts the mini-assessment algorithm, when does the adjustment become effective? When DDD adjusts the mini-assessment algorithm, the adjustment becomes effective at your initial or next mini-assessment or reassessment following the date of the algorithm adjustment.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0310, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0320 Are there appeal rights to the mini-assessment? (1) You and/or your designated representative(s) have the right to a hearing when:

(a) You disagree with the information entered into the mini-assessment; or
(b) DDD denies you and/or your designated representative's request to have a reassessment performed.
(2) You do not have the right to appeal the mini-assessment algorithm.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0320, filed 11/8/05, effective 12/10/05.]

WAC 388-824-0330 If you request a hearing to review the results of your mini-assessment, which mini-assessment does the administrative law judge review in the hearing? If you request a hearing to review the results of your mini-assessment, the administrative law judge must review your most recent mini-assessment.

[Statutory Authority: RCW 71A.12.030, Title 71A RCW, 2005 c 518. 05-23-030, § 388-824-0330, filed 11/8/05, effective 12/10/05.]

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Chapter 388-825 WAC**DIVISION OF DEVELOPMENTAL DISABILITIES
SERVICES RULES**

(Formerly chapter 275-27 WAC)

WAC

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388-825-544	If I meet eligibility for FSP, will I receive paid services?	388-825-070	What happens if I do not spend the funds paid directly to me for employment/day programs as specified in WAC 388-825-064? [Statutory Authority: RCW 71A.12.030, 71A.10.020, and 2002 c 371. 04-11-087, § 388-825-070, filed 5/18/04, effective 6/18/04; 04-02-014, § 388-825-070, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.
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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER			
388-825-030	Eligibility for services. [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-030, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.10.020, 92-04-004 (Order 3319), § 275-27-026, filed 1/23/92, effective 2/23/92. Statutory Authority: RCW 71.20.070, 89-06-049 (Order 2767), § 275-27-026, filed 2/28/89.] Repealed by 05-12-130, filed 6/1/05, effective 7/2/05. Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW.	388-825-078	How will the warrant/check be sent? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-078, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.
388-825-035	Determination of eligibility. [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-035, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070, 89-06-049 (Order 2767), § 275-27-030, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-030, filed 7/18/84; Order 1143, § 275-27-030, filed 8/11/76.] Repealed by 05-12-130, filed 6/1/05, effective 7/2/05. Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW.	388-825-085	What is a representative payee? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-085, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.
		388-825-086	Who can be a representative payee for my DDD direct payment funds for employment/day program services? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-086, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.
		388-825-087	What are the responsibilities of a representative payee? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-087, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.
388-825-040	Application for services. [99-19-104, recodified as § 388-825-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-040, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-040, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-040, filed 3/16/78; Order 1143, § 275-27-040, filed 8/11/76.] Repealed by 05-12-130, filed 6/1/05, effective 7/2/05. Statutory Authority: RCW 71A.10.020, 71A.12.030, 71A.12.050, 71A.12.070, 71A.16.020, 71A.16.030, 71A.16.040, 71A.16.050, and chapters 71A.10, 71A.12, and 71A.16 RCW.	388-825-090	When will DDD recover direct payment funds sent to me for employment/day program services? [Statutory Authority: RCW 71A.12.030, 71A.10.020, and 2002 c 371. 04-11-087, § 388-825-090, filed 5/18/04, effective 6/18/04; 04-02-014, § 388-825-090, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.
		388-825-095	Who is liable for repayment of an overpayment? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-095, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.
388-825-060	What are the eligibility requirements for persons who receive funds directly for employment/day programs? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-060, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.	388-825-170	Community alternatives program (CAP). [99-19-104, recodified as § 388-825-170, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-800, filed 3/14/84.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
388-825-064	What are the restrictions on the use of the funds paid directly to persons for employment/day programs? [Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-064, filed 12/29/03, effective 1/29/04.] Repealed by 05-11-015, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW.	388-825-180	Eligible persons. [99-19-104, recodified as § 388-825-180, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-810, filed 3/14/84.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
		388-825-190	Community alternatives program (CAP)—Services. [99-19-104, recodified as § 388-825-190, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW

Repealed by 05-17-135, filed 8/19/05, effective 9/19/05.
Statutory Authority: RCW 71A.12.030, 71A.12.120.

- 71A.16.020. 91-17-005 (Order 3230), § 275-27-820, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.020. 84-07-018 (Order 2086), § 275-27-820, filed 3/14/84.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-260 What are qualifications for individual service providers? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-260, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-262 What services do individuals provide for persons with developmental disabilities? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-262, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-264 If I want to provide services to persons with developmental disabilities, what do I do? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-264, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-266 If I want to provide respite care in my home, what is required? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-266, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-268 What is required for agencies wanting to provide care in the home of a person with developmental disabilities? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-268, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-270 Are there exceptions to the licensing requirement? [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-270, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-270, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-272 What are the minimum requirements to become an individual provider? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-272, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-276 What are required skills and abilities for this job? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-276, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-278 Are there any educational requirements for individual providers? [Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-278, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-278, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-280 What are the requirements for an individual supportive living service (also known as a companion home) contract? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-280, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-282 What is "abandonment of a vulnerable adult"? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-282, filed 11/9/99, effective 12/10/99.] Repealed by 05-17-135, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.12.120.
- 388-825-284 Are providers expected to report abuse? [Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, § 388-825-284, filed 11/9/99, effective 12/10/99.]

WAC 388-825-020 Definitions. "Abandonment" means action or inaction by a person or entity with a duty to care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Adolescent" means a DDD eligible child age thirteen through seventeen years.

"Attendant care" means provision of physical and/or behavioral support to protect the safety and well being of a client.

"Best interest" includes, but is not limited to, client-centered benefits to:

- (1) Prevent regression or loss of skills already acquired;
- (2) Achieve or maintain economic self-support;
- (3) Achieve or maintain self-sufficiency;
- (4) Prevent or remedy neglect, abuse, or exploitation of individuals unable to protect their own interest;
- (5) Preserve or reunite families; and
- (6) Provide the least-restrictive setting that will meet the person's medical and personal needs.

"Client or person" means a person the division determines under RCW 71A.16.040 and WAC 388-825-030 eligible for division-funded services.

"Community support services" means one or more of the services listed in RCW 71A.12.040 including, but not limited to the following services: Architectural, case management, early childhood intervention, employment, counseling, family support, respite care, information and referral, health services and equipment, therapy services, and residential support.

"Companion home" means the same as **"intensive individual supported living support."**

"Department" means the department of social and health services of the state of Washington.

"Director" means the director of the division of developmental disabilities.

"Division or DDD" means the division of developmental disabilities of the department of social and health services.

"Emergency" means a sudden, unexpected occurrence demanding immediate action.

"Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

"Family" means individuals, of any age, living together in the same household and related by blood, marriage, adoption or as a result of sharing legal custody of a minor child.

"Family resources coordinator" means the person who is:

- (1) Recognized by the IDEA Part C lead agency; and
- (2) Responsible for:
 - (a) Providing family resources coordination;
 - (b) Coordinating services across agencies; and
 - (c) Serving as a single contact to help families receiving assistance and services for their eligible children who are under three years of age.

"ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded by Title XIX to provide services to the mentally retarded or persons with related conditions.

"ICF/MR eligible" for admission to an ICF/MR means a person is determined by DDD as needing active treatment as defined in CFR 483.440. Active treatment requires:

- (1) Twenty-four hour supervision; and
- (2) Continuous training and physical assistance in order to function on a daily basis due to deficits in the following areas: Toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication.

"Individual" means a person applying for services from the division.

"Individual alternative living" means provision of community-based individualized client training, assistance and/or ongoing support to enable a client to live as independently as possible with minimal services.

"Intelligence quotient score" means a full scale score on the Wechsler, or the intelligence quotient score on the Stanford-Binet or the Leiter International Performance Scale.

"Intensive individual supported living support" (also known as companion home) means provision of twenty-four hour residential support in a nonlicensed home for no more than one adult person with developmental disabilities in a regular family residence approved and contracted by the department ensuring client health, safety and well-being.

"Medicaid personal care" is the provision of medically necessary personal care tasks as defined in chapter 388-15 WAC.

"Nonresidential programs" means programs including, but not limited to, county-funded habilitation services.

"Nursing facility eligible" means a person is assessed by DDD as meeting the requirements for admission to a licensed nursing home as defined in WAC 388-71-0700 (3) through (5). The person must require twenty-four hour care provided by or under the supervision of a licensed nurse.

"Other resources" means resources that may be available to the client, including but not limited to:

- (1) Private insurance;
- (2) Medicaid;
- (3) Indian health care;
- (4) Public school services through the office of the superintendent of public instruction; and
- (5) Services through the department of health.

"Part C" means early intervention for children from birth through thirty-five months of age as defined in the Individuals with Disabilities Education Act (IDEA), Part C and 34 CFR, Part 303 and Washington's federally approved grant.

"Residential habilitation center" or **"RHC"** means a state-operated facility certified to provide ICF/MR and/or nursing facility level of care for persons with developmental disabilities.

"RHC capacity" means the maximum number of eligible persons that can reside in a residential habilitation center without exceeding its 1997 legislated budgeted capacity.

"Residential programs" means provision of support for persons in community living situations. Residential programs include DDD certified community residential services and support, both facility-based such as, licensed group homes, and nonfacility based, i.e., supportive living, intensive tenant support, and state-operated living alternatives (SOLA). Other residential programs include individual alternative living, intensive individual supportive living services,

adult family homes, adult residential care services, nursing homes, and children's foster homes.

"Respite care" means temporary residential services provided to a person and/or the person's family on an emergency or planned basis.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"State supplementary payment (SSP)" is the state paid cash assistance program for certain DDD eligible SSI clients.

"Vacancy" means an opening at a RHC, which when filled, would not require the RHC to exceed its 1997 biannually budgeted capacity, minus:

- (1) Twenty-six beds designated for respite care use; and
- (2) Any downsizing related to negotiations with the Department of Justice regarding community placements.

"Vulnerable adult" means a person who has a developmental disability as defined under RCW 71A.10.020.

[Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-020, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-020, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 99-23-021, amended and recodified as § 388-825-020, filed 11/9/99, effective 12/10/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-020, filed 2/1/99, effective 3/4/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-020, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.14.030 and 71A.16.020. 92-09-115 (Order 3373), § 275-27-020, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-020, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 89-06-049 (Order 2767), § 275-27-020, filed 2/28/89; 84-15-058 (Order 2124), § 275-27-020, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-020, filed 3/16/78; Order 1143, § 275-27-020, filed 8/11/76.]

WAC 388-825-025 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 388-825-020 provided an:

- (a) Assessment of the exemption shall not undermine the legislative intent of Title 71A RCW; and
- (b) Evaluation of the exemption request shows granting the exemption shall not adversely affect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

(3) Exemption requests are not subject to appeal.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-025, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-023, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-023, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-023, filed 8/9/91, effective 9/9/91.]

WAC 388-825-045 Determination for necessary services. (1) Within sixty days from the date of the division's decision that a person is eligible for division funded services, the appropriate division field services office shall evaluate the person's needs to determine which services, if any, are necessary to serve the client's best interest. DDD shall

explain to the person/family their available service options. In addition, DDD shall do what is reasonable to:

(a) Provide choice of service options within available funding that assists people to remain in their homes and communities;

(b) Plan and develop community support services that take into consideration the unique needs of the individual and family.

(2) After the evaluation is completed, and if appropriate, the division will develop an individual service plan pursuant to WAC 388-825-050.

(3) Determination of necessary services is not a guarantee of service authorization or delivery. Service authorization and delivery of services are pursuant to WAC 388-825-055.

(4) The department will develop an outreach program to ensure that eligible persons are aware of all of the services provided by DDD, including community support services and residential habilitation centers.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-045, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-050, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-050, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-050, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-050, filed 3/16/78; Order 1143, § 275-27-050, filed 8/11/76.]

WAC 388-825-050 Individual service plan. (1) The division may develop a written individual service plan (ISP) or other planning documents for each person determined eligible for division and department services within ninety days of the eligibility date. Interim services may be provided if necessary.

(2) An ISP shall be based on an assessment of a person's needs and will specify the services adjudged to be in the best interests of the person and meet the person's habilitation needs. The ISP shall be in the form and manner specified by the director.

(3) A person, the parent if a person is seventeen years of age or younger, or the person's guardian, or an advocate, or the service provider may request review or modification of the service plan at any time based on changed circumstances.

(4) The department's implementation of specific provisions of the plan shall require the development, review, and may require significant modifications of the ISP and shall include, to the maximum extent possible:

(a) Appropriate division staff;

(b) The person;

(c) The person's parent or guardian;

(d) Advocate; and

(e) Representatives of the agency or facility which is, or will be, primarily responsible for the implementation of specific provisions of the plan.

(5) An ISP shall be a planning document, and shall not be an authorization for services. An ISP shall not guarantee the authorization or delivery of services. The authorization of such services is described under WAC 388-825-055.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-050, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-

17-005 (Order 3230), § 275-27-060, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-060, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-060, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-060, filed 3/16/78; Order 1143, § 275-27-060, filed 8/11/76.]

WAC 388-825-055 Authorization of services. (1) The division's field services section shall be responsible for authorizing services agreed to by the person/family including, but not limited to:

(a) Placement to and from residential habilitation centers;

(b) Community residential services;

(c) Family support services;

(d) Nonresidential programs; and

(e) Employment/day programs.

(2) The division's authorization of state-only funded services shall be based on the services and funding available, subject to the following limitations:

(a) Persons must meet the programmatic and financial eligibility requirements for the specific services;

(b) Funding for state-only paid services is available in the state operating budget; and

(c) SSP funding is not available to the client.

(3) The division will include the following persons in the process of determining which services will be authorized:

(a) The person; and

(b) The person's parent or guardian and may include:

(i) The person's advocate; or

(ii) Other responsible parties.

(4) Per RCW 71A.16.010 the division shall offer adults the choice of remaining in the community or admittance to a residential habilitation center if all of the following conditions exist:

(a) An RHC vacancy is available;

(b) Funding, specifically designated for this purpose in the state operating budget, is available for alternative community support services;

(c) The person or their family is requesting residential services;

(d) The person meets ICF/MR or nursing facility eligibility for the available RHC vacancy;

(e) The person is the most in need of residential services as determined by DDD after reviewing all persons determined eligible for ICF/MR or nursing facility level of care. DDD will make this selection based on the following criteria:

(i) The person is age eighteen or older;

(ii) The person's/family's health and safety is in jeopardy due to the lack of necessary residential support and supervision;

(A) Priority is given to eligible persons/families currently without necessary residential supports;

(B) Other eligible persons will be considered based on their risk of losing residential supports due to unstable or deteriorating circumstances.

(f) The person's alternative DDD funded community support services would cost seventy percent or more of the average RHC rate, assuming a minimum household size of three persons.

(5) If RHC capacity is not being used for permanent residents, the division will make these vacancies available for

respite care or any other services the department determines are needed and allowable within the rules governing the use of federal funds. Conditions for making these vacancies available for respite care include:

(a) Written approval of the division director or designee for admission if a child or adolescent to an RHC for respite care; and

(b) Respite care exceeding thirty days in a calendar year is subject to subsection (6) of this section.

(6) The division shall not make an emergency or temporary admission of a person to a residential habilitation center for thirty-one days or more without the written approval of the division director or the director's designee if the admission is not a choice provided under subsection (4) of this section. Additionally, the following conditions apply:

(a) Children twelve years of age and younger shall not be admitted to an RHC; and

(b) Admission of an adolescent to an RHC can only occur if:

(i) DDD determines that foster placement services cannot meet the emergency needs of the child/family; and

(ii) A voluntary placement plan is in place with DDD with the goal of community placement or family reunification; and

(iii) Progress towards placement planning is reported to the division director at least every ninety days.

(7) The division shall authorize county-funded services only when the service is included in a department contract and:

(a) The person is at least twenty-one years of age and is no longer attending school; or

(b) The person is age twenty and graduates prior to his/her July or August twenty-first birthday; or

(c) The child is two years of age or younger and eligible for early intervention services.

(8) The department shall require a person to participate in defraying the cost of services provided when mandated by state or federal regulation or statute.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-825-055, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-055, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-055, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.12A.030 and 71A.16.030. 98-20-044, § 275-27-230, filed 9/30/98, effective 10/7/98. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-230, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-230, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-230, filed 7/18/84. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-27-230, filed 3/1/82. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-230, filed 3/16/78; Order 1143, § 275-27-230, filed 8/11/76.]

WAC 388-825-065 Financial services. The division's field services may include services to protect the financial interests of developmentally disabled individuals.

[99-19-104, recodified as § 388-825-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-240, filed 7/18/84; Order 1143, § 275-27-240, filed 8/11/76.]

(2007 Ed.)

WAC 388-825-080 Guardianship services. If it appears an eligible individual requires a guardian, the division's field services may assure initiation of and/or assist in guardianship proceedings.

[99-19-104, recodified as § 388-825-080, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070. 84-15-058 (Order 2124), § 275-27-250, filed 7/18/84; Order 1143, § 275-27-250, filed 8/11/76.]

WAC 388-825-100 How will I be notified of department decisions? (1) Whenever possible, DDD will notify all parties affected by the decision by phone or in person.

(2) Written notifications will be mailed to you and at least one other person in the following priority:

(a) Your parent if you are under the age of eighteen;

(b) Your guardian or other legal representative;

(c) Other relatives;

(d) An advocacy agency such as Washington Protection and Advocacy System;

(e) A person who is not an employee of the department or to a person who contracts with the department.

(3) If you are an adult and do not have a legal guardian, the department will ask you to identify someone else to receive these notices in addition to yourself.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-100, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-100, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-100, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-400, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-400, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-400, filed 8/29/86; 84-15-058 (Order 2124), § 275-27-400, filed 7/18/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-400, filed 3/16/78; Order 1143, § 275-27-400, filed 8/11/76.]

WAC 388-825-101 Why does the department need to send my notices to someone else? The department sends your notice to someone else, if needed, to have others assist you to understand the information and your appeal rights to department decisions.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-101, filed 7/16/04, effective 8/16/04.]

WAC 388-825-102 What if I do not want my notices sent to anyone else? (1) If you are an adult and do not have a legal guardian, you may request in writing that your notices be given only to you.

(2) The department will review your request and comply with your request unless it determines there to be a risk of your losing rights.

(3) You will be given appeal rights to a denial of this request.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-102, filed 7/16/04, effective 8/16/04.]

WAC 388-825-103 When will I receive written notice of decisions made by DDD? You will receive written notice from DDD of the following decisions:

(1) The denial or termination of eligibility under WAC 388-825-030 and 388-825-035;

(2) The authorization, denial, reduction, or termination of services or the payment of SSP set forth in chapter 388-827 WAC that are authorized by DDD;

(3) The admission or readmission to, or discharge from a residential habilitation center.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-825-103, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-103, filed 7/16/04, effective 8/16/04.]

WAC 388-825-104 What information will the notice include? The notice from DDD will include:

- (1) The decision;
- (2) The reason for the decision;
- (3) The effective date of the action;
- (4) Appeal rights to the decision; and
- (5) The name and phone number of a department person you can contact for further information.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-104, filed 7/16/04, effective 8/16/04.]

WAC 388-825-105 Am I given any advance notice of termination or reduction or eligibility or services? (1) DDD will provide you at least ten-days advance notice, as described in WAC 388-458-0040 (1), (2) and (3), of any action to terminate your eligibility, or terminate or reduce your services.

(2) DDD will provide you at least thirty-days advance notice prior to transferring you from a residential habilitation center to the community under RCW 71A.20.080.

[Statutory Authority: RCW 71A.12.030, 71A.20.080, and Title 71A RCW. 06-10-055, § 388-825-105, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 71A.12.030, 71A.10.020, and 71A.16.040. 04-15-093, § 388-825-105, filed 7/16/04, effective 8/16/04.]

WAC 388-825-120 When can I appeal department decisions through an administrative hearing process? (1) Administrative hearings are governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 71A.10.050, the rules in this chapter and by chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC or WAC 388-440-0001(3), the provision in this chapter shall prevail.

(2) A client, former client, or applicant acting on the applicant's own behalf or through an authorized representative has the right to an administrative hearing.

(3) You have the right to an administrative hearing to dispute the following department actions:

- (a) Authorization, denial, reduction, or termination of services;
- (b) Reduction or termination of a service that was initially approved through an exception to rule;
- (c) Authorization, denial, or termination of eligibility;
- (d) Authorization, denial, reduction, or termination of payment of SSP authorized by DDD set forth in chapter 388-827 WAC;
- (e) Admission or readmission to, or discharge from, a residential habilitation center;
- (f) Refusal to abide by your request not to send notices to any other person;

[Title 388 WAC—p. 1256]

(g) Refusal to comply with your request to consult only with you;

(h) A decision to move you to a different type of residential service;

(i) Denial or termination of the provider of your choice or the denial of payment for any reason listed in WAC 388-825-375 through 388-825-390;

(j) An unreasonable delay to act on an application for eligibility or service;

(k) A claim the client, former client, or applicant owes an overpayment debt.

[Statutory Authority: RCW 71A.12.030. 06-19-037, § 388-825-120, filed 9/13/06, effective 10/14/06. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-120, filed 8/19/05, effective 9/19/05. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-120, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-120, filed 7/25/02, effective 8/25/02; 99-19-104, recodified as § 388-825-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.16.020. 91-17-005 (Order 3230), § 275-27-500, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-27-500, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 71.20.070. 86-18-049 (Order 2418), § 275-27-500, filed 8/29/86. Statutory Authority: RCW 72.33.161. 84-15-038 (Order 2122), § 275-27-500, filed 7/13/84. Statutory Authority: RCW 72.01.090, 72.33.040, 72.33.125 and 72.33.165. 78-04-033 (Order 1280), § 275-27-500, filed 3/16/78; Order 1143, § 275-27-500, filed 8/11/76.]

WAC 388-825-125 How do I request an administrative hearing? (1) Your notice of the department decision will include instructions on how to file an administrative hearing, where to send it, and the length of time you have to file for a hearing.

(2) Your request may be made orally or in writing.

(3) You may request assistance in requesting an administrative hearing by calling DDD staff as stated in WAC 388-825-135.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-125, filed 8/19/05, effective 9/19/05.]

WAC 388-825-130 How long do I have to file a request for an administrative hearing? (1) The following rules apply to all situations except a decision to transfer you from a state residential habilitation center (RHC) to the community under RCW 71A.20.080. The rules for administrative hearings regarding the department's decision to transfer you from an RHC to the community are contained in WAC 388-825-155.

(2) You have to request an administrative hearing within ninety days of receipt of the notification of the decision you are disputing.

(3) You must request an administrative hearing within the ten-day notice period, as described in WAC 388-458-0040 (1), (2) and (3), if you wish to maintain current services during the appeal process.

(4) The notification sent to you will include the date that the ten-day notice period ends.

[Statutory Authority: RCW 71A.12.030, 71A.20.080, and Title 71A RCW. 06-10-055, § 388-825-130, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-130, filed 8/19/05, effective 9/19/05.]

WAC 388-825-135 What if I need help to request an administrative hearing? (1) You may call the department staff person listed in your notification letter and tell them you want to appeal the decision. The department staff person will notify the office of administrative hearings on your behalf.

(2) An oral request for an administrative hearing is complete if it contains enough information to identify the person making the request, the DDD action, and the case involved in the hearing request.

(3) The effective date of an oral request for an administrative hearing is the date that someone makes a complete oral request for hearing to any DDD representative in person or by leaving a message on the automated voice mail system of any DDD field office.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-135, filed 8/19/05, effective 9/19/05.]

WAC 388-825-140 Who else can help me appeal a department decision? Department staff may assist you in requesting an administrative hearing. However, you can authorize anyone except an employee of the department to represent you at an administrative hearing.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-140, filed 8/19/05, effective 9/19/05.]

WAC 388-825-145 Will my benefits continue if I request an administrative hearing? (1) If you request an administrative hearing regarding the department's decision to transfer you from a residential habilitation center to the community under RCW 71A.20.080, the rules in WAC 388-825-155 apply.

(2) If you request an administrative hearing within the ten-day notice period, as described in chapter 388-458 WAC, unless one or more of the conditions in WAC 388-825-150 applies, the department will take no action until there is a final decision on your appeal of the department's decision to:

- (a) Terminate your eligibility;
- (b) Reduce or terminate your services; or
- (c) Reduce or terminate the payment of SSP set forth in chapter 388-827 WAC.

(3) The department will take no action until there is a final decision on your appeal of the department's decision to remove or transfer you to another residential service unless one or more of the conditions in WAC 388-825-150 applies.

(4) The department will take no action to terminate your provider of choice unless one or more of the circumstances described in WAC 388-825-150 applies.

(5) After the administrative hearing, you may have to pay back continued benefits you get, as described in chapter 388-410 WAC, if the administrative hearing decision is in favor of the department.

[Statutory Authority: RCW 71A.12.030, 71A.20.080, and Title 71A RCW. 06-10-055, § 388-825-145, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-145, filed 8/19/05, effective 9/19/05.]

WAC 388-825-150 When can the department proceed to take action during my appeal? The department will proceed to take action during your appeal if:

- (1) It is an eligibility denial and you are not currently an eligible client.

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(2) Your DDD eligibility has expired, per WAC 388-823-0010 and 388-823-1040.

(3) There is no longer funding for state-only funded service.

(4) The state-only funded service no longer exists, the Medicaid state plan has been amended, or the HCBS waiver agreement with the federal Centers for Medicare and Medicaid has been amended.

(5) The administrative law judge or review judge rules that you have caused unreasonable delay in the proceedings.

(6) You are in imminent jeopardy.

(7) Your provider is no longer qualified to provide services due to:

- (a) A lack of a contract;
- (b) Decertification;
- (c) Revocation or suspension of a license; or
- (d) Lack of required registration, certification, or licensure.

(8) The parent of a person under the age of eighteen or the legal guardian approves the department's decision.

(9) You did not file your request for an administrative hearing within the ten-day notice period, as described in chapter 388-458 WAC.

(10) You:

(a) Tell us in writing that you do not want continued benefits;

(b) Withdraw your administrative hearing request in writing; or

(c) Do not follow through with the administrative hearing process.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-150, filed 8/19/05, effective 9/19/05.]

WAC 388-825-155 What are my appeal rights if I am appealing a decision to transfer me from a state residential habilitation center to the community? (1) The procedures in RCW 71A.10.050(2) and 71A.20.080 govern the proceeding.

(2) You have thirty days from date that you receive notice to request an administrative hearing appealing the department's decision to transfer you from a residential habilitation center to the community under RCW 71A.20.080.

(3) The department will take no action to transfer you from a state residential habilitation center to the community under RCW 71A.20.080 during the period that an appeal can be requested or while an appeal is pending and undecided unless you or your legal representative consent, or a court order authorizes the transfer, or an administrative law judge or review judge rules that you are not diligently pursuing your appeal.

(4) The burden of proof is on the department.

(5) The burden of proof is whether the proposed placement is in your best interest.

[Statutory Authority: RCW 71A.12.030, 71A.20.080, and Title 71A RCW. 06-10-055, § 388-825-155, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-155, filed 8/19/05, effective 9/19/05.]

WAC 388-825-160 When will a decision on my appeal be made? The administrative law judge shall issue a

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hearing decision within ninety calendar days of the date the hearing is requested.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 05-17-135, § 388-825-160, filed 8/19/05, effective 9/19/05.]

WAC 388-825-165 Can I appeal the initial order of the administrative law judge? You may file a petition for administrative review, pursuant to chapter 388-02 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 05-17-135, § 388-825-165, filed 8/19/05, effective 9/19/05.]

WAC 388-825-200 What is the purpose of the family support opportunity program? The purpose of the family support opportunity program is to:

- (1) Strengthen family functioning through use of the program elements;
- (2) Provide a wide range of supports that will assist and stabilize families;
- (3) Encourage individuals and local communities to provide support for the persons with developmental disabilities that live with families;
- (4) Complement other public and private resources in providing supports;
- (5) Recognize the ability of communities to participate in a variety of ways;
- (6) Allow families to make use of all program elements according to the individual and family needs; and
- (7) Provide assistance to as many families as possible.

[99-19-104, recodified as § 388-825-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 99-04-071, § 275-27-180, filed 2/1/99, effective 3/4/99.]

WAC 388-825-205 Who is eligible to participate in the family support opportunity program? (1) All individuals living with their families determined to be developmentally disabled according to WAC 388-825-030 and 388-825-035 are eligible to participate in the program if their family requires assistance in meeting their needs. However, the program will fund or provide support services only as funding is available.

(2) Persons currently receiving services under WAC 388-825-252, Family support services, may volunteer to participate in the program.

(3) Families will receive program services based on one or more of the following criteria: The date of application, the date the family was placed on the wait list, eligibility for SSP or other available funding, and/or HCBS waiver status.

(4) Availability of the SSP makes the family ineligible for other state only funding for the same service.

[Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371, 04-02-014, § 388-825-205, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125, 02-16-014, § 388-825-205, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 99-04-071, § 275-27-185, filed 2/1/99, effective 3/4/99.]

WAC 388-825-210 What basic services can my family receive from the family support opportunity program? A number of basic services are available. Some services have their own eligibility requirements. Specific services are:

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(1) **Family support plan:** The family and the case manager will develop a family support plan which includes needs assessment, referral, service coordination, service authorization, case monitoring and coordination for community guide services.

(2) **Community guide services** per WAC 388-825-220 through 388-825-226.

(3) **Short-term intervention services** per WAC 388-825-228 and 388-825-230.

(4) **Emergency services:** Your family can request emergency funds to be used to respond to a single incident, situation or short term crisis such as care giver hospitalization, absence, or incapacity. Your request must be made through your case manager and include an explanation of how you plan to resolve the emergency situation. Your request will be reviewed by DDD.

(a) If approved, you will receive emergency services for a limited time period, not to exceed two months.

(b) If denied, you have no appeal rights.

(5) **Serious need services** per WAC 388-825-232 through 388-825-238.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW, 04-22-068, § 388-825-210, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125, 02-16-014, § 388-825-210, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 99-04-071, § 275-27-190, filed 2/1/99, effective 3/4/99.]

WAC 388-825-220 What is the purpose of community guide services? (1) Community guide services are available to support your family and help you become well connected to resources or supports in your community. After an assessment, your case manager will give you information about a community guide, whose services can be used, if desired by the family.

(2) This guide will assist your family in using the natural and informal community supports relevant to the age of your child with developmental disabilities and your family's specific needs.

[99-19-104, recodified as § 388-825-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 99-04-071, § 275-27-191, filed 2/1/99, effective 3/4/99.]

WAC 388-825-222 Who can become a community guide? To be a guide, a person must demonstrate his/her connections to the informal structures of their community. The department may contract with an individual, agency or organization. Guides must be knowledgeable about resources in their community and comfortable assisting families and persons with developmental disabilities. DDD will provide appropriate training for community guides within available resources.

[99-19-104, recodified as § 388-825-222, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 99-04-071, § 275-27-192, filed 2/1/99, effective 3/4/99.]

WAC 388-825-224 Does my family have a choice in selecting its community guide? Your family will be offered a choice of community guides that best meets the needs of your family. At your family's discretion, your family resources coordinator may serve as your community guide if

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your developmentally disabled child is thirty-five months of age or younger.

[99-19-104, recodified as § 388-825-224, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-193, filed 2/1/99, effective 3/4/99.]

WAC 388-825-226 Can the family support opportunity program help my family obtain financial assistance for community guide services? The program will authorize up to two hundred twelve dollars per year for community guide services for your family.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-226, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-226, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-226, filed 4/5/00, effective 5/6/00. 99-19-104, recodified as § 388-825-226, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-194, filed 2/1/99, effective 3/4/99.]

WAC 388-825-228 How can short-term intervention services through the family support opportunity program help my family? If your family is eligible, you may receive up to one thousand five hundred dollars per year in short-term intervention funding to pay for necessary services not otherwise available.

(1) Short-term intervention funds can be authorized for a one-time only need or for an episodic service need that occurs over a one-year period.

(2) Short-term intervention funding cannot be used for basic subsistence such as food or shelter but is available for those specialized costs directly related to and resulting from your child's disability.

[Statutory Authority: RCW 71A.12.030, 2005 c 518 § 205 (1)(a). 06-11-082, § 388-825-228, filed 5/16/06, effective 6/16/06. Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-228, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-228, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-228, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-228, filed 4/5/00, effective 5/6/00. 99-19-104, recodified as § 388-825-228, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-195, filed 2/1/99, effective 3/4/99.]

WAC 388-825-230 Specifically how can short-term intervention funds be used? Short-term intervention funds can be used to purchase the following services related to and resulting from the client's disability:

(1) Respite care for intermittent relief to the family caregiver and may include community activities providing respite;

(2) Training and supports such as disability related support groups or parenting classes. This does not include registration or costs related to conferences;

(3) The purchase, rental, loan or refurbishment of specialized equipment, adaptive equipment or supplies not covered by other resources, including Medicaid. Specific examples are mobility devices such as walkers and wheelchairs, communication devices and medical supplies. Diapers may be approved only for those three years of age and older.

(4) Environmental modifications including home damage repairs caused by the client and home modifications specific to the client's disability;

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(5) Occupational therapy, physical therapy, communication therapy, behavior management, visual and auditory services, or counseling needed by developmentally disabled individuals and not covered by another resource such as Medicaid, public schools or child development services funding;

(6) Medical/dental services not covered by any other resource. These services may include the payment of insurance premiums and deductibles but are limited to the portion of the premium or deduction that applies to the client.

(7) Nursing services, not covered by another resource, that can only be rendered by a registered or licensed practical nurse. Examples of such services are ventilation, catheterization, and insulin shots. Parents can provide this service without licensure and will not be paid providers of this service for their natural, step or adopted child;

(8) Special formulas or specially prepared foods necessary because of the client's disability and prescribed by a licensed physician;

(9) Parent/family counseling for grief and loss issues, genetic counseling or behavior management. Payments cannot be approved for services occurring after the death of the DDD client;

(10) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(11) Specialized utility costs including extraordinary utility costs resulting from the client's disability or medical condition;

(12) If another resource is not available, transportation costs, including gas, ferry or transit cost, so a client can receive essential services and appointments; per diem costs may be reimbursed for medical appointments.

Funds cannot be used for the purchase or rental of a car or for airfare.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-230, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-196, filed 2/1/99, effective 3/4/99.]

WAC 388-825-232 How can serious need funds help my family? Your family may need extraordinary support that exceeds your annual family support opportunity allotment for the child or adult with developmental disabilities living in your home. The purpose of serious need funds is to help you get that support when you need it.

(1) If funding is available and your request is approved, it may be short or long-term in nature and can be used for services such as respite care, behavior management and licensed nursing care.

(2) If your request is denied, there is no right to appeal since this request exceeds your annual family support opportunity allotment.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-232, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-232, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-197, filed 2/1/99, effective 3/4/99.]

WAC 388-825-234 How can my family qualify for serious need funds? Your family may qualify for serious need funds if all of the following conditions are met:

(1) The basic program services outlined in WAC 388-825-210 (community guide, short-term intervention services, etc.) are currently being used by your family or they have been exhausted;

(2) You and your case manager have examined other resources such as Medicaid personal care, medically intensive services; private insurance, local mental health programs and programs available through the public schools and the department determines that your need exceeds these services; and

(3) The support is crucial for the child or adult with developmental disabilities to continue living in your home.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-234, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-234, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-234, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-198, filed 2/1/99, effective 3/4/99.]

WAC 388-825-236 How does my family request serious need funds? You must contact your case manager to request serious need funds. The request must:

- (1) Indicate the type of services your family needs;
- (2) Explain why those services can only be obtained through the use of serious need funds;
- (3) Outline the changes you anticipate in your family situation if the requested services are not received; and
- (4) Estimate the length of time your family will need the requested services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-236, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-236, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-199, filed 2/1/99, effective 3/4/99.]

WAC 388-825-238 What amount of serious need funding is available to my family? (1) The maximum amount of funding available is four hundred fifty-two dollars per month or two thousand seven hundred twelve dollars in a six-month period, unless the department determines your family member requires licensed nursing care and the funding is used to pay for nursing care. If licensed care is required, the maximum funding level is two thousand four hundred fifty dollars per month.

(2) Funding must be available in order to receive serious need services.

(3) Services paid for by serious needs funds will be reviewed by DDD every six months.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-238, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-238, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-238, filed 11/21/00, effective 12/22/00. 99-19-104, recodified as § 388-825-238, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-200, filed 2/1/99, effective 3/4/99.]

WAC 388-825-240 Who determines what family support services my family can receive? Your family and your case manager determine what services your family needs. The department has final approval over service authorization.

[Title 388 WAC—p. 1260]

[99-19-104, recodified as § 388-825-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-202, filed 2/1/99, effective 3/4/99.]

WAC 388-825-242 What department restrictions apply to family support payments? (1) Family support opportunity services payments are authorized only after you have accessed what is available to you under Medicaid and any other private health insurance plan, including Medicaid personal care, to meet your identified need.

(2) All family support service payments must be authorized by the department.

(3) The department may contract directly with:

- (a) A service provider, or
- (b) A parent for the reimbursement of goods or services purchased by the parent, or
- (c) An agency to purchase goods and services on behalf of a client.

(4) The department's authorization period will start when you agree to be in this program. The period will last one year and may be renewed if you continue to need services.

(5) The department does not pay for treatment determined by DSHS/medical assistance administration (MAA) or private insurance to be experimental.

(6) Respite care cannot be a replacement for child care while the parent or guardian is at work regardless of the age of the client.

(7) The department shall not authorize a birth parent, adoptive parent, stepparent or any other primary caregiver (or their spouse) living in the same household with the client for respite, nursing, therapy, or counseling services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-242, filed 10/29/04, effective 11/29/04. 99-19-104, recodified as § 388-825-242, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-204, filed 2/1/99, effective 3/4/99.]

WAC 388-825-244 What are regional family support advisory councils? (1) Each division of developmental disabilities regional administrator must appoint a family support advisory council which may serve as a subcommittee of the regional advisory council. The membership of the family support advisory council must include at least one parent representative and at least one case manager.

(2) The purpose of these family support advisory councils is to advise the regional administrator regarding:

- (a) Family support issues;
- (b) Guidelines for approving or denying short term intervention requests;
- (c) Community needs; and
- (d) Recommendations for community service grants.

(3) Family support advisory councils must meet at least twice a year.

[99-19-104, recodified as § 388-825-244, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-211, filed 2/1/99, effective 3/4/99.]

WAC 388-825-246 What are community service grants? (1) Community service grants are funded by the division of developmental disabilities family support program to promote community oriented projects that benefit

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families. Community service grants may fund long-term or short-term projects that benefit children and/or adults.

Agencies or individuals may apply for funding. The department will announce the availability of funding.

(2) To qualify for funding, a proposed project must address one or more of the following topics:

- (a) Provider support and development;
- (b) Parent helping parent; or
- (c) Community resource development for inclusion of all.

(3) Goals for community service projects are as follows:

- (a) Enable families to use generic resources;
- (b) Reflect geographic, cultural and other local differences;
- (c) Support families in a variety of noncrisis-oriented ways;
- (d) Prioritize support for unserved families;
- (e) Address the diverse needs of Native Americans, communities of color and limited or non-English speaking groups;
- (f) Be family focused;
- (g) Increase inclusion of persons with developmental disabilities;
- (h) Benefit families who have children or adults eligible for services from DDD; and
- (i) Promote community collaboration, joint funding, planning and decision making.

(4) Decisions to approve or reject community service grant requests are made by DDD regional administrators considering the recommendations of their regional family support advisory councils. The DDD director has the discretion to award community service grants that have statewide significance.

(5) DDD may sponsor two family support conferences in different areas of the state each year. The purpose of these conferences is to discuss areas addressed by community service grants and other issues of importance to families.

[99-19-104, recodified as § 388-825-246, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-212, filed 2/1/99, effective 3/4/99.]

WAC 388-825-248 Who is covered under these rules? These sections (WAC 388-825-200 through 388-825-242) apply to persons enrolled in family support after June 1996. Those enrolled before June 1996 are covered under WAC 388-825-252 through 388-825-256.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-248, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-248, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-248, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030. 99-04-071, § 275-27-213, filed 2/1/99, effective 3/4/99.]

WAC 388-825-250 Continuity of family support services. (1) It is the policy of the department to recognize the dependence of individuals currently receiving family support services at a given level of services, and to avoid disruption of those services at that given level when possible.

(2) In order for the department to maximize the continuity of service while remaining within appropriated funds for family support services, when appropriated funds for family

support services do not permit serving new applicants or increasing services to current recipients without reducing services to existing clients, the department may deny requests for new or increased services based on the lack of funds pursuant to WAC 388-825-055.

(3) These requests may be denied even if the service need levels, as described in WAC 388-825-030, of new applicants or current recipients are of a higher priority than those currently receiving services.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-250, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-250, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.040. 92-13-024 (Order 3394), § 275-27-219, filed 6/9/92, effective 7/10/92.]

WAC 388-825-252 Family support services. (1) The purpose of the family support program is to reduce or eliminate the need for out-of-home residential placement of an individual with developmental disabilities where it is in the best interest of the person to continue living with their family.

(2) The department's family support services include the following and become available only after you have used your full benefits through Medicaid, private insurance, school and child development services:

(a) Respite care is intermittent relief to the family caregiver and may include community activities which provide respite;

(b) Nursing services provided by a registered nurse or licensed practical nurse, that cannot be provided by an unlicensed caregiver, including but not limited to, ventilation, catheterization, insulin injections, etc.;

(c) Therapeutic services including occupational therapy, physical therapy, communication therapy, behavior management, or counseling needed by individuals with developmental disabilities.

(3) Receiving family support services is based on:

(a) Funding for state paid services available in the state operating budget;

(b) SSP funding available to the individual/family.

(4) The following rules, subsections (5) through (9), apply only to family support services authorized by the department and do not govern services purchased by the family with SSP (state supplementary payment) funding (see WAC 388-827-0145 and 388-827-0170).

(5) Up to nine hundred dollars of the service need level amount in WAC 388-825-254 may be used during a one year period for use as follows. The requested service must be necessary as a result of the disability of the individual and after you have used your full benefits through Medicaid, private insurance, school and child development services:

(a) Training and supports including parenting classes and disability related support groups. This does not include registration or costs related to conferences;

(b) Specialized equipment and supplies including the purchase, rental, loan or refurbishment of specialized equipment or adaptive equipment not covered by another resource including Medicaid. Mobility devices such as walkers and wheelchairs are included, as well as communication devices and medical supplies such as diapers for children three years of age and older;

(c) Environmental modification including home repairs for damages or modifications to the home needed because of the disability of the individual;

(d) Medical/dental services not covered by any other resource. This may include the payment of insurance premiums and deductibles and is limited to the premiums and deductibles of the individual;

(e) Special formulas or specially prepared foods as prescribed by a licensed physician and needed because of the disability of the individual;

(f) Parent/family counseling related to the individual's disability, dealing with a diagnosis, grief and loss issues, genetic counseling and behavior management. Payments cannot be approved for services occurring after the death of the eligible individual;

(g) Specialized clothing adapted for a physical disability, excessive wear clothing, or specialized footwear;

(h) Specialized utility costs including extraordinary supplemental utility costs related to the individual's disability or medical condition;

(i) If another resource is not available, transportation costs, including gas, ferry or transit cost, so an individual can receive essential services and appointments; per diem costs may be reimbursed for medical appointments. Funds cannot be used for the purchase or rental of a car or for airfare.

(6) Recommendations will be made to the regional administrator by a review committee. The regional administrator will approve or disapprove the request and will communicate reasons for denial to the committee.

(7) Payment for services specified in subsection (5) shall cover only the portion of cost attributable to the individual.

(8) Requests must be received by DDD no later than midway through the service authorization period unless circumstances exist justifying an emergency.

(9) A plan shall be developed jointly by the family and the department for each service authorization period. The department may choose whether to contract directly with the vendor, to authorize purchase by another agency, or may reimburse the parent of the individual.

(10) Emergency services. Emergency funds may be requested for use in response to a single incident or situation or short term crisis such as care giver hospitalization, absence, or incapacity. The request shall include anticipated resolution of the situation. Funds shall be provided for a limited period not to exceed two months. All requests are to be reviewed and approved or denied by DDD.

(a) If approved, you will receive emergency services for a limited time period, not to exceed two months.

(b) If denied, you have no appeal rights.

(11) If the individual becomes eligible and begins to receive Medicaid personal care services as defined in chapters 388-71 and 388-72A WAC or other DSHS in-home residential support service, the family support funding will be reduced at the beginning of the next month of service. The family will receive notice of the reconfiguration of services at least five working days before the beginning of the month.

(12) Family support services may be authorized below the amount requested by the family for the period. When, during the authorized service period, family support services are reduced or terminated below the amount specified in ser-

vice authorizations, the department shall deem such actions as a reduction or termination of services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-252, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-252, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-825-252, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-825-252, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-220, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-220, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-220, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-220, filed 2/5/88; 86-18-049 (Order 2418), § 275-27-220, filed 8/29/86.]

WAC 388-825-253 Family support service restrictions. (1) Family support services payments are authorized only after you have used what is available to you under Medicaid and any other private health insurance plan.

(2) All family support service payments must be authorized by the department.

(3) The department may contract directly with:

(a) A service provider; or

(b) A parent for the reimbursement of goods purchased by the parent; or

(c) An agency to purchase goods and services on behalf of an individual.

(4) The department's authorization period will start when you agree to be in this program. The period will last one year and may be renewed if you continue to need services.

(5) The department does not pay for treatment determined by DSHS/MAA or private insurance to be experimental.

(6) Respite cannot be a replacement for child care while the parent or guardian is at work regardless of the age of the individual.

(7) The department shall not authorize a birth parent, adoptive parent, stepparent or any other primary caregiver (or their spouse) living in the same household with the individual to provide respite, nursing, therapy, or counseling services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-253, filed 10/29/04, effective 11/29/04.]

WAC 388-825-254 Service need level rates. (1) The department shall base periodic service authorizations on:

(a) Requests for family support services described in WAC 388-825-252 (2) and (5);

(b) Service need levels. The amount of SSP (state supplementary payment) available to an individual will be included when calculating the monthly allocation of state family support dollars.

(c) Availability of family support funding;

(d) Authorization by a review committee, in each regional office, which reviews each request for service;

(e) The amounts designated in subsection (2)(a) through (d) of this section are subject to periodic increase if vendor rate increases are mandated by the legislature.

(2) Service need level lid amounts as follows:

(a) Clients designated for service need level one (WAC 388-825-256) may receive up to fifteen thousand four hundred dollars per year or twenty-nine thousand four hundred dollars per year if the individual requires licensed nursing care in the home:

(i) If an individual is receiving funding through Medicaid personal care or other DSHS in-home residential support, the maximum payable through family support shall be six thousand eight hundred dollars per year;

(ii) If the combined total of family support services at this maximum plus in-home support is less than six thousand eight hundred dollars additional family support can be authorized to bring the total to six thousand eight hundred dollars per year.

(b) Clients designated for service need level two (WAC 388-825-256) may receive up to six thousand dollars per year if not receiving funding through Medicaid personal care:

(i) If an individual is receiving funds through Medicaid personal care or other DSHS in-home residential support service, the maximum receivable through family support shall be three thousand four hundred dollars per year;

(ii) If the combined total of family support services at this maximum plus in-home support is less than six thousand dollars, additional family support can be authorized to bring the total to six thousand dollars per year.

(c) Clients designated for service need level three (WAC 388-825-256) may receive up to three thousand four hundred dollars per year provided the individual is not receiving Medicaid personal care. If the individual is receiving Medicaid personal care or other DSHS in-home residential support service, the maximum receivable through family support shall be one thousand seven hundred dollars per year; and

(d) Clients designated for service level four (WAC 388-825-256) may receive up to one thousand seven hundred dollars per year family support services.

(3) The department shall authorize family support services contingent upon the applicant providing accurate and complete information on disability-related requests.

(4) The department shall ensure service authorizations do not exceed maximum amounts for each service need level based on the availability of funds.

[Statutory Authority: RCW 71A.12.030, 2005 c 518 § 205 (1)(a), 06-11-082, § 388-825-254, filed 5/16/06, effective 6/16/06. Statutory Authority: RCW 71A.12.030, 71A.12.120 [71A.12.120], and chapter 71A.12 RCW. 04-22-068, § 388-825-254, filed 10/29/04, effective 11/29/04. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-825-254, filed 12/29/03, effective 1/29/04. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2001 2nd sp.s. c 7. 02-01-074, § 388-825-254, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 71A.12.030 and 71A.12.040. 00-23-106, § 388-825-254, filed 11/21/00, effective 12/22/00; 00-08-090, § 388-825-254, filed 4/5/00, effective 5/6/00. 99-19-104, recodified as § 388-825-254, filed 9/20/99, effective 10/21/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-222, filed 6/13/97, effective 7/14/97.]

WAC 388-825-256 Service need levels. (1) The department shall use service need levels to determine periodic family support service authorizations.

(2) The department shall determine service need levels in order of priority for funding as follows:

(a) Service need level 1: Client is at immediate risk of out-of-home placement without the provision of family support services. The client needs intensive residential support to

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assist the client's family to care for the family's child or adult requiring nursing services, attendant care, or support due to difficult behaviors. A client shall:

(i) Have received, over the past three months, at least ten days or eighty hours of service; or

(ii) Requires at least ten days or eighty hours per month of service to prevent immediate out-of-home placement, based upon an assessment conducted by the department;

(b) Service need level 2: Client is at high risk of out-of-home placement without the provision of family support services and has one or more of the following documented in writing:

(i) The client:

(A) Currently receives adult protective services or division of children and family services as an active:

(I) Child protective service client;

(II) Child welfare service client; or

(III) Family reconciliation service client.

(B) Has returned home from foster care or group care placement within the last six months;

(C) Has a serious medical problem requiring close and ongoing monitoring and/or specialized treatment, such as:

(I) Apnea monitor;

(II) Tracheotomy;

(III) Heart monitor;

(IV) Ventilator;

(V) Constant monitoring due to continuous seizures;

(VI) Immediate life-saving intervention due to life threatening seizures;

(VII) Short bowel syndrome; or

(VIII) Brittle bone syndrome.

(D) Has a dual diagnosis based on current mental health DSM Axis I diagnosis;

(E) Has an extreme behavioral challenge resulting in health and safety issues for self and/or others which:

(I) Resulted in serious physical injury to self or others within the last year;

(II) For a client who is two years of age or older, requires constant monitoring when awake for personal safety reasons; or

(III) Is of imminent danger to self or others as determined by a psychiatrist, psychologist, or other qualified professional.

(F) Is ten years of age or older or weighs forty pounds or more, requires lifting, and needs direct physical assistance in three or more of the following areas:

(I) Bathing;

(II) Toileting;

(III) Feeding;

(IV) Mobility; or

(V) Dressing.

(ii) The caregiver:

(A) Is a division of developmental disabilities client;

(B) Has a physical or medical problem that interferes with providing care; or

(C) Has serious mental health or substance abuse problems and:

(I) Is receiving counseling for these problems; or

(II) Has received or applied for counseling within the past six months.

(c) Service need level 3: The family is at risk of significant deterioration which could result in an out-of-home placement of the client without provision of family support services due to the following:

(i) The client requires direct physical assistance, above what is typical for such client's age, in three or more of the following areas:

- (A) Bathing;
- (B) Toileting;
- (C) Feeding;
- (D) Mobility; or
- (E) Dressing.

(ii) The client has current behavioral episodes resulting in:

- (A) Physical injury to the client or others;
- (B) Substantial damage to property; and/or
- (C) Chronic sleep pattern disturbances or chronic continuous screaming behavior.

(iii) The client has medical problems requiring substantial extra care; and/or

(iv) The family is:

- (A) Experiencing acute and/or chronic stress;
- (B) Has acute or chronic physical limitations; or
- (C) Has acute or chronic mental or emotional limitations.

(d) Service need level 4: Family needs temporary or ongoing services in order to:

(i) Receive support to relieve and/or prevent stress of caregiver/family; or

(ii) Enhance the current functioning of the family.

(3) The department, through regional review committees, shall determine service need level of the client's service request by reviewing information received from the client, family, and other sources about:

(a) Whether client is an active recipient of services from the division of children and family services or adult protective services;

(b) Whether indicators of risk of out-of-home placement exist, and the imminence of such an event. The department's assessment of such risk may include:

(i) Review of family's requests for placement;

(ii) History of family's involvement with children's protective services or adult protective services;

(iii) Client's current adjustment;

(iv) Parental history of psychiatric hospitalization;

(v) Clinical assessment of family's condition; and

(vi) Statements from other professionals.

(c) Caregiver conditions, such as acute and/or chronic:

(i) Stress;

(ii) Physical limitations; and

(iii) Mental and/or emotional impairments.

(d) Client's need for intense medical, physical, or behavioral support;

(e) Family's ability to use typical community resources;

(f) Availability of private, local, state, or federal resources to help meet the need for family support;

(g) Severity and chronicity of family or client problems; and

(h) Degree to which family support services will:

(i) Ameliorate or alleviate such problems; and

(ii) Reduce the risk of out-of-home placement.

[99-19-104, recodified as § 388-825-256, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.12.030, 71A.12.040 and Title 71A RCW. 97-13-051, § 275-27-223, filed 6/13/97, effective 7/14/97. Statutory Authority: RCW 71A.12.040 and 43.43.745. 94-04-092 (Order 3702), § 275-27-223, filed 2/1/94, effective 3/4/94. Statutory Authority: RCW 71A.12.040. 92-09-114 (Order 3372), § 275-27-223, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 71.20.070. 88-05-004 (Order 2596), § 275-27-223, filed 2/5/88.]

INDIVIDUAL PROVIDER AND AGENCY PROVIDER QUALIFICATIONS

WAC 388-825-300 What is the purpose of WAC 388-825-300 through 388-825-400? A client/legal representative may choose a qualified individual, agency, or licensed provider. The intent of WAC 388-825-300 through 388-825-400 is to describe:

(1) Qualification for individuals and agencies providing DDD services in the client's residence or the provider's residence or other setting; and

(2) Conditions under which the department will pay for the services of an individual provider or a home care agency provider or other provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-300, filed 8/19/05, effective 9/19/05.]

WAC 388-825-305 What service providers are governed by the qualifications in these rules? These rules govern individuals and agencies contracted with to provide:

(1) Respite care services;

(2) Companion home services;

(3) Personal care services through the Medicaid personal care program or DDD HCBS Basic, Basic Plus, or CORE waivers;

(4) Alternative living services; or

(5) Attendant care services.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-305, filed 8/19/05, effective 9/19/05.]

WAC 388-825-310 What are the qualifications for providers? (1) Individuals and agencies providing Medicaid personal care (chapters 388-71 and 388-106 WAC) and DDD HCBS waiver personal care (chapter 388-845 WAC) must meet the qualifications and training requirements in WAC 388-71-0500 through 388-71-05909.

(2) Individuals and agencies providing nonwaiver DDD home and community based services (HCBS) in the client's residence or the provider's residence or other setting must meet the requirements in WAC 388-825-300 through 388-825-400.

(3) Individuals and agencies providing HCBS waiver services must meet the provider qualifications in chapter 388-845 WAC for the specific service.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-310, filed 8/19/05, effective 9/19/05.]

WAC 388-825-315 What is your responsibility when you hire an individual respite care, attendant care or personal care provider? You or your legal representative:

(1) Have the primary responsibility for locating, screening, hiring, supervising, and terminating an individual respite care, attendant care or personal care provider;

(2) Establish an employer/employee relationship with the individual provider; and

(3) May receive assistance from the social worker/case manager or other resources in this process.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-315, filed 8/19/05, effective 9/19/05.]

WAC 388-825-316 How do I choose a companion home or alternative living provider? You can choose a qualified companion home or alternative living provider contracted with DDD or refer your choice of provider to DDD for contracting if your provider does not have a contract with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-316, filed 8/19/05, effective 9/19/05.]

WAC 388-825-320 How does a person become an individual provider, companion home provider or an alternative living provider? In order to become an individual provider, companion home provider or an alternative living provider, a person must:

(1) Be eighteen years of age or older.
(2) Provide the social worker/case manager/designee with:

- (a) Picture identification; and
- (b) A Social Security card.

(3) Complete and submit to the social worker/case manager/designee the department's criminal conviction background inquiry application, unless the provider is also the parent of the adult DDD client and exempted, per chapter 74.15 RCW.

(a) Preliminary results may require a thumbprint for identification purposes.

(b) An FBI fingerprint-based background check is required if the person has lived in the state of Washington less than three years.

(4) Provide references as requested.

(5) Complete orientation, if contracting as an individual provider.

(6) Sign a service provider contract to provide services to a DDD client.

(7) Meet additional requirements in WAC 388-825-355.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-320, filed 8/19/05, effective 9/19/05.]

WAC 388-825-325 What are required skills and abilities for individuals and agencies contracted to provide respite care, companion home services, personal care services through the Medicaid personal care program or the DDD HCBS Basic, Basic Plus or CORE waivers, alternative living services or attendant care services? (1) As a provider of respite care, companion home services, personal care services through the Medicaid personal care program or the DDD HCBS Basic, Basic Plus, or CORE waivers, alternative living services or attendant care services, you must be able to:

(a) Adequately maintain records of services performed and payments received;

(b) Read and understand the person's service plan. Translation services may be used if needed;

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(c) Be kind and caring to the DSHS client for whom services are authorized;

(d) Identify problem situations and take the necessary action;

(e) Respond to emergencies without direct supervision;

(f) Understand the way your employer wants you to do things and carry out instructions;

(g) Work independently;

(h) Be dependable and responsible;

(i) Know when and how to contact the client's representative and the client's case resource manager;

(j) Participate in any quality assurance reviews required by DSHS;

(2) If you are working with an adult client of DSHS as a provider of alternative living, attendant care or companion home services, you must also:

(a) Be knowledgeable about the person's preferences regarding the care provided;

(b) Know the resources in the community the person prefers to use and enable the person to use them;

(c) Know who the person's friends are and enable the person to see those friends; and

(d) Enable the person to keep in touch with his/her family as preferred by the person.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-325, filed 8/19/05, effective 9/19/05.]

WAC 388-825-330 What is required for agencies wanting to provide care in the home of a person with developmental disabilities? (1) Agencies providing personal care services must be licensed as a home care agency or a home health agency through the department of health.

(2) If a residential agency certified per chapter 388-820 WAC wishes to provide Medicaid personal care or respite care in the client's home, the agency must have home care agency certification or a home health license.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-330, filed 8/19/05, effective 9/19/05.]

WAC 388-825-335 Is a background check required of a home care agency provider? In order to be a home care agency provider, a person must complete the department's criminal conviction background inquiry application, which is submitted by the agency to the department. This includes an FBI fingerprint-based background check if the home care agency provider has lived in the state of Washington less than three years.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-335, filed 8/19/05, effective 9/19/05.]

WAC 388-825-340 What is required for a provider to provide respite or residential service in their home? Unless you are related to the client, or the client lives in a companion home, respite or residential services must take place in a home licensed by DSHS. Services are limited to those age-specific services contained in your license.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-340, filed 8/19/05, effective 9/19/05.]

WAC 388-825-345 What "related" providers are exempt from licensing? (1) Relatives of a specified degree are exempt from the licensing requirement and may provide out-of-home respite in their home.

(2) Relatives of specified degree include parents, grandparents, brother, sister, stepparent, stepbrother, stepsister, uncle, aunt, first cousin, niece or nephew.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-345, filed 8/19/05, effective 9/19/05.]

WAC 388-825-355 Are there any educational requirements for individuals providing respite care, attendant care, personal care services, companion home services, or alternative living services? (1) If you are an individual providing personal care services for adults, you must meet the training requirements in WAC 388-71-05665 through 388-71-05909.

(2) If you are an individual contracted to provide companion homes services or alternative living services, you must:

- (a) Have a high school diploma or GED;
- (b) Successfully complete DDD specialty training within the first six months of beginning service; and
- (c) Complete ten hours of continuing education related to the job responsibilities each subsequent calendar year.

(3) If you provide personal care for children, or provide respite care, there is no required training but DDD retains the authority to require training of any provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-355, filed 8/19/05, effective 9/19/05.]

WAC 388-825-360 How does an individual terminate employment as a provider? State law makes it a crime to abandon a vulnerable adult. "Abandon" means leaving a person without the means or ability to obtain any of the basic necessities of life.

(1) If an individual wishes to "quit" or terminate employment as a provider, the individual must give at least two weeks written notice to his/her employer, their representative (if applicable) and the DDD case manager.

(2) The individual will be expected to continue working until the termination date unless otherwise determined by DSHS.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-360, filed 8/19/05, effective 9/19/05.]

WAC 388-825-365 Are providers expected to report abuse, neglect, exploitation or financial exploitation? Providers are expected to report any abuse or suspected abuse immediately to child protective services, adult protective services or local law enforcement and make a follow-up call to the person's case manager.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-365, filed 8/19/05, effective 9/19/05.]

WAC 388-825-370 What are the responsibilities of an individual or home care agency when employed to provide respite care, attendant care, personal care, companion home services or alternative living services to a client? An individual or home care agency employed to provide

respite care, attendant care, personal care, companion home services, or alternative living services must:

(1) Understand the client's individual service plan or plan of care that is signed by the client or legal representative and social worker/case manager, and translated or interpreted, as necessary, for the client and the provider;

(2) Provide the services as outlined on the client's service plan, within the scope of practice in WAC 388-71-0215 and 388-71-0230;

(3) Accommodate client's individual preferences and differences in providing care, within the scope of the service plan;

(4) Contact the client's representative and case manager when there are changes which affect the personal care and other tasks listed on the service plan;

(5) Observe the client for change(s) in health, take appropriate action, and respond to emergencies;

(6) Notify the case manager immediately when the client enters a hospital, or moves to another setting;

(7) Notify the case manager immediately if the client dies;

(8) Notify the department immediately when unable to staff/serve the client; and

(9) Notify the department when the individual or home care agency will no longer provide services. Notification to the client/legal guardian must:

- (a) Give at least two weeks' notice, and
- (b) Be in writing.

(10) Complete and keep accurate time sheets that are accessible to the social worker/case manager; and

(11) Comply with all applicable laws, regulations and contract requirements.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-370, filed 8/19/05, effective 9/19/05.]

WAC 388-825-375 When will the department deny payment for services of an individual or home care agency providing respite care, attendant care, personal care, companion home services or alternative living services? (1) The department will deny payment for the services of an individual or home care agency providing respite care, attendant care, personal care, companion home services or alternative living services who:

(a) Is the client's spouse, per 42 C.F.R. 441.360(g), except in the case of an individual provider for a chore services client. Note: For chore spousal providers, the department pays a rate not to exceed the amount of a one-person standard for a continuing general assistance grant, per WAC 388-478-0030;

(b) Is providing services under this chapter to their natural/step/adoptive minor client aged seventeen or younger;

(c) Has been convicted of a disqualifying crime, under RCW 43.43.830 and 43.43.842 or of a crime relating to drugs as defined in RCW 43.43.830;

(d) Has abused, neglected, abandoned, or exploited a minor or vulnerable adult, as defined in chapter 74.34 RCW;

(e) Has had a license, certification, or a contract for the care of children or vulnerable adults denied, suspended, revoked, or terminated for noncompliance with state and/or federal regulations;

(f) Does not successfully complete the training requirements within the time limits required in WAC 388-71-05665 through 388-71-05909; or

(g) Is terminated by the client (in the case of an individual provider) or by the home care agency (in the case of an agency provider).

(2) The department will deny payment for the services of an individual or a home care agency providing companion home services or alternative living services to their natural/step/adoptive adult child.

(3) The department will deny payment for services of a legal representative appointed by the courts providing companion home services to the client for whom they are the legal representative.

(4) In addition, the department may deny payment to or terminate the contract of an individual provider as provided under WAC 388-825-380, 388-825-381, 388-825-385 and 388-825-390.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-375, filed 8/19/05, effective 9/19/05.]

WAC 388-825-380 When can the department reject the client's choice of an individual respite care, attendant care or personal care provider? The department may reject a client's request to have a family member or other person serve as his or her individual respite care, attendant care or personal care provider if the case manager has a reasonable, good faith belief that the person will be unable to appropriately meet the client's needs. Examples of circumstances indicating an inability to meet the client's needs could include, without limitation:

(1) Evidence of alcohol or drug abuse;

(2) A reported history of domestic violence, no-contact orders, or criminal conduct (whether or not the conduct is disqualifying under RCW 43.43.830 and 43.43.842);

(3) A report from the client's health care provider or other knowledgeable person that the requested provider lacks the ability or willingness to provide adequate care;

(4) Other employment or responsibilities that prevent or interfere with the provision of required services;

(5) Excessive commuting distance that would make it impractical to provide services as they are needed and outlined in the client's service plan.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-380, filed 8/19/05, effective 9/19/05.]

WAC 388-825-381 When can the department reject the client's choice of a companion home services or alternative living services provider? The department can reject the client's choice of a companion home services or alternative living services provider for any reason listed in WAC 388-825-380 or when:

(1) The department has assessed the client to need more than forty hours of alternative living services, thereby requiring services be provided by a DDD certified supportive living agency per chapter 388-820 WAC; and/or

(2) The client's choice of companion home provider is the client's parent or court appointed legal representative unless the provider was contracted and paid to provide companion home services prior to February 2005.

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[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-381, filed 8/19/05, effective 9/19/05.]

WAC 388-825-385 When can the department terminate or summarily suspend an individual respite care, attendant care, personal care, companion home services or alternative living services provider's contract? The department may take action to terminate an individual respite care, attendant care, personal care, companion home services or alternative living services provider's contract if the provider's inadequate performance or inability to deliver quality care is jeopardizing the client's health, safety, or well-being. The department may summarily or immediately suspend the contract pending a hearing based on a reasonable, good faith belief that the client's health, safety, or well-being is in imminent jeopardy. Examples of circumstances indicating jeopardy to the client could include, without limitation:

(1) Domestic violence or abuse, neglect, abandonment, or exploitation of a minor or vulnerable adult;

(2) Using or being under the influence of alcohol or illegal drugs during working hours;

(3) Other behavior directed toward the client or other persons involved in the client's life that places the client at risk of harm;

(4) A report from the client's health care provider that the client's health is negatively affected by inadequate care;

(5) A complaint from the client or client's representative that the client is not receiving adequate care;

(6) The absence of essential interventions identified in the service plan, such as medications or medical supplies; and/or

(7) Failure to respond appropriately to emergencies.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-385, filed 8/19/05, effective 9/19/05.]

WAC 388-825-390 When can the department otherwise terminate an individual's contract to provide respite care, attendant care, personal care, companion home services or alternative living services? The department may otherwise terminate the individual's contract to provide respite care, attendant care, personal care, companion home services or alternative living services for default or convenience in accordance with the terms of the contract and to the extent that those terms are not inconsistent with these rules.

[Statutory Authority: RCW 71A.12.030, 71A.12.120. 05-17-135, § 388-825-390, filed 8/19/05, effective 9/19/05.]

WAC 388-825-395 What are the client's rights if the department denies, terminates, or summarily suspends an individual's contract to provide respite care, attendant care, personal care, companion home services or alternative living services? If the department denies, terminates, or summarily (immediately) suspends the individual's contract to provide respite care, attendant care, personal care, companion home services or alternative living services, the client has the right to:

(1) A fair hearing to appeal the decision, per chapter 388-02 WAC and WAC 388-825-120; and

(2) Receive services from another currently contracted individual or home care agency, or other options the client is eligible for, if a contract is summarily suspended.

[Title 388 WAC—p. 1267]

(3) The hearing rights afforded under this section are those of the client, not the individual provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 05-17-135, § 388-825-395, filed 8/19/05, effective 9/19/05.]

WAC 388-825-396 Does the provider of respite care, attendant care, personal care, companion home services or alternative living services have a right to a fair hearing? (1) The hearing rights afforded under WAC 388-825-395(1) are those of the client.

(2) The provider of respite care, attendant care, personal care, companion home services or alternative living services does not have a right to a fair hearing.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 05-17-135, § 388-825-396, filed 8/19/05, effective 9/19/05.]

WAC 388-825-400 Self-directed care—Who must direct self-directed care? Self-directed care under chapter 74.39 RCW must be directed by an adult client for whom the health-related tasks are provided. The adult client is responsible to train the individual provider in the health-related tasks which the client self-directs.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 05-17-135, § 388-825-400, filed 8/19/05, effective 9/19/05.]

WAC 388-825-500 What is the family support pilot? (1) The Family Support Pilot (FSP) is a new state-only program funded by the legislature to provide services in a new program through June 2007.

(2) The purpose of the family support pilot is to provide paid services in a flexible manner to eligible DDD clients.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e), 06-06-040, § 388-825-500, filed 2/23/06, effective 3/26/06.]

WAC 388-825-505 What is the statutory authority for the family support pilot? The legislature directed DDD to implement the family support pilot in the 2005-2007 conference budget, section 205(1)(e), chapter 518, Laws of 2005.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e), 06-06-040, § 388-825-505, filed 2/23/06, effective 3/26/06.]

WAC 388-825-510 Who is eligible to participate in the family support pilot? To be eligible to participate in the Family Support Pilot (FSP), you must meet all of the following criteria:

- (1) Be a client of DDD.
 - (a) Your eligibility must be current.
 - (b) WAC 388-823-1010 may require a review of your eligibility prior to any approval of paid services.
- (2) Be in DDD's current database as having requested FSP.
- (3) Live with family as defined in WAC 388-825-512.
- (4) Not be receiving any other DDD paid services as defined in WAC 388-825-516.
- (5) Have been determined ineligible for Medicaid Personal Care (MPC).
- (6) Have a gross household annual income of less than or equal to 400% of federal poverty level (FPL).

[Title 388 WAC—p. 1268]

(7) Have completed a mini-assessment per chapter 388-824 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e), 06-06-040, § 388-825-510, filed 2/23/06, effective 3/26/06.]

WAC 388-825-512 What is the definition of family? Family means relatives who live in the same home with the eligible client. Relatives include parents, grandparents, brother, sister, stepparent, stepbrother, stepsister, uncle, aunt, first cousin, niece or nephew.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e), 06-06-040, § 388-825-512, filed 2/23/06, effective 3/26/06.]

WAC 388-825-513 What is the definition of an "award"? (1) An award is the dollar amount of services performed by a provider for an eligible client.

(2) The award will be paid directly to the provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e), 06-06-040, § 388-825-513, filed 2/23/06, effective 3/26/06.]

WAC 388-825-514 If I participate in the FSP, will I be eligible for services through the DDD home and community based services (HCBS) waiver? You may request to be served in the DDD HCBS waiver per WAC 388-845-0050 but waiver enrollment is limited by waiver capacity and funding. Participation in the FSP will not affect your potential waiver eligibility.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e), 06-06-040, § 388-825-514, filed 2/23/06, effective 3/26/06.]

WAC 388-825-516 If I receive other DDD funded services do I qualify for the FSP? You do not qualify for the FSP if any of the following apply:

- (1) You receive other DDD funded services identified in WAC 388-823-1015, including services through the DDD HCBS waiver per WAC 388-845-0050;
- (2) You are eligible for Medicaid personal care;
- (3) You receive the state supplementary payment administered by DDD; or
- (4) You are under age three. (All children under age three receive or are eligible to receive services through the infant toddler early intervention program and/or child development services through DDD.)

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e), 06-06-040, § 388-825-516, filed 2/23/06, effective 3/26/06.]

WAC 388-825-520 If I qualify for and receive an FSP award, will my name remain on the family support waitlist? Participation in the FSP does not remove your name from the family support waitlist.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e), 06-06-040, § 388-825-520, filed 2/23/06, effective 3/26/06.]

WAC 388-825-524 How do I apply for the FSP? You may apply for the FSP by completing and returning an FSP

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questionnaire that DDD will send to individuals and families who are on the family support waitlist as of August 1, 2005.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-524, filed 2/23/06, effective 3/26/06.]

WAC 388-825-528 What will DDD do with the FSP questionnaire that you return? When you return the FSP questionnaire, DDD will determine your eligibility according to the criteria contained in WAC 388-825-510 and notify you of its decision according to WAC 388-825-588.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-528, filed 2/23/06, effective 3/26/06.]

WAC 388-825-532 How does DDD determine the federal poverty level (FPL) for my household? DDD determines the federal poverty level (FPL) for your household by asking you for your gross annual household income and the number of people living in your household.

(1) DDD cannot determine your financial eligibility for FSP without this information.

(2) If you do not provide this information, you will not be eligible for FSP services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-532, filed 2/23/06, effective 3/26/06.]

WAC 388-825-534 What are the annual federal poverty levels? (1) The annual federal poverty levels (FPL) are based on household size and established by the federal Office of Management and Budget.

(2) Effective April 2005, the annual federal poverty levels are:

Household Size	100% FPL	200% FPL	300% FPL	400% FPL
One	\$9,570	\$19,140	\$28,710	\$38,280
Two	\$12,830	\$25,660	\$38,490	\$51,320
Three	\$16,090	\$32,180	\$48,270	\$64,360
Four	\$19,350	\$38,700	\$58,050	\$77,400
Five	\$22,610	\$45,220	\$67,830	\$90,440
Six	\$25,870	\$51,740	\$77,610	\$103,480
Seven	\$29,130	\$58,260	\$87,390	\$116,520
Eight	\$32,390	\$64,780	\$97,170	\$129,560
Nine	\$35,650	\$71,300	\$106,950	\$142,600
Ten	\$38,910	\$77,820	\$116,730	\$155,640

For each household member over ten, add the following amounts to the ten-person standard:

100% FPL	200% FPL	300% FPL	400% FPL
\$3,260	\$6,520	\$9,780	\$13,040

(3) Effective April 2006, the annual federal poverty levels are:

Household Size	100% FPL	200% FPL	300% FPL	400% FPL
One	\$9,800	\$19,600	\$29,400	\$39,200
Two	\$13,200	\$26,400	\$39,600	\$52,800
Three	\$16,600	\$33,200	\$49,800	\$66,400
Four	\$20,000	\$40,000	\$60,000	\$80,000

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Household Size	100% FPL	200% FPL	300% FPL	400% FPL
Five	\$23,400	\$46,800	\$70,200	\$93,600
Six	\$26,800	\$53,600	\$80,400	\$107,200
Seven	\$30,200	\$60,400	\$90,600	\$120,800
Eight	\$33,600	\$67,200	\$100,800	\$134,400
Nine	\$37,000	\$74,000	\$111,000	\$148,000
Ten	\$40,400	\$80,800	\$121,200	\$161,600

For each household member over ten, add the following amounts to the ten-person standard:

100% FPL	200% FPL	300% FPL	400% FPL
\$3,400	\$6,800	\$10,200	\$13,600

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-534, filed 2/23/06, effective 3/26/06.]

WAC 388-825-536 What is "gross annual household income"? Gross annual household income means total unearned and earned income prior to any deductions or taxes for the past calendar year.

(1) Ownership of income is defined in WAC 388-450-0005.

(2) Income that is not counted is defined in WAC 388-450-0015.

(3) Unearned income is defined in WAC 388-450-0025.

(4) Earned income is defined in WAC 388-450-0030.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-536, filed 2/23/06, effective 3/26/06.]

WAC 388-825-538 What is the definition of household? For the purpose of determining household size and gross annual household income, the definition of household follows:

(1) If you are under age eighteen, your household includes:

(a) You;

(b) Your natural or adoptive parent(s) or stepparent(s) living with you;

(c) Your full, half, step, or adoptive siblings living with you if they are:

(i) Not married;

(ii) Not the head of a household; and

(iii) Under age eighteen, or under age twenty-two if they are students regularly attending school or college or training that is designed to prepare the siblings for a paying job.

(2) If you are age eighteen or older, your household includes only you.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-538, filed 2/23/06, effective 3/26/06.]

WAC 388-825-540 Who must declare their income? If you are a child under age of eighteen at the time you are declaring income, your custodial, natural/step/adoptive parent(s) or guardian(s) must declare income.

(2) If you are age eighteen or older, you are the only household member to declare income. You must report all unearned and earned income.

(3) Income is subject to verification upon department request.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-540, filed 2/23/06, effective 3/26/06.]

WAC 388-825-544 If I meet eligibility for FSP, will I receive paid services? You will have access to an amount of paid services called an "FSP Award" if:

- (1) You are determined eligible by DDD to participate in FSP;
- (2) You meet one of the priority groups in WAC 388-825-554; and
- (3) There is funding available.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-544, filed 2/23/06, effective 3/26/06.]

WAC 388-825-548 What is the amount of the FSP awards? FSP Awards are based on your gross household income and the annual Federal Poverty Level (FPL) based on your household size and income.

Amount of Annual Income	Amount of Award
Equal to or less than 100% FPL	Up to \$4,000 per year
Greater than 100% but equal to or less than 200% FPL	Up to \$3,000 per year
Greater than 200% but equal to or less than 300% FPL	Up to \$2,000 per year
Greater than 300% but equal to or less than 400% FPL	Up to \$1,000 per year

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-548, filed 2/23/06, effective 3/26/06.]

WAC 388-825-552 What if there are two or more family members who qualify for FSP? Each family member who is eligible will be considered for an award.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-552, filed 2/23/06, effective 3/26/06.]

WAC 388-825-554 How will DDD determine who will receive awards for FSP? Within the availability of staff time, DDD will distribute the awards to eligible FSP clients in order of the following priorities:

- (1) Client or caregiver with health and safety needs that places the client at immediate risk of out-of-home placement in a nursing facility or ICF/MR.
- (2) Clients living in single parent households;
- (3) Clients with multiple disabilities; and
- (4) Clients who are at least twenty-one years old and graduated from high school who need employment services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-554, filed 2/23/06, effective 3/26/06.]

WAC 388-825-558 What FSP services can my family and I receive? You and your family can use your FSP award to pay for any of the following services identified and agreed to in your FSP service plan with DDD:

[Title 388 WAC—p. 1270]

(1) Respite care which is intermittent relief to your caregiver.

(a) Respite care may be provided in your home or the home of a relative or licensed provider, or community setting/activity contracted for respite care.

(b) The respite provider must be a qualified individual or agency per WAC 388-825-300 through 388-825-400.

(c) Respite care may be provided by a registered or licensed nurse if you require a licensed health professional as determined by DDD.

(2) Training and consultation for you or your family, including:

(a) Counseling related to your disability or genetic counseling.

(b) Parenting classes and disability related support groups.

(c) Behavior management/counseling.

(3) Assistive technologies or specialized or adaptive equipment related to your development disability:

(a) Mobility devices such as walkers and wheelchairs are included, as well as communication devices and medical supplies such as diapers for children three years of age or older.

(b) Professional justifications may be required by the department.

(4) Employment services for those clients twenty-one years of age and older. See chapter 388-850 WAC.

(5) Extraordinary household expenses resulting from the client's developmental disability such as a portion of the power bill for a ventilator dependent client.

(a) The expense is limited to the total cost divided by the total number of persons living in the family.

(b) This will not include the purchase of any appliances, furniture, or floor coverings.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-558, filed 2/23/06, effective 3/26/06.]

WAC 388-825-560 What department restrictions apply to FSP? The following department restrictions apply to FSP:

(1) FSP services are authorized only after you have accessed what is available to you under Medicaid, and any other private health insurance plan, school or child development services.

(2) All FSP service payments must be agreed to by DDD and the client in a written service plan.

(3) The department will contract directly with a service provider, or a parent for the reimbursement of goods or services purchased by the parent. FSP funding cannot be authorized for services or treatments determined by the department to be experimental.

(4) Your choice of qualified providers and services is limited to the most cost effective option that meets your assessed need.

(5) Respite care cannot be a replacement for child care while the parent or guardian is at work regardless of the age of the child.

(6) The department shall not authorize a birth parent, adoptive parent, stepparent or any other primary caregiver or their spouse living in the same household with the client to provide respite, nursing, therapy or counseling services.

(2007 Ed.)

(7) FSP will not pay for conference registrations.

(8) FSP will not pay for behavior management/counseling procedures, modifications, or equipment that are restrictive.

(9) FSP will not pay for services provided after the death of the eligible client. Payment may occur after the date of death, but not the service.

(10) FSP will not pay for employment services if you are under age twenty-one or are designated to receive DDD funded transition services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, 2005 c 518 § 205 (1)(e), Title 71A RCW. 06-19-036, § 388-825-560, filed 9/13/06, effective 10/14/06; 06-06-040, § 388-825-560, filed 2/23/06, effective 3/26/06.]

WAC 388-825-562 What is an FSP plan? (1) An FSP plan is a written plan you develop with your DDD case resource manager that identifies the services you will purchase with your FSP award.

(2) The FSP plan will last for up to twelve months, but cannot extend beyond June 30, 2007.

(3) The department has the final approval over service authorization.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-562, filed 2/23/06, effective 3/26/06.]

WAC 388-825-564 Does my family have a choice of FSP services? The individual and family identify and choose FSP services per WAC 388-825-558 through the department's assessment and planning process. Adult clients are included in the choice of FSP services.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-564, filed 2/23/06, effective 3/26/06.]

WAC 388-825-572 What if I have needs that exceed my FSP award limit? If you have needs that exceed your FSP award limit, DDD may approve additional funding to meet certain extraordinary needs as "one-time award." This approval is an exception to your award limit and you cannot appeal the amount of the exception or denial of an exception.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-572, filed 2/23/06, effective 3/26/06.]

WAC 388-825-575 What are one-time awards? A one-time award is limited to extraordinary support for individuals receiving FSP funding.

(1) The one-time award can only be approved for the following services performed by a DDD contracted provider:

- (a) Respite care; and/or
- (b) Behavior management/counseling.

(2) A one-time award may be approved only once during the period of time covered by your FSP plan.

(3) Providers of the services in subsection (1) of this section must be contracted with and paid directly by DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-575, filed 2/23/06, effective 3/26/06.]

(2007 Ed.)

WAC 388-825-576 How do I apply for a one-time award? You may apply for a one-time award by following the procedures contained in WAC 388-825-236.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-576, filed 2/23/06, effective 3/26/06.]

WAC 388-825-578 What amount of one-time funding is available for my family? The maximum amount of one-time funding available for respite care and/or behavior management/counseling is the same as the amount of your award, determined by WAC 388-825-548.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-578, filed 2/23/06, effective 3/26/06.]

WAC 388-825-581 How long do I remain eligible for the FSP? (1) If you are approved for an FSP award, your FSP plan will be reviewed annually for continued funding as long as FSP funding is available.

(2) The family support pilot ends June 30, 2007.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-581, filed 2/23/06, effective 3/26/06.]

WAC 388-825-584 Can I be terminated from FSP? You will be terminated from FSP if any of the following occur:

(1) Your DDD eligibility is terminated per chapter 388-823 WAC;

(2) You no longer live with a family as defined in WAC 388-825-512;

(3) You begin living independently or with a spouse;

(4) You begin to receive other DDD funded services;

(5) Your household income exceeds 400% of the FPL;

(6) You become eligible for Medicaid personal care; and/or

(7) FSP funding is no longer available.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-584, filed 2/23/06, effective 3/26/06.]

WAC 388-825-586 When are changes in my circumstances considered effective? (1) Except for changes in income and/or household size, changes are effective immediately.

(2) Changes in gross annual household income and changes in household size are effective at the time your FSP plan is reviewed.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-586, filed 2/23/06, effective 3/26/06.]

WAC 388-825-588 How will the department notify me of their decisions? The department will provide written notification to you and your legal representative of all eligibility and service decisions per WAC 388-825-100 through 388-825-105. These notices will include your appeal rights.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-588, filed 2/23/06, effective 3/26/06.]

WAC 388-825-591 What are my appeal rights under the FSP? You have appeal rights under WAC 388-825-120 to the following decisions:

- (1) Denial of eligibility to participate in the FSP per WAC 388-825-510.
- (2) A denial, reduction or termination of FSP services.
- (3) A denial or termination of your choice of a qualified provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-591, filed 2/23/06, effective 3/26/06.]

WAC 388-825-595 How do I appeal a department action? Your appeal rights and procedures to appeal a department decision are in WAC 388-825-120 through 388-825-165.

[Statutory Authority: RCW 71A.12.030, 71A.12.040, Title 71A RCW and 2005 c 518 § 205 (1)(e). 06-06-040, § 388-825-595, filed 2/23/06, effective 3/26/06.]

Chapter 388-826 WAC

VOLUNTARY PLACEMENT PROGRAM

WAC

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388-826-0250	Does DDD make exceptions to the requirements in this chapter?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-826-0100	What happens if the voluntary placement ends? [Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0100, filed 10/31/02, effective 12/1/02.] Decodified by 06-01-107, filed 12/21/05, effective 12/21/05. Recodified as WAC 388-826-0200.
388-826-0105	When the child leaves the voluntary placement program for any reason, what DDD services are available to the child and family when voluntary placement ends? [Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0105, filed 10/31/02, effective 12/1/02.] Decodified by 06-01-107, filed 12/21/05, effective 12/21/05. Recodified as WAC 388-826-0210.
388-826-0110	Will a child or youth continue to receive special education or early intervention services while in VPP? [Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0110, filed 10/31/02, effective 12/1/02.] Decodified by 06-01-107, filed 12/21/05, effective 12/21/05. Recodified as WAC 388-826-0220.
388-826-0115	What happens after a youth turns eighteen? [Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0115, filed 10/31/02, effective 12/1/02.] Decodified by 06-01-107, filed 12/21/05, effective 12/21/05. Recodified as WAC 388-826-0230.
388-826-0120	What happens if a parent disagrees with a decision made by DDD? [Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0120, filed 10/31/02, effective 12/1/02.] Decodified by 06-01-107, filed 12/21/05, effective 12/21/05. Recodified as WAC 388-826-0240.
388-826-0125	Does DDD make exceptions to the requirements in this chapter? [Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0125, filed 10/31/02, effective 12/1/02.] Decodified by 06-01-107, filed 12/21/05, effective 12/21/05. Recodified as WAC 388-826-0250.

WAC 388-826-0001 What is the purpose of the voluntary placement program? The purpose of the voluntary placement program is to:

(1) Support the optimal growth and development of the child or youth in out-of-home placement. The sole reason for the out-of-home placement is the child's developmental disability. Services are offered by DSHS/DDD through a voluntary placement agreement. Parents retain custody of their child or youth.

(2) Support the child and family with a shared parenting arrangement through the use of licensed foster care providers.

(3) Complement other public and private resources in providing supports to the child and family.

(4) Encourage the relationship between the child and parents, even when the child or youth is not living in their own home.

(5) These rules are adopted under the authority of RCW 74.13.350.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0001, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0005 Definitions. "Best interest" includes, but is not limited to:

- (1) Prevent regression or loss of skills already acquired;
- (2) Achieve or maintain self-sufficiency;

(3) Provide the least restrictive setting that will meet the child's/youth's medical, social, developmental and personal needs;

(4) Benefits the medical, personal, social and developmental needs of the child/youth;

(5) Maintains family relationships.

"Child or youth" means an individual who is eligible for division services per RCW 71A.16.040 and chapter 388-825 WAC, is less than eighteen years of age and who is in the custody of a parent by blood, adoption or legal guardianship.

"Client or person" means an individual is eligible for division services per RCW 71A.16.040 and WAC 388-825-030.

"Community support services" means one or more of the services listed in RCW 71A.12.040 including, but not limited to the following services: Architectural, social work, early childhood intervention, employment, family counseling, respite care, information and referral, health services, legal services, therapy services, residential services and support, transportation services, and vocational services.

"Department" means the department of social and health services of the state of Washington.

"Director" means the director of the division of developmental disabilities.

"DDD" means the division of developmental disabilities of the department of social and health services.

"Emergency" means a sudden, unexpected occurrence demanding immediate action.

"Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

"Family" means individuals of any age, living together in the same household related by blood, marriage, adoption or as a result of sharing legal custody of a minor child.

"Foster care provider" means the individual person licensed by the DSHS, children's administration, division of licensed resources (DLR) (chapter 388-148 WAC) to provide foster care in the person's home; or a group care agency licensed by DLR to provide foster care for an individual in a group facility or staffed residential setting.

"In the voluntary placement program the legal status of the child" means that the child is in legal custody of the biological or adoptive parent(s) or legal and custodial guardian.

"The judicial determination and review" means a process that occurs in court and its purpose is to affirm that out-of-home placement is in the best interest of the child. The parent is notified of the court date and may appear in court with the child's DDD social worker.

"Out-of-home placement" means a DLR licensed home, a licensed group care facility or another licensed setting.

"Parent" means the individual who is the biological or adoptive person or legal custodial guardian who has legal responsibility for and physical custody of the child.

"Shared parenting" means biological or adoptive parents or legal guardians and foster care providers share responsibilities. Responsibilities are for the physical and emotional care, education and medical well-being of child/youth who meets DDD eligibility criteria and who is in a voluntary out of home placement as is described in the shared parenting agreement.

(2007 Ed.)

"Shared parenting plan" means a written plan among the parent, a foster care provider and DDD, with the expectation of sharing responsibilities for care of a child/youth, including exchanging information on a routine basis about medical, education, daily routines and special situations in the life of the child/youth.

"Voluntary out-of-home placement" for a child who is eligible for DDD services means:

(1) When a parent and the division of developmental disabilities (DDD) agree that it is in the best interest of the child to reside out of the home of the parents;

(2) The placement is solely due to the child's disability;

(3) There are no unresolved issues of abuse and neglect;

(4) When the parent or custodial and legal guardian and division sign a voluntary placement agreement; and

(5) When a child lives more than fifty percent of her/his life in a licensed setting that is other than in the parents' home. The setting may be a licensed foster family home, group care facility, or staffed residential home as licensed under chapter 74.15 RCW.

"Voluntary placement agreement," as used in this section, means a written agreement between the department and a child's parent or legal guardian authorizing the department to place the child in a licensed facility.

"Written request for out-of-home placement" means a written request signed by the custodial parent requesting out-of-home placement for the child or youth under eighteen years of age.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0005, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0010 Who is eligible for the voluntary placement program? Children who:

(1) Are determined eligible for DDD services under RCW 71A.16.040;

(2) Are under eighteen years of age when the request for services through VPP is made;

(3) Have no unresolved issues of abuse or neglect pending with DSHS children's administration;

(4) Are in the legal and physical custody of their parent or legal guardian; and

(5) The request is made solely due to the child's disability RCW 74.13.350 and parents have used all other appropriate services for their child through DDD.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0010, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0015 Who else may be eligible to participate in the voluntary placement program? Within available resources:

(1) Children or youth who are eligible for DDD services per RCW 71A.16.040, may transfer from children's administration, as long as they are under eighteen years of age, in a stable guardianship, and have no unresolved issues of abuse or neglect pending with children's administration.

(2) Youth who turn eighteen while in the VPP and reside in a DLR licensed setting, may continue to participate in VPP until age twenty-one as long as her/his placement remains in tact and does not disrupt and she/he remains in school until graduation or reaches age twenty-one, whichever comes first (see WAC 388-826-0115).

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0015, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0020 How does the family, whose child is a client of DDD request access to the VPP? Parents must make a written request for voluntary out-of-home placement services (DSHS 10-277) for their child to their DDD case resource manager. The request is considered when the following criteria are met:

- (1) The child is under eighteen years of age;
- (2) The placement is due solely to the child's disability;
- (3) The family is currently using some DDD services or is on the list for services;
- (4) There are available funds for the VPP;
- (5) There are no issues of abuse and neglect; and
- (6) The custodial parent and the division of developmental disabilities (DDD) agree that it is in the best interest of the child to reside outside of the parent's home.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0020, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0025 What is the process for a child or youth who transfers from children's administration to get into the VPP? (1) At the regional level, a staffing occurs. It involves DDD and DCFS social workers and supervisors, and any other agency representatives who have knowledge of the child or youth's issues.

(2) At the staffing the participants discuss the criteria outlined in WAC 388-826-0010 and 388-826-0015.

(3) Within available resources and when appropriate criteria are met, social workers determine the appropriateness of the transfer of the child's case from one administration to the other.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0025, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0030 How is a decision made for out-of-home placement? A parent makes a written request for out-of-home placement, to her/his child's case manager. Prior to a decision for out-of-home placement, a staffing is held. The purpose of the staffing is to determine whether all other available and appropriate services have been used or could be used by the family. The parents, the DDD case manager, the DDD social worker, and/or resource developer and where appropriate, DCFS social worker may participate in staffings.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0030, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0035 How is a decision made regarding participation in the voluntary placement program?

(1) A decision regarding participation in VPP is based on the premise that all available DDD services to the child and family have been used and that out-of-home placement is in the best interest of the child and that the placement is due solely to the child's disability;

(2) There are funds available in VPP;

(3) Through a staffing, the family's DDD case resource manager, VPP supervisor and VPP social worker, and any other person who can provide useful information, discuss the services used, and share information and resources regarding the needs of the family and child;

[Title 388 WAC—p. 1274]

(4) DDD and the parents must be in agreement about the need for out-of-home placement and that the request fits the criteria for the program. When both parties are in agreement, a written voluntary placement agreement is signed by the parent and DDD representative:

(a) If there are no funds available, parents may sign a request for out-of-home placement (DSHS 10-277);

(b) When it is determined that the request is appropriate, the child or youth is eligible for out-of-home placement, there are available funds and there is a placement, the agreement is signed and the child's file is transferred to a DDD social worker in the voluntary placement program;

(c) If there are funds available, the consideration for out-of-home placement continues. The name of the child/youth is placed on the VPP data base for consideration of placement outside the home.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0035, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0040 What is a voluntary placement agreement? It is a mutually voluntary and written document between the parent and the department. It must be signed by the child's parent and the DSHS/DDD representative to be in effect. An agreement regarding a Native American child is not valid unless executed in writing before the court and filed with the court as provided in RCW 13.34.130. Any party to the voluntary placement agreement may terminate the agreement at any time. When one party ends the agreement, per the VPA, the voluntary agreement is ended.

The agreement authorizes DSHS/DDD to facilitate a placement for the child who is under eighteen years of age in a licensed facility. Under the term of the agreement, the parent retains legal custody. DSHS/DDD is responsible for the child's placement and care. The agreement shall at a minimum specify the legal status of the child and the rights and obligations of the parent or legal guardian, the child, and the department while the child is in placement.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0040, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0045 What happens after a voluntary placement agreement is signed, what are the legal issues and who is responsible? When the DDD social worker facilitates the placement of a child in a licensed out-of-home care arrangement, under a DDD voluntary placement agreement, the department has the responsibility for the child's placement and care. The department shall:

(1) In conjunction with the parents, develop an individual services plan for the child no later than sixty days from the date that the department assumes responsibility for the child's placement and care;

(2) Develop a shared parenting plan with foster care providers and parents;

(3) Obtain a judicial determination, within one hundred eighty days of placement, in accordance with RCW 13.34.030 and 13.34.270 that the placement is in the best interest of the child;

(4) Attend the permanency planning hearing reviews where a review of the child's out-of-home placement determines if it continues to be in the best interest of the child to continue the out-of-home placement;

(2007 Ed.)

(5) Make a face-to-face visit with the child and visit with the child in their licensed placement, every ninety days;

(6) Facilitate a judicial review at one hundred eighty days and annually thereafter, unless the child's placement ends before one hundred eighty days have elapsed;

(7) Provide for periodic administrative reviews of the child's case, unless a judicial review occurs every one hundred eighty days after initial placement.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0045, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0050 Is there an ongoing court process when the child is in out-of-home placement and how does the process work? The ongoing court process involves the following activities:

(1) When a child is placed in a licensed out-of-home setting, within one hundred eighty days, the DDD social worker must file an order with the court that says the custodial and legal parent has signed a voluntary placement agreement with DDD and voluntarily requests placement of their child in out-of-home care;

(2) The child's DDD social worker prepares the necessary papers and files them with the court clerk; and

(3) Once a year, the DDD social worker prepares a report that must be presented to the court. It is called an order for continued placement and it describes in the words of the social worker, why the out-of-home placement continues to be in the best interest of the child.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0050, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0055 What basic services may a child receive from the voluntary placement program? (1) Shared parenting between foster care providers and parents on daily routines;

(2) Medical coverage, under a medical coupon issued from the foster care medical unit (FCMU);

(3) Coordination with special education services in the local school district when the child meets eligibility criteria;

(4) Supervised special activities in the community when appropriate;

(5) Safe, developmentally appropriate care;

(6) Supervision by a DDD social worker who has responsibility for visiting the child/youth at a minimum, every ninety days;

(7) An individual services plan for the child within sixty days from the date that DSHS/DDD assumes responsibility for the child's placement and care;

(8) DDD social worker prepares documents for court, and pursuant to RCW 13.34.030 and 13.34.270 shares the documents at the court hearings in order to determine that the placement is in the best interest of the child;

(9) Social work services such as needs assessment, referral, service coordination and case monitoring;

(10) Early intervention services: DDD ensures coordination of services for children from birth through thirty-five months of age with early intervention and special education; and

(11) Medically intensive services under WAC 388-531-3000.

(2007 Ed.)

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0055, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0060 Are there other services a child may receive in this program? In-home supports may be available to support a child in the parent's home. Approval of in-home support services is based on available funds. The criteria to receive in-home supports when there are available funds are:

(1) Children whose current out of home placement disrupts and who are awaiting new out-of-home placements;

(2) Children whose names are on the data base and whose parents have signed a "request for out-of-home placement."

Service need level for in-home services are evaluated every six months and reviewed every ninety days thereafter. Any reduction in service or denial of services allows the child's family the right to appeal the decision under chapter 388-825 WAC.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0060, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0065 What can parents expect if they use in-home supports under this program? Within available funds, the child may sometimes receive supports. Supports may be in the form of respite services, specialized behavioral support, and other services that are needed to support the child's continued living arrangement in the parent's home. A person meeting provider qualifications may provide the supports to the child in the home, through a contract with DDD.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0065, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0070 What is the responsibility of the department for the child who is in out-of-home care? When DDD facilitates an out-of-home placement, DDD is responsible for:

(1) A voluntary placement agreement according to this section;

(2) Monitoring of the child's placement and care;

(3) A permanency plan of care for the child;

(4) A plan that monitors the health, safety and appropriateness of the child's placement at a minimum every ninety days, making face-to-face visits at that time;

(5) The DDD social worker maintains any records as required by court oversight; and

(6) DDD social worker facilitates a needs assessment, individual service plan and a shared parenting plan.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0070, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0075 What are the responsibilities of the parents when their child receives services in the voluntary placement program? Parents retain custody of their child at all times when the child is receiving services in the voluntary placement program. Parents responsibilities include, but are not limited to, the following:

(1) The right to make all major nonemergency decision about medical care, enlistment in military service, marriage

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and other important legal decisions for the person under eighteen years of age;

(2) Maintain ongoing and regular contact with the child;

(3) Agree to work cooperatively with their child's DDD social worker and other DSHS staff and persons caring for their child;

(4) Participate in decision making for their child;

(5) Cooperate with DDD in selecting a representative payee for the child's Social Security benefits, received from the Social Security Administration, and which are used for basic maintenance while the child is in out-of-home care;

(6) Agree that if their child's out-of-home placement disrupts, their child will return to the parents physical care until a new placement is developed. The parent's signature on the voluntary placement agreement confirms their understanding of the responsibilities listed in the VPA.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0075, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0080 What are the expectations for parents when their child is in out-of-home care? Parents are expected to be active in the "shared parenting" plan and continue to be involved in their child's life. The plan is a written agreement between the licensed foster parents or provider caring for the child and the child's parents. It includes:

(1) Responsibilities of legal and foster parents or provider;

(2) Plan for respite;

(3) Emergency procedures;

(4) Planned activities;

(5) Expectations and special considerations; and

(6) Involvement on a regular basis by the parent.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0080, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0085 What other DDD services are available for a child through the voluntary placement program? (1) When a parent signs a voluntary placement agreement and the child is placed in the VPP outside the parental home, the child will no longer be eligible for services from the family support opportunity program, or the Medicaid personal care program.

(2) Children living with their parents may receive personal care services provided under chapter 388-71 WAC.

(3) If the child is covered under the DDD core waiver as described in chapter 388-845 WAC, the child will receive the services identified on the plan of care.

[Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0085, filed 1/31/06, effective 3/2/06. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0085, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0090 What does a parent do with the child's Social Security benefits when the parent's child lives outside the parent's home? (1) When a parent signs a DDD VPA, the DDD social worker shares with the parent a list of representative payee agencies. From the list, parents must select a representative payee for their child's SSI benefits.

(2) Each month, the child's SSI check will be sent to the representative payee. The portion of the check designated for

"room and board," the amount that is allowed for basic maintenance while in foster care and when parents are not caring for their child in their own home, is sent to the licensed foster care provider for reimbursement for basic maintenance.

(3) The representative payee sets aside an amount from the child's SSI warrants designated as "client personal incidentals or CPI" and it is entered into a trust account for the child or youth. It is made available for items that are of a direct benefit to the child. The representative payee monitors the account held in trust for the child and notifies the DDD social worker when the account is within three hundred dollars of the maximum reserve exemption allowance.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0090, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0095 Who pays for a child's care when a child is in out-of-home placement? State funds, federal funds and the child's SSI, that is used for basic maintenance support the cost of the child's care while the child is in licensed out-of-home placement. The parent is encouraged to continue to support their child with typical activities, e.g., presents, clothing, special items, special outings. Licensed providers who care for the child in a licensed setting will be paid directly through a contract with DDD and according to an established rate structure, established within DDD.

[Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0095, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0130 How is the foster care rate determined in VPP? (1) The basic foster care room and board rate is published by children's administration each year. See WAC 388-25-0120.

(2) The foster care assessment is completed annually by DDD to determine the amount of any specialized rate that will be paid to the foster parent in addition to the basic rate.

(3) The department administers the assessment with the foster parent. Based on information given by the foster parent and information gathered by the department, the standardized assessment will determine a score and assign a level.

(4) Algorithms determine the score corresponding to the care needs for each child. Each level is assigned a rate. The rate will be paid to the foster parent caring for the child.

[Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0130, filed 1/31/06, effective 3/3/06.]

WAC 388-826-0140 What areas are covered in the foster care assessment? (1) Areas covered in the foster care assessment include:

(a) Behaviors;

(b) Physical needs; and

(c) Therapeutic assistance and other activities requiring the assistance of the foster parent.

(2) These activities are beyond those needed by a typically developing child.

[Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0140, filed 1/31/06, effective 3/2/06.]

WAC 388-826-0150 What happens if the level assigned to the child changes? The care needs of all children in foster care will be reassessed annually or more often if a major life change occurs.

(1) A "major life change" is an unexpected, documented change in a child's medical or psychological condition that affects the level of care required.

(2) If the assessed level changes and results in a rate change, the foster parent will receive at least thirty days written notice of the rate change. The notice will include the date that the rate change takes effect.

[Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0150, filed 1/31/06, effective 3/2/06.]

WAC 388-826-0160 What limitations exist on administrative hearings regarding foster care payments in VPP? The foster care provider and the parents are not entitled to request an administrative hearing to dispute the established foster care rates.

[Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0160, filed 1/31/06, effective 3/2/06.]

WAC 388-826-0170 How are rates for licensed staffed residential homes determined in VPP? Rates for licensed staffed residential homes are determined by the department after review of the needs of the child, the proposal from the licensed staffed residential agency and the proposed staffing schedule.

[Statutory Authority: RCW 71A.12.030, 74.13.350, and Title 71A RCW. 06-04-088, § 388-826-0170, filed 1/31/06, effective 3/2/06.]

WAC 388-826-0200 What happens if the voluntary placement ends? The child must be returned to the physical care of the child's legal parent unless the child has been taken into custody pursuant to RCW 13.34.050 or 26.44.050, placed in shelter care pursuant to RCW 13.34.060, or placed in foster care pursuant to RCW 13.34.130. The agreement as described in RCW 74.13.350, between DDD and legal parents is completely voluntary. Per RCW 74.13.350, any party may terminate the agreement at any time.

[06-01-107, recodified as § 388-826-0200, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0100, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0210 When the child leaves the voluntary placement program for any reason, what DDD services are available to the child and family when voluntary placement ends? Depending on availability of funds, the child and family may be eligible for other DDD programs and that would support the child.

[06-01-107, recodified as § 388-826-0210, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0105, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0220 Will a child or youth continue to receive special education or early intervention services while in VPP? (1) Early intervention services are available to a child, birth through thirty-five months when in VPP and when that child meets the early intervention eligibility criteria.

(2) When a child or youth meets eligibility criteria for special education programs, ages three to twenty-one years, the child or youth continues to receive special education services through their local public school district.

(3) Office of superintendent of public instruction is responsible for the special education program for the eligible children, ages three to twenty-one years, RCW 28A.155.220 allows that children and youth who meet eligibility criteria may remain in special education until graduation, if that occurs during the school year.

[06-01-107, recodified as § 388-826-0220, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0110, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0230 What happens after a youth turns eighteen? When a youth turns eighteen, and is considered an adult, while in the voluntary placement program, the youth may remain in the child foster home, in VPP, under the following circumstances:

(1) Youth remains in the education or vocational program in the local public school district in which he/she has been enrolled until graduation or age twenty-one, whichever is earlier, per WAC 392-172-030(2), RCW 74.13.031 (10) and (13), 28A.155.020, and 28A.155.030;

(2) The placement remains intact and does not disrupt;

(3) When needed, youth who turns eighteen can self-administer medication;

(4) Youth cannot remain in foster care, living in a child foster home, and in VPP, after eighteen years of age when:

(a) The child foster home placement disrupts;

(b) The youth leaves education or vocational program; or

(c) The youth who turns eighteen needs someone to administer medication.

Dependency guardianships end at age eighteen. If a youth has been in a legal guardianship, under chapter 11.88 RCW and if the reason for guardianship was the minority of the child the guardianship ends.

[06-01-107, recodified as § 388-826-0230, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0115, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0240 What happens if a parent disagrees with a decision made by DDD? If a parent disagrees with a decision made by DDD staff, the parent has the right to pursue the appeal process, as outlined in RCW 71A.10.050 and chapter 388-02 WAC.

[06-01-107, recodified as § 388-826-0240, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0120, filed 10/31/02, effective 12/1/02.]

WAC 388-826-0250 Does DDD make exceptions to the requirements in this chapter? DDD may grant exceptions to the requirements specified in this chapter as long as the DDD director approves the request in writing within sixty days.

[06-01-107, recodified as § 388-826-0250, filed 12/21/05, effective 12/21/05. Statutory Authority: RCW 74.13.350. 02-22-057, § 388-826-0125, filed 10/31/02, effective 12/1/02.]

Chapter 388-827 WAC**STATE SUPPLEMENTARY PAYMENT PROGRAM****WAC**

388-827-0100	What is the state supplementary payment (SSP) that is administered by the division of developmental disabilities (DDD)?
388-827-0105	What are the eligibility requirements for the DDD/SSP program?
388-827-0110	What are the financial eligibility requirements to receive DDD/SSP?
388-827-0115	What are the programmatic eligibility requirements for DDD/SSP?
388-827-0120	How often will my eligibility for DDD/SSP be redetermined?
388-827-0125	How will I know if I am eligible to receive a DDD/SSP payment?
388-827-0130	Can I choose not to accept DDD/SSP payments?
388-827-0131	What happens if I no longer meet the financial or programmatic requirements after my funding has been converted to the DDD/SSP program?
388-827-0135	Can I apply for the DDD/SSP program if I am not identified by DDD as eligible for the DDD/SSP program?
388-827-0140	What are my appeal rights if DDD determines that I am not eligible for DDD/SSP?
388-827-0145	How much money will I receive?
388-827-0146	May I voluntarily remove myself from the home and community based services (HCBS) waiver administered by DDD in order to increase the amount of my SSP?
388-827-0150	How often will I receive my DDD/SSP warrant/check?
388-827-0155	Who will the warrant/check be sent to?
388-827-0160	How will the warrant/check be sent?
388-827-0170	Are there rules restricting how I use my DDD/SSP money?
388-827-0175	What changes must I report to the department?
388-827-0180	Do I have additional responsibilities when I purchase my own services?
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388-827-0200	What is a representative payee?
388-827-0210	Who can be a representative payee for my DDD/SSP?
388-827-0215	What are the responsibilities of a representative payee?
388-827-0300	Does DSHS make exceptions to the requirements in this chapter?
388-827-0400	What is an SSP overpayment?
388-827-0410	When can an overpayment occur?
388-827-0420	Who is liable for repayment of an overpayment?

WAC 388-827-0100 What is the state supplementary payment (SSP) that is administered by the division of developmental disabilities (DDD)? The state supplementary payment (SSP) is a state-paid cash assistance program for certain clients of the division of developmental disabilities.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0100, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0105 What are the eligibility requirements for the DDD/SSP program? To be eligible to receive DDD/SSP, you must be determined DDD eligible under RCW 71A.10.020 and meet all of the financial and programmatic criteria for DDD/SSP.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0105, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0110 What are the financial eligibility requirements to receive DDD/SSP? (1) You must be eligible for or receive supplemental security income (SSI) cash assistance in the month in which the DDD/SSP is issued; or

(2) You receive Social Security Title II benefits as a disabled adult child and you would be eligible for SSI if you did not receive these benefits.

[Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0110, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0110, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0115 What are the programmatic eligibility requirements for DDD/SSP? (1) You received one or more of the following services from DDD with state-only funding between March 1, 2001 and June 30, 2003 and continue to demonstrate a need for and meet the DDD program eligibility requirements for these services. Additionally, you must have been eligible for or received SSI prior to July 1, 2006; or you received Social Security Title II benefits as a disabled adult child prior to July 1, 2006 and would have been eligible for SSI if you did not receive these benefits.

(a) Certain voluntary placement program services, which include:

- (i) Foster care basic maintenance,
- (ii) Foster care specialized support,
- (iii) Agency specialized support,
- (iv) Staffed residential home,
- (v) Out-of-home respite care,
- (vi) Agency in-home specialized support,
- (vii) Group care basic maintenance,
- (viii) Group care specialized support,
- (ix) Transportation,
- (x) Agency attendant care,
- (xi) Child care,
- (xii) Professional services,
- (xiii) Nursing services,
- (xiv) Interpreter services,
- (b) Family support;
- (c) One or more of the following residential services:
- (i) Adult family home,
- (ii) Adult residential care facility,
- (iii) Alternative living,
- (iv) Group home,
- (v) Supported living,
- (vi) Agency attendant care,
- (vii) Supported living or other residential service allowance,

(viii) Intensive individual supported living support (companion homes).

(2) For individuals with community protection issues as defined in WAC 388-820-020, the department will determine eligibility for SSP on a case-by-case basis.

(3) For new authorizations of family support opportunity:

(a) You were on the family support opportunity waiting list prior to January 1, 2003; and

(b) You are on the home and community based services (HCBS) waiver administered by DDD; and

(c) You continue to meet the eligibility requirements for the family support opportunity program contained in WAC 388-825-200 through 388-825-242; and

(d) You must have been eligible for or received SSI prior to July 1, 2003; or you received Social Security Title II benefits as a disabled adult child prior to July 1, 2003 and would

have been eligible for SSI if you did not receive these benefits.

(4) For individuals on one of the HCBS waivers administered by DDD (Basic, Basic Plus, Core or community protection):

(a) You must have been eligible for or received SSI prior to April 1, 2004; and

(b) You were determined eligible for SSP prior to April 1, 2004.

(5) You received Medicaid personal care (MPC) between September 2003 and August 2004; and

(a) You are under age eighteen at the time of your initial comprehensive assessment and reporting evaluation (CARE) assessment;

(b) You received or were eligible to receive SSI at the time of your initial CARE assessment;

(c) You are not on a home and community based services waiver administered by DDD; and

(d) You live with your family, as defined in WAC 388-825-020.

(6) If you meet all of the requirements listed in (5) above, your SSP will continue.

(7) You received one or more of the following state-only funded residential services between July 1, 2003 and June 30, 2006 and continue to demonstrate a need for and meet the DDD program eligibility requirements for these services:

(a) Adult residential care facility;

(b) Alternative living;

(c) Group home;

(d) Supported living;

(e) Agency attendant care;

(f) Supported living or other residential allowance.

[Statutory Authority: RCW 71A.12.030, 74.04.057 and 20 C.F.R. 416.2099, 06-24-074, § 388-827-0115, filed 12/4/06, effective 1/4/07. Statutory Authority: RCW 71A.12.030, 71A.12.120, and chapter 71A.12 RCW. 05-10-039, § 388-827-0115, filed 4/28/05, effective 5/29/05. Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0115, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0115, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0120 How often will my eligibility for DDD/SSP be redetermined? Redetermination of eligibility for the DDD/SSP program will be conducted at least every twelve months, or more frequently if deemed necessary by DDD.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0120, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0125 How will I know if I am eligible to receive a DDD/SSP payment? You will receive a written notification from DDD if you have been identified as eligible for this program.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0125, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0130 Can I choose not to accept DDD/SSP payments? If your service funding has been converted to the DDD/SSP program, DDD/SSP payments are the only way you can receive that funding.

(1) If you choose not to receive DDD/SSP payments, you will not receive department funding for that service.

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(2) Your home and community based services (HCBS) waiver service(s) administered by DDD but not funded by DDD/SSP payments will not be affected by your choice to receive or reject DDD/SSP payments.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0130, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0131 What happens if I no longer meet the financial or programmatic requirements after my funding has been converted to the DDD/SSP program? If you no longer meet the eligibility requirements in WAC 388-827-0105, 388-827-0110, or 388-827-0115, you may continue to receive services only if an exception to the rules is approved in accordance with WAC 388-827-0300.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0131, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0135 Can I apply for the DDD/SSP program if I am not identified by DDD as eligible for the DDD/SSP program? You can apply through your case resource manager to determine eligibility for SSP but eligibility is limited to those meeting the eligibility requirements in WAC 388-827-0105, 388-827-0110, and 388-827-0115.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0135, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0140 What are my appeal rights if DDD determines that I am not eligible for DDD/SSP? (1) You have the right to appeal the department's denial, termination, or reduction of services. Your rights to an adjudicative proceeding are in WAC 388-825-120.

(2) Your current services will not be continued while the matter is being appealed if the service termination or transfer is for a specific group of clients in order to meet the legislative intent of and comply with sections 205 and 207, chapter 371, Laws of 2002.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0140, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0145 How much money will I receive? The purpose of the SSP is to increase the amount of income to meet your needs. The department will determine your payment amount based on your living arrangement and your assessed needs.

(1) For residential and voluntary placement program services, the amount of your SSP will be based on the amount of state-only dollars spent on certain services at the time the funding source was converted to SSP. If the type of your residential living arrangement changes, your need will be reassessed and your payment adjusted based on your new living arrangement and assessed need.

(2) For family support services, refer to WAC 388-825-200 through 388-825-256.

(a) If you are on the home and community based services (HCBS) waiver administered by DDD:

(i) You will receive nine hundred dollars DDD/SSP money per year to use as you determine.

(ii) The remainder up to the maximum yearly award for traditional family support or family support opportunities

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may be authorized by DDD to purchase HCBS waiver services and will be paid directly to the provider.

(b) If you are not on the HCBS waiver administered by DDD, and you received state-only funding for the Traditional Family Support Program between March 1, 2001 and June 30, 2003 the amount of your SSP will be based on the yearly maximum allowed at the time the funding source was converted to SSP unless your need changes.

(i) Need is based on your Service Need Level and whether you receive Medicaid Personal Care as specified in WAC 388-825-254.

(ii) If your need changes, the amount of your SSP will be adjusted accordingly.

(c) If you are not on the HCBS waiver administered by DDD, and you received state-only funding for the Family Support Opportunity Program between March 1, 2001 and June 30, 2003 the amount of your SSP will be fifteen hundred dollars per year.

(d) The yearly amount of DDD/SSP money will be prorated into monthly amounts. You will receive one twelfth of the yearly amount each month.

(3) If you are eligible for SSP because you meet the criteria in WAC 388-827-0115(5), you will receive one hundred dollars per month.

(4) DDD may authorize additional payments to certain individuals if the SSP budget has sufficient funds to allow this payment.

[Statutory Authority: RCW 71A.12.030, 74.04.057 and 20 C.F.R. 416.2099, 06-24-074, § 388-827-0145, filed 12/4/06, effective 1/4/07. Statutory Authority: RCW 71A.12.030, 71A.12.120, and chapter 71A.12 RCW. 05-10-039, § 388-827-0145, filed 4/28/05, effective 5/29/05. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0145, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0146 May I voluntarily remove myself from the home and community based services (HCBS) waiver administered by DDD in order to increase the amount of my SSP? You may voluntarily remove yourself from the HCBS waiver administered by DDD but your SSP will not increase because of this action.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0146, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0150 How often will I receive my DDD/SSP warrant/check? You will receive a monthly warrant/check from the state.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0150, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0155 Who will the warrant/check be sent to? (1) If you are a child under the age of eighteen, the warrant/check will be sent to your legal representative or protective payee or representative payee.

(2) If you are a person age eighteen and older, the warrant/check will be sent directly to your protective payee or representative payee if you have one.

(3) If you do not have a protective payee or representative payee, the warrant/check will be sent directly to you.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0155, filed 12/29/03, effective 1/29/04.]

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WAC 388-827-0160 How will the warrant/check be sent? You may choose to have your check delivered through the U.S. Postal Service, or as an electronic funds transfer.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0160, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0170 Are there rules restricting how I use my DDD/SSP money? There are no restrictions on how you use your DDD/SSP money.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0170, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0175 What changes must I report to the department? You must report changes in your circumstances within ten days from the date you become aware of the change. You must tell us if:

(1) Your SSI stops and you became ineligible for SSI for reasons other than the receipt of Social Security Title II benefits as a disabled adult child;

(2) Your address changes; or

(3) There is a change in your living arrangement that affects your assessed need.

[Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0175, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0175, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0180 Do I have additional responsibilities when I purchase my own services? (1) When you use DDD/SSP funds paid directly to you to purchase in-home services from individuals, you become the employer. As the employer, you may have tax liabilities. If you have questions regarding employer tax issues, you can contact the Internal Revenue Service.

(2) If you want to obtain a criminal background check of any employee who will have unsupervised access to children or adults with developmental disabilities, you may get the background check done through the Washington State Patrol. You can ask your DDD case resource manager to assist you with completing these background checks.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0180, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0185 When will the department stop sending my DDD/SSP money? The department will stop sending your DDD/SSP money when:

(1) You no longer are eligible for or receive SSI cash benefits and are ineligible for SSI for reasons other than the receipt of Social Security Title II benefits as a disabled adult child;

(2) You no longer demonstrate a need for the services as described in WAC 388-827-0115; or

(3) Your DDD eligibility is terminated.

[Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0185, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0185, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0200 What is a representative payee? A representative payee is a person, organization, institution

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or agency that manages your DDD/SSP. They may also provide services such as helping you manage your money.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0200, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0210 Who can be a representative payee for my DDD/SSP? (1) A representative payee may be:

(a) The person, organization, institution or agency that acts as your representative payee for Supplemental Security Income (SSI);

(b) Your parent, if you are under eighteen;

(c) Your spouse; or

(d) A person, organization, institution or agency you select if the department approves your selection.

(2) If you select a representative payee under subsection (1) (d) of this section, the department will evaluate the selection according to the following criteria:

(a) The relationship of the payee to you;

(b) The amount of interest the payee shows in you;

(c) Any legal authority the payee has to act on your behalf;

(d) Whether the payee has custody of you; and

(e) Whether the payee is in a position to know of and look after your needs.

(3) The DDD director or designee will approve or deny your request for a representative under subsection (1)(d) of this section.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0210, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0215 What are the responsibilities of a representative payee? A representative payee has the responsibility to:

(1) Spend the DDD/SSP on you or your behalf;

(2) Notify the department if any event happens that may affect the amount of benefits you receive;

(3) Submit to the department, upon our request, a written report accounting for the payments received; and

(4) Notify the department of any change in the payee's circumstances that would affect performance of the payee responsibilities.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0215, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0300 Does DSHS make exceptions to the requirements in this chapter? DSHS may grant exceptions to the requirements specified in this chapter as long as the following conditions are met:

(1) You or your case manager may request an exception to a rule in this chapter.

(2) The case manager must submit a written request for an exception to his or her DDD regional administrator.

(3) DSHS will evaluate requests for exceptions, considering:

(a) The federal and state rules governing SSP; and

(b) The impact on the client if the exception is not approved.

(4) The DDD regional administrator will forward the request to the DDD director together with the regional

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administrator's recommendation to approve or deny the request.

(5) The DDD director or designee will approve or deny the request in writing within sixty calendar days after receiving the request from the case manager.

(6) The department will notify you of the decision.

(7) You do not have rights to adjudicative proceedings when you receive a denial from DSHS for an exception to the rules in this chapter.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0300, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0400 What is an SSP overpayment?

(1) An overpayment means any SSP paid that is more than the amount you were eligible to receive.

(2) If you request a hearing and the hearing decision determines that you received any DDD/SSP money that you were not eligible to receive, then some or all of the DDD/SSP you received before the hearing decision must be paid back to the department.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0400, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0410 When can an overpayment occur? An overpayment can occur when:

(1) You were not eligible for and did not receive supplemental security income in the month in which the SSP was issued and were ineligible for SSI for reasons other than the receipt of Social Security Title II benefits as a disabled adult child;

(2) You were no longer eligible for services from the division of developmental disabilities in the month in which the SSP was issued; or

(3) Your assessed need has changed.

[Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0410, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0410, filed 12/29/03, effective 1/29/04.]

WAC 388-827-0420 Who is liable for repayment of an overpayment? (1) If you received the money in your own name, you are responsible for repayment.

(2) If you are paid through a representative payee, both you and the representative payee may be responsible for repayment.

(a) You are responsible to the extent that the incorrect payments were spent on you or your behalf. Funds conserved by a representative payee to which you do not have direct access have not been spent on you or your behalf.

(b) If the incorrect payments were spent on you or your behalf and the representative payee is without fault in connection with the overpayment, you are solely responsible for repayment.

(c) The representative payee is solely responsible for repayment if:

(i) The incorrect payments were not spent on you or your behalf; and

(ii) The representative payee is at fault in connection with the overpayment.

(d) A government entity or an institution can be a representative payee and can be found responsible for repayment, just as a private individual can.

(e) You and the representative payee are both responsible for repayment when the incorrect payments have been spent on you or your behalf and the representative payee is at fault.

(3) The representative payee is at fault when the representative payee was aware of the reason you were not eligible for the SSP.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0420, filed 12/29/03, effective 1/29/04.]

Chapter 388-830 WAC

DIVISION OF DEVELOPMENTAL DISABILITIES PROGRAM OPTION RULES

(Formerly chapter 275-31 WAC)

WAC

388-830-005	Purpose.
388-830-010	Definitions.
388-830-015	Determination of eligibility.
388-830-020	Notification to potential applicants.
388-830-025	Application for services.
388-830-030	Individual service plan.
388-830-035	Implementation of necessary services.
388-830-040	Criteria for determining costs.
388-830-045	Method of rate determination.

WAC 388-830-005 Purpose. (1) In order for developmentally disabled individuals to live in the most independent settings possible, and in order for these individuals and families to have access to services best suited to their needs, the division of developmental disabilities may approve alternative service plans for individuals.

(2) Measurable outcomes producing a positive result for individuals will be demonstrated as a result of services provided under such alternative plans.

(3) Cost savings will be demonstrated when costs of services under alternative plans are compared with costs of services provided prior to alternative plans.

[99-19-104, recodified as § 388-830-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-005, filed 1/18/84.]

WAC 388-830-010 Definitions. (1) "Department" means the department of social and health services of the state of Washington.

(2) "Division" means the division of developmental disabilities of the department of social and health services.

(3) "Field services" means the section of the division providing case management services and resource management to division clients living in the community.

(4) "Individual" means the person for whom an alternative plan is being developed.

(5) "Individual habilitation plan" means an individual written plan of care prepared by an interdisciplinary team that sets measurable goals or objectives stated in terms of desirable behavior and that prescribes an integrated program of activities, experiences, or therapies necessary for the individual to reach those goals or objectives. The overall purpose of the plan is to help the individual function at the greatest physical,

intellectual, social, or vocational level the individual can presently or potentially achieve.

(6) "Individual program plan" means an individual service plan or individual habilitation plan.

(7) "Individual service plan" means the written plan, specifying goals and objectives, developed by division staff, parent or parents and/or guardian, the individual, and others whose participation is relevant to identifying needs of the individual.

(8) "Less dependent program" means an alternative program which will provide increased numbers and variety of community contacts for the individual or will require fewer hours of staff supervision/support for the individual.

(9) "Provider" means the person or agency contracted by the department to provide training, support, or other services as designated in the alternative plan.

(10) "Secretary" means the secretary of the department of social and health services or such officer of the department as the secretary may designate to carry out administration of the provision of these rules.

[99-19-104, recodified as § 388-830-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-010, filed 1/18/84.]

WAC 388-830-015 Determination of eligibility. An individual shall be eligible for services under an alternative plan, provided that the division has determined the individual has a disability as defined in WAC 388-825-030 and the individual is receiving current services from the department.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-830-015, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-830-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-020, filed 1/18/84.]

WAC 388-830-020 Notification to potential applicants. (1) Field services shall, prior to March 15, 1984, contact by mail all individuals determined to have a disability as defined in WAC 388-825-030, along with the guardians and agencies entitled to custody of such disabled individuals and parents of disabled individuals who are minors. Thereafter, the aforementioned persons shall be advised once in each calendar year.

(2) Potential applicants shall be informed of the process by which they may develop an alternative plan for services.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-830-020, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-830-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-030, filed 1/18/84.]

WAC 388-830-025 Application for services. (1) In the case of a minor individual, an application can be made by the parent or parents, the guardian or limited guardian, or by the person or agency legally entitled to custody.

(2) In the case of an adult, an application can be made by the individual, by the guardian or limited guardian, or by the person or agency legally entitled to custody.

(3) Application will be made on the forms supplied by the department and the applicant will state the following:

- (a) The outline of services proposed;
- (b) Service providers for each service;

(c) Tasks necessary to the delivery of each service and the person/organization responsible for each task;

(d) All costs of services currently provided for the individual;

(e) The cost of each service component proposed in the alternative plan;

(f) Information explaining why the alternative plan is a less dependent program than the current program; and

(g) Information explaining why the alternative plan is appropriate under the goals and objectives of the individual program plan.

(4) Applicants must be notified within ninety days after the alternative plan has been received by the department of the secretary's approval or denial of the plan.

(5) The notification of the department's decision is subject to appeal rights pursuant to WAC 388-825-100 and 388-825-120.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-830-025, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-830-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-040, filed 1/18/84.]

WAC 388-830-030 Individual service plan. The division shall ensure a current individual service plan is available for each individual prior to approval of application.

[99-19-104, recodified as § 388-830-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-050, filed 1/18/84.]

WAC 388-830-035 Implementation of necessary services. (1) Plans meeting all the criteria specified in WAC 388-825-050 shall be implemented as soon as reasonable, but not later than one hundred twenty days after the completion of the determination process.

(2) Approval and reasonableness may be reviewed for a new determination if the plan has not been implemented within one hundred twenty days.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-830-035, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-830-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-070, filed 1/18/84.]

WAC 388-830-040 Criteria for determining costs. (1) The term "all costs" includes, but is not limited to: Residential support, habilitation, medical care, income grants to the persons, support to assist their families or other caregivers, and nonrecurring start up expenses. All residential costs will recognize capital investment, using federal or professional accounting conventions. The department will take the following costs into account:

(a) All costs paid by the department, including costs borne by the federal government. Income grants paid by the federal government directly to the person (or payee) will be considered.

(b) All costs of the current or proposed program.

(2) The department will estimate a monthly average cost based on a two-year prospective cost period.

(3) Where costs are paid or records kept for a group of individuals rather than for one individual in question, the department will primarily use average cost for that group,

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such as all individuals living at the particular group home or particular residential habilitation center, or all the persons supported by the particular day habilitation program. Exceptions will be considered for persons receiving substantial services above the services received by the typical person in the group.

(4) The analysis of the proposed alternative service plan should show that proposed services can be provided at eighty percent of the current service cost. Exceptions will be considered for persons needing substantial services.

[99-19-104, recodified as § 388-830-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-080, filed 1/18/84.]

WAC 388-830-045 Method of rate determination. Prevailing rates for comparable services will ordinarily be utilized in determining reimbursement for cost components of the alternative plan.

[99-19-104, recodified as § 388-830-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 72.33.125. 84-03-054 (Order 2066), § 275-31-090, filed 1/18/84.]

Chapter 388-835 WAC ICF/MR PROGRAM AND REIMBURSEMENT SYSTEM

(Formerly chapter 275-38 WAC)

WAC

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388-835-0670	Are bonuses paid to a provider's employees allowable costs?		
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388-835-0680	How is the administration and operations rate component computed?		
388-835-0685	How is the property rate component computed?		
388-835-0690	Does DSHS pay a return on equity to providers?		
388-835-0695	How is a return on equity calculated?		
388-835-0700	What if a provider's cost report covers a period shorter than twelve months?		
388-835-0705	Are return on equity calculations subject to field audits?		
388-835-0710	How does DSHS use field audit results?		
388-835-0715	Does DSHS place upper limits on the reimbursement rates it pays providers?		
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388-835-0720	What general requirements apply to settlements between DSHS and providers?		
388-835-0725	What requirements apply to paying overpayments and underpayments?		
388-835-0730	What if the amount of overpayment or underpayment is being disputed?		
388-835-0735	What requirements apply to a provider's proposed preliminary settlement?		
388-835-0740	How must DSHS respond to a provider's proposed preliminary settlement?		
388-835-0745	What recourse does a provider have if DSHS rejects their proposed preliminary settlement?		
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388-835-0760	What if DSHS conducts an audit during the final settlement process?		
388-835-0765	Why is a state facility settlement important?		
388-835-0770	How is a state facility settlement calculated?		
388-835-0775	How is a state facility settlement implemented?		
388-835-0780	Does DSHS have a responsibility to notify each provider regarding prospective reimbursement rates?		
388-835-0785	Can DSHS increase prospective reimbursement rates?		
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388-835-0795	What requirements apply to providers who receive rate increases?		
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388-835-0800	What if DSHS discovers that a prospective rate calculation was affected by an error or omission?		
388-835-0805	What if a provider discovers an error or omission that affected their cost report?		
388-835-0810	What other requirements apply to rate adjustments resulting from errors or omissions?		
388-835-0815	What requirements apply to repayment of amounts owed due to errors or omissions?		
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388-835-0825	What is DSHS' public disclosure responsibility regarding rate setting methodology?		
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388-835-0830	How does a provider bill DSHS for services provided?		
388-835-0835	How does DSHS pay a provider?		
388-835-0840	Can DSHS withhold provider payments?		
388-835-0845	Can DSHS terminate Medicaid Title XIX payments to providers?		
388-835-0850	Who is responsible for collecting from residents any amounts they may own for their care?		
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388-835-0860	What is the role of a receiver when an ICF/MR facility is placed in receivership?		
388-835-0865	How does DSHS determine prospective reimbursement rates during receivership?		
388-835-0870	What if the court asks DSHS to recommend a receiver's compensation?		
388-835-0875	Can DSHS give emergency or transitional financial assistance to a receiver?		
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388-835-0885	What disputes between providers and DSHS can be resolved through the administrative review process?		
388-835-0890	What disputes cannot be resolved through the administrative review and fair hearing processes?		
388-835-0900	How does a provider request an administrative review?		
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388-835-0915	Can DSHS withhold an undisputed overpayment amount from a current ICF/MR payment?		
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388-835-0925	What is the purpose of this section?		
388-835-0930	How is the payment for residential facilities set?		
388-835-0935	How much of a resident's income is exempt from paying their care?		
388-835-0940	What if the estate of a resident is able to pay all or a portion of their monthly cost?		
388-835-0945	If a resident or guardian is served by DSHS with a NFR when is payment due?		
388-835-0950	May a resident or guardian request a hearing if they disagree with the NFR?		
388-835-0955	What information must be included in the request for a hearing?		
DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER			
388-835-010	Terms—Definitions. [99-19-104, recodified as § 388-835-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-001, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-001, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-001, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-001, filed 9/17/84; 82-16-080 (Order 1853), § 275-38-001, filed 8/3/82.] Repealed		

	by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.		275-38-060, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-0135	What are DSHS responsibilities when it decides to transfer a resident? [Statutory Authority: RCW 71A.20.140, 01-10-013, § 388-835-0135, filed 4/20/01, effective 5/21/01.] Repealed by 04-16-018, filed 7/23/04, effective 8/23/04. Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205.		
388-835-015	Exemptions. [99-19-104, recodified as § 388-835-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-003, filed 8/9/91, effective 9/9/91.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-070	Transfer or discharge planning. [99-19-104, recodified as § 388-835-070, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-065, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-065, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-020	ICF/MR care. [99-19-104, recodified as § 388-835-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-005, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-005, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-005, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-075	Discharge, readmission, and incident reporting. [99-19-104, recodified as § 388-835-075, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-075, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-075, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-025	Name of IMR. [99-19-104, recodified as § 388-835-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-015, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-080	Social leave for IMR residents. [99-19-104, recodified as § 388-835-080, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-080, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-030	Closure of an IMR facility. [99-19-104, recodified as § 388-835-030, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-020, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-085	Superintendent's limited authority to hold. [99-19-104, recodified as § 388-835-085, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-090, filed 8/9/91, effective 9/9/91.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-035	Adequate IMR care. [99-19-104, recodified as § 388-835-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-025, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-090	Prospective cost-related reimbursement. [99-19-104, recodified as § 388-835-090, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-510, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-040	Continuity of resident care. [99-19-104, recodified as § 388-835-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-030, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-095	Conditions of participation. [99-19-104, recodified as § 388-835-095, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-515, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-045	IMR contract—Noncompliance. [99-19-104, recodified as § 388-835-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-035, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-100	Projected budget for new contractors. [99-19-104, recodified as § 388-835-100, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-520, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-520, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-050	Minimum staff requirements. [99-19-104, recodified as § 388-835-050, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-045, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-045, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-105	Change of ownership. [99-19-104, recodified as § 388-835-105, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-525, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-525, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-055	Placement of client. [99-19-104, recodified as § 388-835-055, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-050, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-050, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-110	Termination of contract. [99-19-104, recodified as § 388-835-110, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-530, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-530, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-060	Transfer of client—Relocation. [99-19-104, recodified as § 388-835-060, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-055, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-055, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-115	Due dates for reports. [99-19-104, recodified as § 388-835-115, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-535, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-535, filed 9/17/84; 82-16-080 (Order 1853), § 275-38-535, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-065	Resident rights—Relocation redetermination of eligibility. [99-19-104, recodified as § 388-835-065, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120 and 71A.20.140. 91-17-005 (Order 3230), § 275-38-060, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), §	388-835-120	Requests for extensions. [99-19-104, recodified as § 388-835-120, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-540, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-540, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-125	Reports. [99-19-104, recodified as § 388-835-125, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-545, filed

	6/1/88; 82-16-080 (Order 1853), § 275-38-545, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
388-835-130	Failure to submit final reports. [99-19-104, recodified as § 388-835-130, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-546, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-190
388-835-135	Improperly completed or late reports. [99-19-104, recodified as § 388-835-135, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-550, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-550, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-195
388-835-140	Completing reports and maintaining records. [99-19-104, recodified as § 388-835-140, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-555, filed 6/1/88; 86-18-002 (Order 2412), § 275-38-555, filed 8/21/86; 82-16-080 (Order 1853), § 275-38-555, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-200
388-835-145	Certification requirement. [99-19-104, recodified as § 388-835-145, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-560, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-560, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-205
388-835-150	Reports—False information. [99-19-104, recodified as § 388-835-150, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-565, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-565, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-210
388-835-155	Amendments to reports. [99-19-104, recodified as § 388-835-155, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-570, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-570, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-215
388-835-160	Requirement for retention of reports by the department. [99-19-104, recodified as § 388-835-160, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-585, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-585, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-220
388-835-165	Requirements for retention of records by the contractor. [99-19-104, recodified as § 388-835-165, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-586, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-225
388-835-170	Disclosure of IMR facility reports. [99-19-104, recodified as § 388-835-170, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-590, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-230
388-835-175	Desk review. [99-19-104, recodified as § 388-835-175, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-595, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-235
388-835-180	Field audits. [99-19-104, recodified as § 388-835-180, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-600, filed 6/1/88; 84-09-018 (Order 2091), § 275-38-600, filed 4/10/84; 82-16-080 (Order 1853), § 275-38-600, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-240
388-835-185	Preparation for audit by the contractor. [99-19-104, recodified as § 388-835-185, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-605, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-605, filed 8/3/82.] Repealed	388-835-245
	by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-250
	Scope of field audits. [99-19-104, recodified as § 388-835-190, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-610, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-610, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Inadequate documentation. [99-19-104, recodified as § 388-835-195, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-615, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-615, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Deadline for completion of audits. [99-19-104, recodified as § 388-835-200, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-620, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-620, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Disclosure of audit narratives and summaries. [99-19-104, recodified as § 388-835-205, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-625, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Resident trust accounts. [99-19-104, recodified as § 388-835-210, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-645, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Accounting procedures for resident trust accounts. [99-19-104, recodified as § 388-835-215, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-650, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-650, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Trust moneys—Imprest fund. [99-19-104, recodified as § 388-835-220, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-655, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-655, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Trust moneys control or disbursement. [99-19-104, recodified as § 388-835-225, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-660, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-660, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Trust moneys availability. [99-19-104, recodified as § 388-835-230, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-665, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Accounting upon change of ownership. [99-19-104, recodified as § 388-835-235, filed 9/20/99, effective 9/20/99. Statutory Authority: 74.09.120. 88-12-087 (Order 2629), § 275-38-667, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-667, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Procedure for refunding trust money. [99-19-104, recodified as § 388-835-240, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-670, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Liquidation of trust fund. [99-19-104, recodified as § 388-835-245, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-675, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	
	Resident property records. [99-19-104, recodified as § 388-835-250, filed 9/20/99, effective 9/20/99. Statutory Authority: 74.09.120. 82-16-080 (Order 1853), § 275-	

	38-678, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.		
388-835-255	Allowable costs. [99-19-104, recodified as § 388-835-255, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-680, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-680, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-315	Operating leases of facilities and equipment. [99-19-104, recodified as § 388-835-315, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-760, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-260	Substance prevails over form. [99-19-104, recodified as § 388-835-260, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-685, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-685, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-320	Rental expense paid to related organizations. [99-19-104, recodified as § 388-835-320, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-765, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-265	Offset of miscellaneous revenues. [99-19-104, recodified as § 388-835-265, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-690, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-690, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-325	Capitalization. [99-19-104, recodified as § 388-835-325, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 90-15-017 (Order 3037), § 275-38-770, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-770, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-770, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-270	Costs of meeting standards. [99-19-104, recodified as § 388-835-270, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-695, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-695, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-330	Depreciation expense. [99-19-104, recodified as § 388-835-330, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-775, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-775, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-275	Limit on costs to related organizations. [99-19-104, recodified as § 388-835-275, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-700, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-700, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-335	Depreciable assets. [99-19-104, recodified as § 388-835-335, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-780, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-780, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-280	Start-up costs. [99-19-104, recodified as § 388-835-280, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-705, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-705, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-340	Depreciation base. [99-19-104, recodified as § 388-835-340, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-785, filed 6/1/88; 86-01-008 (Order 2312), § 275-38-785, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-785, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-785, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-285	Organization costs. [99-19-104, recodified as § 388-835-285, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-706, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-345	Depreciation base—Donated or inherited assets. [99-19-104, recodified as § 388-835-345, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-790, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-790, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-290	Education and training. [99-19-104, recodified as § 388-835-290, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-715, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-715, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-350	Lives. [99-19-104, recodified as § 388-835-350, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-795, filed 12/5/85; 82-16-080 (Order 1853), § 275-38-795, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-295	Total compensation—Owners, relatives, and certain administrative personnel. [99-19-104, recodified as § 388-835-295, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-720, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-720, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-355	Methods of depreciation. [99-19-104, recodified as § 388-835-355, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-800, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-800, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-300	Owner or relative—Compensation. [99-19-104, recodified as § 388-835-300, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-725, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-725, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-360	Retirement of depreciable assets. [99-19-104, recodified as § 388-835-360, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-805, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-305	Allowable interest. [99-19-104, recodified as § 388-835-305, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-745, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-745, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-745, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-365	Handling of gains and losses upon retirement of depreciable assets. [99-19-104, recodified as § 388-835-365, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-810, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
388-835-310	Offset of interest income. [99-19-104, recodified as § 388-835-310, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), §	388-835-370	Handling of gains and losses upon retirement of depreciable assets—Other periods. [99-19-104, recodified as § 388-835-370, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order

	2629), § 275-38-812, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-812, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-375	Handling of gains and losses upon retirement of depreciable assets. [99-19-104, recodified as § 388-835-375, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-813, filed 12/5/85.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.		
	Recovery of excess over straight-line depreciation. [99-19-104, recodified as § 388-835-380, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-815, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-815, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-380			
	Unallowable costs. [99-19-104, recodified as § 388-835-385, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-820, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-820, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-385			
	Reimbursement principles. [99-19-104, recodified as § 388-835-390, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-831, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-831, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-831, filed 8/19/83.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-390			
	Program services not covered by the reimbursement rate. [99-19-104, recodified as § 388-835-395, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-835, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-395			
	Prospective reimbursement rate for new contractors. [99-19-104, recodified as § 388-835-400, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-840, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-840, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-400			
	Rate determination. [99-19-104, recodified as § 388-835-405, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-845, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-845, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-845, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-845, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-405			
	Desk review for rate determination. [99-19-104, recodified as § 388-835-410, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-846, filed 6/1/88; 83-17-074 (Order 2012), § 275-38-846, filed 8/19/83.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-410			
	Cost centers. [99-19-104, recodified as § 388-835-415, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-850, filed 3/6/85; 82-16-080 (Order 1853), § 275-38-850, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-415			
	Resident care and habilitation cost center rate. [99-19-104, recodified as § 388-835-420, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 93-17-034 (Order 3616), § 275-38-860, filed 8/11/93, effective 9/11/93; 90-15-017 (Order 3037), § 275-38-860, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-860, filed 6/1/88; 86-18-002 (Order 2412), § 275-38-860, filed 8/21/86; 86-01-008 (Order 2312), § 275-38-860, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-860, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-860, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-860, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-860, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.	388-835-420			
		388-835-425			Administration, operations, and property cost center rate. [99-19-104, recodified as § 388-835-425, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-863, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-863, filed 3/6/85.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-430			Food rate component. [99-19-104, recodified as § 388-835-430, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-865, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-865, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-865, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-865, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-435			Maximum allowable compensation of certain administrative personnel. [99-19-104, recodified as § 388-835-435, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 84-19-042 (Order 2150), § 275-38-868, filed 9/17/84. Formerly WAC 275-38-730.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-440			Management agreements, management fees, central office services, and board of directors. [99-19-104, recodified as § 388-835-440, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-869, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-869, filed 9/17/84. Formerly WAC 275-38-740.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-445			Administration and operations rate component. [99-19-104, recodified as § 388-835-445, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 85-06-063 (Order 2213), § 275-38-870, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-870, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-870, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-870, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-450			Property rate component. [99-19-104, recodified as § 388-835-450, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 86-01-008 (Order 2312), § 275-38-875, filed 12/5/85; 85-06-063 (Order 2213), § 275-38-875, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-875, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-875, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-875, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-455			Return on equity. [99-19-104, recodified as § 388-835-455, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-880, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-880, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-880, filed 8/19/83; 82-16-080 (Order 1853), § 275-38-880, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-460			Upper limits to reimbursement rate. [99-19-104, recodified as § 388-835-460, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-885, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-465			Principles of settlement. [99-19-104, recodified as § 388-835-465, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-886, filed 6/1/88; 85-06-063 (Order 2213), § 275-38-886, filed 3/6/85; 84-19-042 (Order 2150), § 275-38-886, filed 9/17/84; 83-17-074 (Order 2012), § 275-38-886, filed 8/19/83.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-470			Procedures for overpayments and underpayments. [99-19-104, recodified as § 388-835-470, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-887, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
		388-835-475			Preliminary settlement. [99-19-104, recodified as § 388-835-475, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), §

- 275-38-888, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-480 Final settlement. [99-19-104, recodified as § 388-835-480, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-889, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-485 Interim rate. [99-19-104, recodified as § 388-835-485, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-890, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-890, filed 9/17/84.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-490 Final payment. [99-19-104, recodified as § 388-835-490, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-892, filed 6/1/88; 84-19-042 (Order 2150), § 275-38-892, filed 9/17/84.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-495 Notification of rates. [99-19-104, recodified as § 388-835-495, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-895, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-500 Adjustments required due to errors or omissions. [99-19-104, recodified as § 388-835-500, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-900, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-900, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-505 Receivership. [99-19-104, recodified as § 388-835-505, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-903, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-510 Adjustments to prospective rates. [99-19-104, recodified as § 388-835-510, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 93-17-034 (Order 3616), § 275-38-906, filed 8/11/93, effective 9/11/93; 90-15-017 (Order 3037), § 275-38-906, filed 7/12/90, effective 8/12/90; 88-12-087 (Order 2629), § 275-38-906, filed 6/1/88.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-515 Public review of rate-setting methods and standards. [99-19-104, recodified as § 388-835-515, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-910, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-520 Public disclosure of rate-setting methodology. [99-19-104, recodified as § 388-835-520, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-915, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-525 Billing period. [99-19-104, recodified as § 388-835-525, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-920, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-530 Billing procedures. [99-19-104, recodified as § 388-835-530, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-925, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-925, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-535 Charges to residents. [99-19-104, recodified as § 388-835-535, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-930, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-540 Payment. [99-19-104, recodified as § 388-835-540, filed 9/20/99, effective 9/20/99. Statutory Authority:

- RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-935, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-545 Suspension of payment. [99-19-104, recodified as § 388-835-545, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-940, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-940, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-550 Termination of payments. [99-19-104, recodified as § 388-835-550, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-945, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-945, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-555 Disputes. [99-19-104, recodified as § 388-835-555, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 82-16-080 (Order 1853), § 275-38-950, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-560 Recoupment of undisputed overpayments. [99-19-104, recodified as § 388-835-560, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-955, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-955, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.
- 388-835-565 Administrative review—Adjudicative proceeding. [99-19-104, recodified as § 388-835-565, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 34.05.220 (1)(a) and 71.12.030 [71A.12.030]. 90-04-074 (Order 2997), § 275-38-960, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 74.09.120. 88-12-087 (Order 2629), § 275-38-960, filed 6/1/88; 82-16-080 (Order 1853), § 275-38-960, filed 8/3/82.] Repealed by 01-10-013, filed 4/20/01, effective 5/21/01. Statutory Authority: RCW 71A.20.140.

PURPOSE

WAC 388-835-0005 What is the purpose of this chapter? (1) The purpose of this chapter is to establish rules authorized by Title 71A RCW, Developmental disabilities that:

- (a) Regulate the purchase and provision of services in intermediate care facility for the mentally retarded (ICF/MR); and
- (b) Assure adequate ICF/MR care, service, and protection are provided through licensing and certification procedures; and
- (c) Establish standards for providing habilitative training, health-related care, supervision, and residential services to eligible persons.

(2) Except where specifically referenced, this chapter supersedes and replaces any and all sections affecting ICF/MR facilities or programs contained in chapter 388-96 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0005, filed 4/20/01, effective 5/21/01.]

DEFINITIONS

WAC 388-835-0010 What terms and definitions are important to understanding this chapter? Unless the context clearly requires otherwise, the following terms and definitions are used consistently throughout the chapter:

"**Accrual method of accounting**" is a method of accounting where:

(1) Revenues are reported when they are earned, regardless of when they are collected; and

(2) Expenses are reported when they are incurred, regardless of when they are paid.

"Active treatment," as used in this chapter, is defined in 42 CFR 483.440(a) and includes implementation of an individual program plan for each resident as outlined in 42 CFR 483.440 (c) through (f).

"Administration and management" means activities used to maintain, control, and evaluate an organization's use of resources while pursuing its goals, objectives and policies.

"Admission" means entering a state-certified facility and being authorized to receive services from it.

"Allowable costs" are documented costs that:

(1) Are necessary, ordinary, and related to providing ICF/MR services to ICF/MR residents; and

(2) Not expressly declared **"nonallowable"** by applicable statutes or regulations.

"Appraisal" is a process performed by a professional person either designated by the American Institute of Real Estate Appraisers as a member, appraisal institute (MAI), or by the Society of Real Estate Appraisers as a senior real estate analyst (SREA) or a senior real property appraiser (SRPA). The appraisal process is used to establish the fair market value of an asset or to reconstruct the historical cost of an asset that was acquired in a past period. The appraisal process includes recording and analyzing property facts, rights, investments and values based on a personal inspection and a property inventory.

"Arm's-length transaction" is a transaction resulting from good faith bargaining between a buyer and seller who hold adverse positions in the market place. Arm's-length transactions are presumed to be objective transactions. A sale or exchange of ICF/MR or nursing home facilities among two or more parties where all parties continue to own one or more of the facilities involved in the transaction is not considered an arm's-length transactions. The sale of an ICF/MR facility that is subsequently leased back to the seller within five years of the date of sale is not considered an arm's-length transaction for purposes of chapter 388-835 WAC.

"Assets" are economic resources of the provider, recognized, and measured in conformity with generally accepted accounting principles. Assets also include deferred charges that are recognized and measured according to generally accepted accounting principles. (The value of assets acquired in a change of ownership transaction entered into after September 30, 1984, cannot exceed the acquisition cost of the owner of record as of July 18, 1984.)

"Bad debts" or **"uncollectable accounts"** are amounts considered uncollectable from accounts and notes receivable. Generally accepted accounting principles must be followed when accounting for bad debts.

"Beds," unless otherwise specified, means the number of set-up beds in an ICF/MR facility. The number of set-up beds cannot exceed the number of licensed beds for the facility.

"Beneficial owner": For a definition, see WAC 388-835-0015.

"Boarding home" means any home or other institution licensed according to the requirements of chapter 18.20 RCW.

"Capitalization" means recording expenditures as assets.

"Capitalized lease" is a lease that is recorded, according to generally accepted accounting principles, as an asset with an associated liability.

"Cash method of accounting" is a method of accounting where revenues are recorded only when cash is received and expenses are not recorded until cash is paid.

"Change of ownership," see WAC 388-835-0020.

"Charity allowances" are reductions in a provider's charges because of the indigence or medical indigence of a resident.

"Consent" means the process of obtaining a person's permission before initiating procedures or actions against that person.

"Contract" means a contract between the department and a provider for the delivery of ICF/MR services to eligible Medicaid recipients.

"Provider" means an entity contracting with the department to deliver ICF/MR services to eligible Medicaid recipients.

"Courtesy allowances" are reductions in charges to physicians, clergy, and others for services received from a provider. Employee fringe benefits are not considered courtesy allowances.

"Custody" means the immediate physical confinement, sheltering and supervision of a person in order to provide them with care and protect their welfare.

"DDD" means the division of developmental disabilities of the department.

"Department" means the department of social and health services (DSHS) and its employees.

"Depreciation" is the systematic distribution of the cost (or depreciable base) of a tangible asset over its estimated useful life.

"Discharge" means the process that takes place when:

(1) A resident leaves a residential facility; and

(2) The facility relinquishes any responsibility it acquired when the resident was admitted.

"Donated asset" is an asset given to a provider without any payment in cash, property, or services. An asset is not considered donated if the provider makes a nominal payment when acquiring it. An asset purchased using donated funds is not a donated asset.

"Entity" means an individual, partnership, corporation, public institution established by law, or any other association of individuals, capable of entering into enforceable contracts.

"Equity capital" is the total tangible and other assets that are necessary, ordinary, and related to resident care listed on a provider's most recent cost report minus the total related long-term debt from the same cost report plus working capital as defined in this section.

"Exemption" means a department approved written request asking for an exception to a rule in this chapter.

"Facility" means a residential setting certified, according to federal regulations, as an ICF/MR by the department. A state facility is a state-owned and operated residential living center. A private facility is a residential setting licensed as a nursing home under chapter 18.51 RCW or a boarding home licensed under chapter 18.20 RCW.

"Fair market value" is the purchase price of an asset resulting from an arm's-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

"Financial statements" are statements prepared and presented according to generally accepted accounting principles and practice and the requirements of this chapter. Financial statements and their related notes include, but are not limited to, balance sheet, statement of operations, and statement of change in financial position.

"Fiscal year" is the operating or business year of a provider. Providers report on the basis of a twelve-month fiscal year, but this chapter allows reports covering abbreviated fiscal periods.

"Funded capacity," for a state facility, is the number of beds on file with the office of financial management.

"Generally accepted accounting principles" are the accounting principles currently approved by the financial accounting standard board (FASB).

"Generally accepted auditing standards" are the auditing standards currently approved by the American Institute of Certified Public Accountants (AICPA).

"Goodwill" is the excess of the purchase price of a business over the fair market value of all identifiable, tangible, and intangible assets acquired. **"Goodwill"** also means the excess of the price paid for an asset over fair market value.

"Habilitative services" means those services required by an individual habilitation plan.

"Harmful" is when an individual is at immediate risk of serious bodily harm.

"Historical cost" is the actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies.

"Imprest fund" is a fund:

(1) Regularly replenished for the amounts expended from it; and

(2) The cash in the fund and the receipts for expenditures should always equal a predetermined amount.

(3) An example of an imprest fund is a petty cash fund.

"ICF/MR" means a facility certified by Title XIX as an intermediate care facility for providing services to persons with mental retardation or related conditions.

"Interest" is the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the borrower.

"Joint facility costs" are any expenses incurred that benefit more than one facility or a facility and any other entity.

"Lease agreement" is a contract for a specified period of time between two parties regarding the possession and use of real or personal property and/or assets in exchange for specified periodic payments.

"Medicaid program" means either the state medical assistance program provided under RCW 74.09.500 or authorized state medical services.

"Medical assistance recipient" is an individual that the department declares eligible for medical assistance services provided in chapter 74.09 RCW.

"Modified accrual method of accounting" is a method of accounting that records revenues only when cash is received and records expenses when they are incurred, regardless of when they are paid.

"Net book value" is the historical cost of an asset less its accumulated depreciation.

"Nonallowable costs" are costs that are not documented, necessary, ordinary and related to providing services to residents.

"Nonrestricted funds" are donated funds not restricted to a specific use by the donor. General operating funds are an example of nonrestricted funds.

"Nursing facility" means a home, place, or institution, licensed or certified according to chapter 18.51 RCW.

"Operating lease" is a lease, according to generally accepted accounting principles, that requires rental or lease payments to be charged to current expenses when they are incurred.

"Ordinary costs" are costs that, by their nature and magnitude, a prudent and cost conscious management would pay.

"Owner" means a sole proprietor, general or limited partner, or beneficial interest holder of at least five percent of a corporation's outstanding stock.

"Ownership interest" means all beneficial interests owned by a person (calculated in the aggregate) regardless of the form such beneficial ownership takes. Also, see WAC 388-835-0015.

"Per diem costs" or **"per resident day costs"** are total allowable costs for a fiscal period divided by total resident days for that same period.

"Prospective daily payment rate" is the daily amount the department assigns to each provider for providing services to ICF/MR residents. The rate is used to compute the department's maximum participation in the provider's cost.

"Qualified mental retardation professional (QMRP)" means QMRP as defined under 42 CFR 483.430 (a).

"Qualified therapist," see WAC 388-835-0030.

"Regression analysis" is a statistical technique used to analyze the relationship between a dependent or criterion variable and a set of independent or predictor variables.

"Regional services" are the services of a local office of the division of developmental disabilities.

"Related organization" is an entity that either controls another entity or is controlled by another entity or provider. Control results from common ownership or the ability to exercise significant influence on the other entity's activities. Control occurs when an entity or provider has:

(1) At least a five percent ownership interest in the other entity; or

(2) The ability to influence the activities of the other.

"Relative" means spouse; natural parent, child, or sibling; adopted child or adoptive parent; stepparent, stepchild, stepbrother, stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild; uncle, aunt, nephew, niece, or cousin.

"Resident" or **"person"** means a person the division determines is, under RCW 71A.16.040 eligible for division-funded services.

"Resident day" means a calendar day of resident care. When computing calendar days of resident care, the day of admission is always counted. The day of discharge is counted only when discharge and admission occur on the same day. For the purpose of this definition, a person is considered

admitted when they are assigned a bed and a resident record is opened for them.

"Resident care and training staff" are staff whose primary responsibility is the care and development of the residents, including:

- (1) Resident activity program;
- (2) Domiciliary services; and
- (3) Habilitative services under the supervision of a QMRP.

"Restricted fund" is a fund where the donor restricts the use of the fund principal or income to a specific purpose. Restricted funds generally fall into one of three categories:

- (1) Funds restricted to specific operating purposes; or
- (2) Funds restricted to additions of property, plant, and equipment; or
- (3) Endowment funds.

"RHC" - Residential habilitation center. A facility owned and operated by the state and is certified as an ICF/MR or a nursing facility.

"Secretary" means the secretary of DSHS.

"Start-up costs" are the one-time costs incurred from the time preparations begin on a newly constructed or purchased building until the first resident is admitted. Such **"preopening"** costs include, but are not limited to, administrative and nursing salaries, utility costs, taxes, insurance, repairs and maintenance, and training costs. Start-up costs do not include expenditures for capital assets.

"Superintendent" means the superintendent of a residential habilitation center (RHC) or the superintendent's designee.

"Title XIX" means the 1965 amendments to the Social Security Act, P.L. 89-07, as amended.

"Uniform chart of accounts" means a list of department established account titles and related code numbers that providers must use when reporting costs.

"Vendor number" or **"provider number"** is a number assigned by the department to each provider who delivers ICF/MR services to ICF/MR Medicaid recipients.

"Working capital" is the difference between the total current assets that are necessary, ordinary, and related to resident care, as reported in a provider's most recent cost report, and the total current liabilities necessary, ordinary, and related to resident care reported in the same cost report.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0010, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0015 What is a "beneficial owner"? A beneficial owner is any person who:

(1) Has or shares, by contract, arrangement, understanding, relationship, or otherwise, the power to:

- (a) Vote or direct the voting of an ownership interest; and/or
- (b) Invest, including the power to dispose of or direct the disposition of an ownership interest.

(2) Creates or uses a trust, proxy, power of attorney, pooling arrangement, or any other contract, arrangement, or device to divest a beneficial owner of their ownership or prevent the vesting of their ownership in order to evade the reporting requirements of this chapter;

(3) Has the right to acquire a beneficial ownership interest within sixty days of one of the following occurring:

- (a) Exercising any option, warrant, or right;
 - (b) Converting an ownership interest;
 - (c) Revoking a trust, discretionary account, or similar arrangement; or
 - (d) Automatically terminating a trust, discretionary account, or similar arrangement.
- (e) Any person acquiring an ownership interest by exercising (a), (b) or (c) of this subsection must be deemed the beneficial owner of that interest.

(4) In the ordinary course of business, according to a written pledge agreement, becomes a pledge of an ownership interest. A pledge must not be deemed the beneficial owner of a pledged ownership interest except when all of the following conditions are met:

(a) The pledge must follow all the steps in the pledge agreement and:

- (i) Declare a default and determine the power to vote;
- (ii) Direct the vote; or
- (iii) Dispose of the pledged ownership interest; or
- (iv) Direct how the disposition of the pledged ownership interest will take place.

(b) The agreement must:

- (i) Be bona fide;
- (ii) Not change or influence a provider's control; and
- (iii) Not be related to any transaction attempting to change or influence a provider's control.

(c) The agreement, before default, cannot grant the pledge the power to:

(i) Vote or direct the vote of the pledged ownership interest; or

(ii) Dispose or direct the disposition of the pledged ownership interest except where credit is extended and the pledge is a broker or dealer.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0015, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0020 What is a "change in ownership"? (1) A "change in ownership" is a change in the individual or legal organization responsible for the daily operation of an ICF/MR facility.

(2) Types of events causing a change in ownership include but are not limited to:

(a) Changing the form of legal organization of the owner, such as a sole proprietorship becomes a partnership or corporation;

(b) Transferring the title to the ICF/MR enterprise from the provider to another party;

(c) Leasing the ICF/MR facility to another party or an existing lease is terminated;

(d) When the provider is a partnership, any event that dissolves the partnership;

(e) When the provider is a corporation and the corporation:

- (i) Is dissolved;
- (ii) Merges with another corporation which is the survivor; or
- (iii) Consolidates with one or more other corporations to form a new corporation.

(3) Ownership does not change when:

(a) The provider contracts with another party to manage the facility and act as the provider's agent subject to the provider's general approval of daily operating decisions; or

(b) When the provider is a corporation, some or all of its corporate stock is transferred.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0020, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0025 How can lease agreements be terminated? (1) Lease agreements can be terminated by:

(a) Eliminating or adding parties to the agreement;

(b) Expiration of the agreement;

(c) Modifying of any lease term in the agreement;

(d) Terminating the agreement by any means by either party; or

(e) Extending or renewing the agreement, even if done according to its renewal provision, creates a new agreement and effectively terminates the old one.

(2) A strictly formal change in a lease agreement modifying the method, frequency, or manner in which lease payments are made without increasing the total payment obligation of the lessee is not considered a modification of the lease terms.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0025, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0030 What is a "qualified therapist"?

A qualified therapist is any of the following:

(1) An activity specialist who has department specified specialized education, training, or experience;

(2) An audiologist eligible for a certificate of clinical competency in audiology or possessing the equivalent education and clinical experience;

(3) A dental hygienist defined, licensed and regulated by chapter 18.29 RCW;

(4) A dietitian either:

(a) Eligible for registration by the American Dietetic Association under requirements in effect on January 17, 1974; or

(b) With a baccalaureate degree whose major studies covered food and nutrition, dietetics, or food service management; plus one year supervisory experience in the dietetic service of a health care institution; and annual participation in continuing dietetic education;

(5) An occupational therapist who graduated from a program in occupational therapy or who possesses the equivalent of such education or training and meets all Washington state legal requirements;

(6) A pharmacist who is licensed by the Washington state board of pharmacy to engage in the practice of pharmacy;

(7) A physical therapist, meaning someone practicing physical therapy as defined in RCW 18.74.010(3). Physical therapist does not include massage operators as defined in RCW 18.108.010;

(8) A physician as defined, licensed and regulated by chapter 18.71 RCW or an osteopathic physician as defined, licensed and regulated by chapter 18.57 RCW;

(9) A psychologist as defined, licensed and regulated by chapter 18.83 RCW;

(10) A qualified mental retardation professional;

(11) A registered nurse as defined by chapter 18.88A RCW;

(12) A social worker who is a graduate of a school of social work; or

(13) A speech pathologist either:

(a) Eligible for a certificate of clinical competence in speech pathology; or

(b) Possessing the equivalent education and clinical experience.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0030, filed 4/20/01, effective 5/21/01.]

EXEMPTIONS

WAC 388-835-0035 Does DSHS grant exemptions to these rules? (1) DSHS may approve an exemption to a specific rule in this chapter if an:

(a) Assessment of the request concludes that the exemption will not undermine the legislative intent of Title 71A RCW, Developmental disabilities; and

(b) Evaluation of the request shows that the exemption will not adversely effect the quality of service, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers must retain a copy of each department-approved exemption.

(3) Actions regarding exemption requests are not subject to appeal.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0035, filed 4/20/01, effective 5/21/01.]

GENERAL REQUIREMENTS

WAC 388-835-0040 What general requirements apply to ICF/MR care facilities? The following general requirements apply:

(1) The division will recognize only the official name of an ICF/MR as shown on the license.

(2) All state and private ICF/MR facilities must be certified as a Title XIX IMR ICF/MR facility.

(3) All private ICF/MR facilities with a certified capacity of at least sixteen beds must be licensed as a nursing home under chapter 18.51 RCW, Nursing homes.

(4) All private ICF/MR facilities with a certified capacity of less than sixteen beds must be licensed as a boarding home for the aged under chapter 18.20 RCW.

(5) All facilities certified to provide ICF/MR services must comply with all applicable Title XIX, Section 1905 of the Social Security Act 42 U.S.C federal regulations as amended. In addition, all private-operated facilities must comply with state regulation governing the licensing of nursing homes or boarding homes for the aged and any other relevant state regulations.

(6) All certified facilities must only admit persons with developmental disabilities as residents.

(7) State facilities may not exceed funded capacity unless authorized by the secretary to do so (see RCW 71A.20.090).

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0040, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0045 What are the minimum staff requirements for an ICF/MR facility? All ICF/MR facilities must provide sufficient number of qualified staff to meet the needs of their residents.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0045, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0050 What general requirements apply to the quality of ICF/MR services? (1) DSHS is responsible for assuring the:

(a) Health care and habilitative training needs of an individual are identified and met according to state and federal regulations.

(b) Individual is placed in a facility certified as capable of meeting their needs.

(2) DDD regional service staff is responsible for authorizing changes in residential services.

(3) All services provided must be essential to the resident's habilitation and health care needs and to achieving the primary goal of attaining the highest level of independence possible for each individual resident.

(4) A resident in an ICF/MR is eligible for community residential services when such services meet their needs.

(5) Every ICF/MR must provide habilitative training and health care that at least includes the following:

(a) Active treatment;

(b) Services according to the identified needs of the individual resident and provided by or under the supervision of qualified therapists;

(c) Routine items and supplies provided uniformly to all residents;

(d) Providing necessary surgical appliances, prosthetic devices, and aids to mobility for the exclusive use of individual residents;

(e) Nonreusable supplies not usually provided to all residents may be individually ordered. A department representative must authorize requests for such supplies.

(6) Each ICF/MR facility is responsible for providing transportation for residents. This responsibility may include the guarantee of a resident's use of public transportation.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0050, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0055 What are the resident's rights if DSHS decides that they are no longer eligible for ICF/MR services? (1) A resident, their guardian, next-of-kin, or responsible party must be informed by DSHS in writing thirty days before any redetermination of their eligibility for ICF/MR services takes place.

(2) The redetermination notice must include:

(a) The reasons for the proposed eligibility change;

(b) A statement that the resident or any other individual designated by the resident has a right to a conference with a DDD representative within thirty days of receipt of the notice;

(c) A statement that the resident has the right to request a hearing to contest the department's decision within thirty days of the notice;

(d) Information as to how a hearing can be requested;

(e) A statement that the resident has the right to be represented at the hearing by an authorized representative; and

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(f) Information regarding the availability and location of legal services within the resident's community.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0055, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0060 What are DSHS responsibilities when it decides to redetermine a resident eligibility for ICF/MR services? DSHS must send a hearing request form with the notice of redetermination.

(1) If the resident requests a hearing within the thirty-day time period, DSHS must not redetermine eligibility until a hearing decision is reached or appeal rights have been exhausted unless redetermination is warranted by the resident's health or safety needs.

(2) If the secretary or the secretary's designee concludes that redetermination is not appropriate, no further action will be taken to redetermine eligibility unless there is a change in the situation or circumstances. If there is a change in the situation or circumstances, the request may be resubmitted.

(3) If the secretary or the secretary's designee affirms the decision to change the resident's eligibility and no judicial review is filed within thirty days of the receipt of notice of redetermination, the department must proceed with the planned action.

(4) If the secretary or secretary's designee affirms the decision to change the resident's eligibility and a request for judicial review has been filed, any proposed redetermination must be delayed until the appeal process is complete unless a delay jeopardizes the resident's health or safety.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0060, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0065 Do residents always have a right to a hearing? Advance notice and planning does not include a right to a hearing for a resident when the department concludes that the facility where the resident resides cannot provide Title XIX services due to:

(1) Termination of the facility's contract;

(2) Decertification of the facility;

(3) Nonrenewal of the facility's contract;

(4) Revocation of the facility's license; or

(5) An emergency suspension of the facility's license.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0065, filed 4/20/01, effective 5/21/01.]

PLACEMENT—TRANSFER—RELOCATION— DISCHARGE

WAC 388-835-0070 What requirements apply to the placement of individuals in an ICF/MR facility? (1) Placing individuals in an ICF/MR facility is the responsibility of the division of developmental disabilities and must be done according to applicable federal and state regulations.

(2) A facility may not admit an individual who requires services the facility cannot provide.

(3) Department representatives must determine an individual's eligibility for ICF/MR services before payment can be approved.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0070, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0075 What if an individual is transferred between facilities? (1) When an individual is transferred between facilities, all essential information concerning the individual, their condition, regimen of care and training must be transmitted, in writing, by the sending facility to the receiving facility at the time of the transfer.

(2) "Transferred between facilities" means transferred from:

- (a) An ICF/MR to ICF/MR;
- (b) An ICF/MR to a hospital;
- (c) A hospital to an ICF/MR; or
- (d) An ICF/MR or hospital to alternative community placement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0075, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0080 What if an ICF/MR facility is closed? (1) When a facility plans to close, it must notify the department, in writing, at least one hundred and eighty days before the date of closure.

(2) Upon receipt of a notice of closure, the department must stop referring individuals to the facility and begin the orderly transfer of its residents.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0080, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0085 Why is an individual transferred or discharged? An individual admitted to a facility can be transferred or discharged only for:

- (1) Medical reasons;
- (2) A change in the individual's habilitation needs;
- (3) The individual's welfare;
- (4) The welfare of other residents;
- (5) At the request of the resident or legal guardian;
- (6) Partial closure of the facility; or
- (7) Closure of the facility.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.-140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-835-0085, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0085, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0090 What is the basis of the decision to transfer or discharge an individual? The decision to transfer or discharge an individual must be based on:

- (1) An assessment of the resident in consultation with the service provider and the parent or guardian; and
- (2) A review of the relevant records; or
- (3) Partial closure of the facility; or
- (4) Closure of the facility.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.-140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-835-0090, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0090, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0095 Is a transfer plan required for each resident? (1) DDD must prepare a written plan for each resident to be transferred.

(2) These plans must:

- (a) Identify the location of available facilities that provide services appropriate and consistent with the resident's needs;

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(b) Provide for coordination between the staffs of the old and new agencies;

(c) Allow for a pre-transfer visit, when the resident's condition permits, to the new facility, so the resident can become familiar with the new surroundings and residents;

(d) Encourage active participation by the resident's guardian or family in the transfer preparation;

(e) Facilitate discussions between the staffs of the old and new facilities regarding expectations;

(f) Provide opportunities for consultations on request between the two staffs; and

(g) Require follow-up by DDD to monitor the effects of the transfer.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0095, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0100 Why would an individual move? An individual may move if:

(1) The services provided to an individual do not meet their needs;

(2) A facility's ICF/MR certification or license is revoked or suspended;

(3) Medical reasons dictate relocation;

(4) A resident's welfare would be improved;

(5) The welfare of the other residents would be enhanced;

(6) There is no payment for services provided to the resident during their stay at the facility;

(7) The resident and/or guardian make a formal request;

(8) The facility is partially closing; or

(9) The facility is closing.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.-140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-835-0100, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0100, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0105 What are DSHS' responsibilities for placing individuals? (1) When services available to an individual do not meet their needs, the department is responsible for initiating and facilitating the resident's relocation.

(2) The department may enforce immediate movement of a resident from an ICF/MR facility when the facility's ICF/MR certification or license is revoked or suspended.

(3) The department must notify a resident and their guardian, next of kin, or responsible party, in writing, when:

(a) DSHS or Health Care Financing Administration (HCFA) determines a facility no longer meets certification requirements as an ICF/MR;

(b) DSHS determines the facility does not meet contract requirements; or

(c) A facility voluntarily terminates their contract with DSHS or stops participating in the ICF/MR program.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0105, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0110 Is DSHS required to give written notice when it intends to transfer an individual? (1) WAC 388-835-0055 requires that DSHS give the resident and their guardian, next of kin, or responsible party thirty days notice, in writing, of its intent to transfer the resident.

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(2) If there is a serious and immediate threat to the resident's health or safety, DSHS is not required to give the resident and their guardian, next of kin, or responsible party thirty days notice of its intent to transfer the resident.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0110, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0110, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0115 Can a facility request that an individual be transferred? Facilities can request that a resident be transferred for the following reasons:

- (1) Medical reasons;
- (2) A change in the individual's habilitation needs;
- (3) The individual's welfare;
- (4) The welfare of the other residents;
- (5) Nonpayment for services provided to the resident during the resident's stay at the facility;
- (6) The facility is partially closing; or
- (7) The facility is closing.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.-140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-835-0115, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0115, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0120 What steps must be followed when a facility makes a transfer request? The following steps apply when a facility wants a resident transferred:

(1) The facility must send their request to the department in writing. The request must explain why the relocation is necessary and document that the interdisciplinary team responsible for developing the resident's habilitation plans agrees with the request.

(2) DSHS must approve or deny the request within fifteen working days of receiving it. The department's decision must be based upon:

- (a) An on-site visit with the resident; and
- (b) A review of the resident's records.

(3) The facility administrator must be informed of the department's decision.

(4) If the facility's request is approved, the department must give the resident and their guardian, next of kin, or responsible party thirty days notice, in writing, of its intent to transfer the resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0120, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0125 Can residents request a transfer? (1) Every resident has a right to:

- (a) Request a transfer; and
- (b) Select where they wish to move.

(2) If the resident's selection is available and appropriate to their habilitation and health care needs, the department must make all reasonable attempts to accomplish transfer.

(3) If the selection is neither appropriate nor available, the resident may make another selection.

(4) All requests by the resident or their guardian must be in writing.

(5) DDD is solely responsible for arranging the resident's transfer.

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[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0125, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0130 What rights are available to a resident regarding a proposed transfer? (1) A resident, their guardian, next-of-kin, or responsible party must be notified in writing at least thirty days before any transfer occurs.

(2) The transfer notice must include:

- (a) The reasons supporting the proposed transfer;
- (b) A statement that the resident or any other individual designated by the resident has a right to a conference with a DDD representative within twenty-eight days of receipt of the notice;
- (c) A statement that the resident has the right to request a hearing to contest the department's decision within thirty days of the notice;
- (d) Information as to how a hearing can be requested;
- (e) A statement that the resident has the right to be represented at the hearing by an authorized representative; and
- (f) Information regarding the availability and location of legal services within the resident's community.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0130, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0140 Do residents always have a right to a hearing? Advance notice and planning does not include a right to a hearing for a resident when the department concludes that the facility where the resident resides cannot provide Title XIX services due to:

- (1) Termination of the facility's contract;
- (2) Decertification of the facility;
- (3) Nonrenewal of the facility's contract;
- (4) Revocation of the facility's license;
- (5) An emergency suspension of the facility's license;
- (6) Partial closure of the facility; or
- (7) Closure of the facility.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.-140, 2003 1st sp.s. c 25 § 205 04-16-018, § 388-835-0140, filed 7/23/04, effective 8/23/04. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0140, filed 4/20/01, effective 5/21/01.]

DISCHARGE/READMISSION AND INCIDENT REPORTING

WAC 388-835-0145 Does a facility have a responsibility to report incidents involving residents? Any facility that has an ICF/MR contract with DSHS must immediately contact their DDD regional services office regarding unauthorized leaves, disappearances, serious accidents, or other traumatic incidents effecting a resident or the resident's health or welfare.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0145, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0150 When does DSHS require discharge and readmission of a resident? DSHS requires discharge and readmission for all residents admitted as hospital inpatients.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0150, filed 4/20/01, effective 5/21/01.]

SOCIAL LEAVE FOR ICF/MR RESIDENTS

WAC 388-835-0155 What requirements apply to social leaves for ICF/MR residents? (1) All social leaves should be consistent with the goals and objectives in the resident's individual habilitation plan.

(2) Any facility vacancies resulting from a resident's social leave will be reimbursed if the leave complies with the individual habilitation plan and the following conditions:

(a) The facility must notify the DDD director or their designee of all social leaves exceeding fifty-three hours.

(b) All social leaves exceeding seven consecutive days must receive prior written approval from the DDD director or their designee.

(c) The DDD director or their designee must give written approval before a resident can accumulate more than seven-teen days of social leave per year.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0155, filed 4/20/01, effective 5/21/01.]

SUPERINTENDENT'S AUTHORITY TO DETAIN A RESIDENT

WAC 388-835-0160 Can residential habilitation center (RHC) superintendents involuntarily detain residents? (1) When an RHC resident decides to initiate a voluntarily discharge, the superintendent must determine if the discharge is harmful to the resident.

(2) If the superintendent concludes that the discharge is harmful, they may detain the resident for up to forty-eight hours until the harm passes. The superintendent may also refer the resident to a mental health professional as defined in RCW 71.05.150.

(3) At the end of the forty-eight hour detention period, the superintendent must release the resident.

(4) If, within six months, the superintendent detains the resident a second time, they must refer the resident to a mental health professional within eight hours of the second detention. During this second detention, the resident may only be held until the mental health professional:

(a) Investigates and evaluates the specific facts surrounding the situation; and

(b) Determines if further detention is necessary (see RCW 71.05.150).

(5) Nothing in this section prevents a superintendent or their designee from allowing a resident to leave the RHC for specified periods necessary for their habilitation or care.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0160, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0165 Is a superintendent required to give notice when they detain a resident? (1) When a superintendent detains an RHC resident, the superintendent or their designee must notify the resident and their legal representative as required in RCW 71A.10.070.

(2) If the resident's legal representative is not available, the superintendent must also notify one or more of the following persons in the order of priority listed:

(a) A parent of the resident;

(b) Other persons of close kinship relationship to the resident;

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(c) The Washington protection and advocacy agency for the rights of a person with a developmental disability, appointed in compliance with 42 USC section 6042; or

(d) A person, who is not a DSHS employee or an ICF/MR but who, in the superintendent's opinion, is concerned with the resident's welfare.

(3) Nothing in this section prevents a superintendent from notifying:

(a) A mental health professional;

(b) Local law enforcement;

(c) Adult protective services;

(d) Child protective services;

(e) Other agencies as appropriate; or

(f) Director, division of developmental disabilities, or designee.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0165, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0170 What is a superintendent's responsibility when a resident voluntarily leaves an RHC? When a resident voluntarily leaves RHC programs and services, the superintendent must initiate discharge proceedings.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0170, filed 4/20/01, effective 5/21/01.]

ICR/MR CONTRACTS

WAC 388-835-0175 What if a facility violates its ICF/MR contract? (1) If a facility violates the terms of their contract, DSHS may temporarily suspend referring residents to it.

(2) Whenever DSHS suspends referrals it must notify the facility immediately, in writing, and give the reasons for its action.

(3) The suspension may continue until DSHS determines that the circumstances leading to it have been corrected.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0175, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0180 What if an ICF/MR contract is terminated? (1) Before a contract is terminated, the provider must give DSHS one hundred and eighty days written notice of the termination.

(2) When a contract is terminated, the provider must submit final reports to DSHS according to the requirements of WAC 388-835-0185.

(3) When notified of a contract termination, DSHS must determine, by preliminary or final settlement calculations, the amount of any overpayments made to the provider, including overpayments disputed by the provider. If preliminary or final settlements are not available for any periods before the termination date of the contract, DSHS must use available relevant information to make a reasonable estimate of any overpayments or underpayments.

(4) The provider must file a properly completed final cost report (see the requirements in WAC 388-835-0225, 388-835-0230, and 388-835-0235). This report may be audited by DSHS. A final settlement must be determined within ninety days after the audit process is completed (including any administrative review of the audit requested

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by the provider) or within twelve months of the termination of the contract if an audit is not performed.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0180, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0180, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0185 Does DSHS withhold payment for services when a contract is terminated? (1) Payment for services provided before a contract was terminated, equal to the amount determined in WAC 388-835-0180(3), may be withheld by DSHS until the provider files a properly completed final annual cost report and a final settlement has been calculated.

(2) Instead of withholding payments, DSHS may allow a provider to offer security equal to the determined and/or estimated overpayments even when the overpayments are being disputed in good faith. Types of security acceptable to DSHS are:

- (a) A surety bond issued by a bonding company acceptable to DSHS;
- (b) An assignment of funds to DSHS;
- (c) Collateral acceptable to DSHS;
- (d) A purchaser's assumption of liability for the provider's overpayment; or
- (e) Any combination of (a) through (d) of this subsection.

(3) DSHS must release any payments withheld if a provider gives acceptable security equal to the determined and/or estimated overpayments.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0185, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0190 What happens to withheld payments and security from a provider when a final settlement is determined? (1) When a final settlement is determined, security held by DSHS must be released to the provider after any related overpayments owed to the department have been paid.

(2) If the provider disagrees with the settlement and does not repay any overpayments owed, DSHS must retain security equal to the amount of the disputed overpayments until the administrative appeal process is completed.

(3) If the total of withheld payments, bonds, and assignments is less than the total of the determined and/or estimated overpayments, the unsecured portion of the overpayments is a debt owed to the state of Washington. This debt becomes a lien against the provider's real and personal property when DSHS files with the auditor in the county where the provider resides or owns property. This lien has preference over all unsecured creditor claims against the provider.

(4) If the total existing overpayments exceed the value of the security held by DSHS, DSHS may use whatever legal means are available to recover the difference.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0190, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0195 What requirements apply to surety bonds or assigned funds used as security by a provider? All surety bonds or assignment of funds, offered as security, must be:

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(1) At least equal in amount to the determined and/or estimated overpayments minus any withheld payments even if the overpayments are the subject of a good faith dispute;

(2) Issued or accepted by a bonding company or financial institution licensed to transact business in Washington state;

(3) For a term sufficient to cover the time period needed to determine a final settlement and exhaust administrative and judicial remedies;

(4) Forfeited to DSHS if the term proves insufficient and the bond or assignment is not renewed for an amount equal to any remaining overpayment in dispute;

(5) Paid to DSHS if a properly completed final cost report is not filed by the provider or if financial records supporting this report are not retained and available to the auditor; and

(6) Paid to DSHS if the provider does not pay the refund owed within sixty days following receipt of a written demand to do so or the conclusion of any administrative or judicial proceedings held to settle the dispute.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0195, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0200 Does decertification, termination or nonrenewal of a contract stop payment of Title XIX funds? A decertification, termination, or nonrenewal of a contract stops the payment of Title XIX funds. Actions such as these do not affect a facility's right to operate as a nursing home or boarding home, but they do disqualify the facility from operating as an ICF/MR facility and receiving federal funds.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0200, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0205 How does a change in ownership affect an ICF/MR contract with DSHS? (1) On the effective date of a change of ownership, DSHS's contract with the former owner is terminated. The former owner must give DSHS one hundred and eighty days written notice before the contract is terminated. When a certificate of need is required for the new owner and the new owner wishes to continue to provide services to residents without interruption, a certificate of need must be obtained before the former owner submits their notice of termination (see chapter 70.38 RCW for certificate of need requirements).

(2) If the new provider plans to participate in the cost related reimbursement system, they must meet the conditions specified in WAC 388-835-0215 and submit the projected budget required in WAC 388-835-0220. The new owner's CF/MR contract is effective on the date ownership changes.

(3) When a contract is terminated, the provider must reverse any accumulated liabilities assumed by a new owner against the appropriate accounts.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0205, filed 4/20/01, effective 5/21/01.]

PROSPECTIVE COST RELATED REIMBURSEMENT SYSTEM

WAC 388-835-0210 What is the prospective cost related reimbursement system (PCRRS)? PCRRS is the

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system used by DSHS pay for ICF/MR services provided to ICF/MR residents. Reimbursement rates for such services are determined according to the principles, methods, and standards contained in this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0210, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0215 What are the requirements for participating in PCRRS? To participate in PCRRS, an entity responsible for operating an ICF/MR facility must:

- (1) Obtain a state certificate of need as required by chapter 70.38 RCW, Health planning and development;
- (2) Possess a current license to operate an appropriate facility (e.g., nursing home, boarding home);
- (3) Be currently certified under Title XIX to provide ICF/MR services;
- (4) Hold a current contract to provide ICF/MR services and comply with all of its provisions; and
- (5) Comply with all applicable federal and state regulations, including the requirements of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0215, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0220 What are the projected budget requirements for new providers? (1) Unless the DDD director approves a shorter period, each new provider must submit a one-year projected budget to DSHS at least sixty days before the contract will become effective.

(2) The projected budget must cover the twelve months immediately following the date the provider will enter the program.

(3) The projected budget must:

- (a) Be prepared according to DSHS instructions;
- (b) Be completed on the forms provided by DSHS; and
- (c) Include all earnest money, purchase, and lease agreements involved in the change of ownership transaction.

(4) A new provider must also clearly identify, in their projected budget, all individuals and organizations having a beneficial ownership interest in the:

- (a) Current operating entity;
- (b) Land, building, or equipment used by the facility; and
- (c) Purchasing or leasing entity.

(5) For purposes of this section, a "new provider" is one:

- (a) Operating a new facility;
- (b) Acquiring or assuming responsibility for operating an existing facility; or
- (c) Obtaining a certificate of need approval due to an addition to or renovation of a facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0220, filed 4/20/01, effective 5/21/01.]

FILING COST REPORTS

WAC 388-835-0225 How should cost reports be prepared? (1) All cost reports must be legible and reproducible. All entries must be in black or dark blue ink or submitted in an acceptable, indelible copy.

(2) All providers must complete reports according to the instructions provided by DSHS. If no specific instruction covers a particular situation, generally accepted accounting principles must be followed.

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(3) All providers must use the accrual method of accounting, except for governmental institutions operated on a modified accrual basis.

(4) All revenue and expense accruals not received or paid within one hundred twenty days after the accrual is made must be reversed against the appropriate accounts, unless special circumstances are documented that justify continuing to carry all or part of the accrual (e.g., contested billings). Accruals for vacation pay, holiday pay, sick pay and taxes may be carried for longer periods if it is the provider's usual policy to do so and generally accepted accounting principles are followed.

(5) Methods of allocating costs, including indirect and overhead costs, must be consistently applied. Providers operating multiservice facilities or facilities incurring joint facility costs must allocate those costs according to the benefits received from the resources represented by those costs.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0225, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0230 Must a cost report be certified?

(1) Every provider cost report required by DSHS must be accompanied by a certification signed on behalf of the provider who was responsible to DSHS during the reporting period.

(2) If a provider files a federal income tax return, the person normally signing the return and the ICF/MR facility administrator must sign the certification.

(3) If someone, who is not an employee of the provider, prepares the cost report, they must submit, as part of the certification, a signed statement indicating their relationship to the provider.

(4) Only original signatures must be affixed to certifications submitted to DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0230, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0235 When are cost reports due to DSHS? (1) Each private provider must submit an annual cost report to DSHS for the period January 1 through December 31 (calendar year) of the preceding year.

(2) Annual calendar year cost reports for a private facility must be submitted to DSHS by March 31 of the following year.

(3) Each state facility must submit an annual cost report to DSHS for the period from July 1 of the preceding year through June 30 of the current year (state fiscal year).

(4) Annual fiscal year cost reports for state facilities must be submitted to DSHS by December 31 following the end of the fiscal year.

(5) If a contract is terminated, the provider must submit a final cost report and any other reports due under subsection (2) within one hundred twenty days after the effective date of termination or the expiration of the final extension granted by DSHS (see WAC 388-835-0340). For these reports, the reporting period is January 1 of the year of termination to the effective date of termination.

(6) A new provider must submit a cost report to DSHS by March 31 of the year following the effective date of their contract or the expiration of the final extension granted by DSHS (see WAC 388-835-0340). The period to be reported

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is the period extending from the contract's effective date through December 31 of that year.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0235, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0240 Does DSHS grant extensions for cost reporting deadlines? (1) DSHS, after receiving a written request stating why an extension is necessary, may grant a maximum of two thirty-day extensions for filing any required reports. However, the written request must be received at least ten days before the due date of the reports.

(2) DSHS grants extensions only when it is clear why the due date cannot be met and the circumstances requiring the extension were not foreseeable by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0240, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0245 What if a provider fails to submit a final report? (1) If a provider does not submit a final report, all payments received by the provider for the unreported period become a debt owed to DSHS. After receiving DSHS's written demand for repayment, the provider has thirty days to repay this debt.

(2) Interest, at the rate of one percent per month on any unpaid balance, will begin to accrue thirty days after the provider receives DSHS's written demand for repayment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0245, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0250 What if a provider submits improperly completed or late reports? (1) All providers must submit an annual report, including their proposed settlement by cost center, that is prepared according to this chapter's requirements and DSHS instructions. If an annual cost report is not properly prepared, DSHS may return it, in whole or in part, to the provider for correction and/or completion.

(2) If DSHS does not receive a properly completed report, including any approved extensions, on or before its due date, all or part of any payments due under the contract may be withheld until the report is properly completed and received by DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0250, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0255 What if a provider files a report containing false information? (1) Knowingly filing a report with false information (or with reason to know) is cause for termination of a provider's contract with DSHS.

(2) Any required adjustments to reimbursement rates because a false report was filed will be made according to WAC 388-835-0900.

(3) DSHS may refer for prosecution under applicable statutes, any provider who files a false report.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0255, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0260 Can providers amend annual cost reports filed with DSHS? DSHS must consider amendments to annual reports only when:

(1) Determining allowable costs affecting a final settlement computation, and

(2) Filed before the provider receives notification that a DSHS field audit has been scheduled.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0260, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0265 Can providers file amendments if a DSHS field audit has been scheduled? (1) A provider may file amendments after receiving a notice of a field audit only when reimbursement rates need to be adjusted because significant errors or omissions were made when they were calculated.

(2) Errors of omissions are considered "significant" if they result in a net difference of two cents or more per resident day or one thousand dollars or more in reported costs, whichever is higher, in any cost area.

(3) Only the pages requiring changes and the certification required by WAC 388-835-0335 must be filed with the amendment.

(4) Any adjustments to reimbursement rates resulting from an amended report will be made according to WAC 388-835-0885.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0265, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0265, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0270 Can providers file amendments if DSHS does not conduct a field audit? If DSHS does not conduct a field audit and the preliminary settlement report becomes the final report, DSHS must consider amendments only when filed within thirty days after the provider receives the final settlement report.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0270, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0275 What requirements apply when amendments are filed? (1) When amendments are filed, a provider must report:

- (a) The circumstances surrounding the amendments;
- (b) The reasons why the amendments are needed; and
- (c) All relevant supporting documentation.

(2) DSHS may refuse to consider any amendment that gives a provider a more favorable settlement or rate if the amendment is the result of:

(a) Circumstances over which the provider has control; or

(b) Good-faith error using the system of cost allocation and accounting in effect during the reporting period in question.

(3) Acceptance or use by DSHS of an amendment to a cost report does not release a provider from civil or criminal liability.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0275, filed 4/20/01, effective 5/21/01.]

MAINTAINING COST REPORT RECORDS

WAC 388-835-0280 Do ICF/MR providers have to maintain records related to their contracts? (1) A provider

must, according to the terms of their contract, maintain adequate records so DSHS can audit reported data to verify provider compliance with generally accepted accounting principles and DSHS reimbursement principles and reporting instructions.

(2) If a provider maintains records based upon a chart of accounts other than the one established by DSHS, they must give DSHS a written schedule clearly illustrating how their individual account numbers correspond to those used by DSHS.

(3) After filing a report with DSHS, a provider must keep for five years, at a location in Washington state specified by the provider, all records supporting the report.

(4) If at the end of five years there are unresolved audit issues related to the report, the records supporting the report must be kept until the issues are resolved.

(5) Providers, according to the terms of their contract, must make records available for review upon demand by authorized personnel from DSHS and the United States Department of Health and Human Services during normal business hours at a location in Washington state specified by the provider.

(6) When a contract is terminated, final settlement must not be made until accessibility to and preservation of the provider's records within Washington state is assured.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0280, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0285 What if a provider fails to maintain records or refuses to let them be reviewed? (1) If a provider fails to maintain adequate records or fails to allow their inspection by authorized personnel, DSHS may suspend all or part of subsequent reimbursement payments due under the contract.

(2) Once the provider complies with the recording keeping and inspection provisions of their contract, DSHS must resume current contract payments and must release payments suspended while the provider was out of compliance.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0285, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0290 Does DSHS have a responsibility to retain provider reports? (1) DSHS must retain required reports for five years following their filing date.

(2) If at the end of five years there are unresolved audit issues surrounding a report, the report must be retained until those issues are resolved.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0290, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0295 Are the reports submitted to DSHS by providers available to the public? According to chapter 388-01 WAC, all required financial and statistical reports submitted by ICF/MR facilities to DSHS are public documents and available to the public upon request.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0295, filed 4/20/01, effective 5/21/01.]

[Title 388 WAC—p. 1302]

FIELD AUDITS

WAC 388-835-0300 What is an ICF/MR field audit?

A field audit consists of an on-site audit of the provider's financial records to verify that information provided on the cost report for the period being audited is accurate and represents allowable cost.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0300, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0305 When does DSHS schedule a field audit? (1) DSHS may schedule cost report field audits using auditors employed by or under contract with DSHS. DSHS must notify a facility selected for an audit within one hundred twenty days after the facility submits a completed and correct cost report.

(2) DSHS must give priority to field audits of final annual reports and, whenever possible, must begin these audits within ninety days after a properly completed final annual report is received.

(3) DSHS normally notifies a provider at least ten working days before the field audit begins.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0305, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0310 When does DSHS complete a field audit? (1) If auditors are given timely access to a ICF/MR facility and to all records necessary to conducting their audit, DSHS must complete an audit within one year:

(a) Of receiving a properly completed annual cost report; or

(b) After the facility is notified it has been selected for an audit.

(2) For a state ICF/MR, DSHS must complete a field audit within three years after a properly completed cost report is received if auditors are given timely access to the facility and all records necessary to conducting their audit.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0310, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0315 How should a provider prepare for a field audit? (1) A provider must allow auditors access to the ICF/MR facility and all financial and statistical records. These records must be available at a location in the state of Washington specified by the provider. They must include:

(a) All income tax returns relating to the audited cost report and work papers supporting the report's data; or

(b) Work papers related to resident trust funds.

(2) The provider must reconcile reported cost data with:

(a) Applicable federal income and payroll tax returns; and

(b) The financial statements for the period covered by the report.

(c) The reconciliation must be in a form that facilitates verification by the auditors.

(3) The provider must designate and make available to the auditors at least one individual familiar with the internal operations of the facility being audited. The designated individual(s) must have sufficient knowledge and access to

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records to effectively respond to auditor questions and requests for information and documentation.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0315, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0320 What is the scope of a field audit? (1) Auditors must review a provider's record keeping and accounting practices and, where appropriate, make written recommendations for improvements.

(2) Auditors must examine a provider's financial and statistical records to verify that:

(a) Supporting records are in agreement with reported data; and

(b) Only assets, liabilities, and revenue and expense items that DSHS has specified as allowable costs have been included by the provider when computing the cost of services provided under the contract;

(c) Allowable costs have been accurately determined and are necessary, ordinary, and related to resident care;

(d) Related organizations and beneficial ownership interests have been correctly disclosed; and

(e) Resident trust funds have been properly maintained.

(3) Auditors must give the provider a draft of their audit narrative and summaries for review and comment before the final narratives and summaries are prepared.

(4) When an audit discloses material discrepancies, undocumented costs, or mishandling of patient trust funds, DSHS auditors, in order to determine if similar problem exist and take corrective action, may:

(a) Reopen a maximum of two prior unaudited cost reporting or trust fund periods; and/or

(b) Select future periods for audit.

(c) DSHS auditors may select reported costs and trust fund accounts for audit on a random or other basis.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0320, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0325 What if an auditor discovers that provider reports are inadequately documented? (1) An auditor must disallow any assets, liabilities, revenues, or expenses reported as allowable that are not supported by adequate documentation in the provider's financial records.

(2) Adequate documentation must show that reported costs were:

(a) Incurred during the period covered by the report;

(b) Related to resident care and training; and

(c) Necessary, ordinary and prudent.

(3) Adequate documentation must also show that reported assets were used to provide resident care and training.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0325, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0330 Are final audit narratives and summaries available to the public? The auditor's final audit narrative and summaries are considered public documents and will be available to the public through the public disclosure process in chapter 388-01 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0330, filed 4/20/01, effective 5/21/01.]

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RESIDENT TRUST ACCOUNTS

WAC 388-835-0335 What general requirements apply to accounting for resident trust accounts? (1) A provider must establish and maintain a bookkeeping system for all resident money received by the facility on behalf of the resident.

(2) This system must be incorporated into the facility's business records and be capable of being audited.

(3) The bookkeeping system must apply to residents that are:

(a) Incapable of handling their money and whose guardian, relative, DDD regional service office administrator, or physician requests in writing that the facility accept this responsibility. (If the Social Security Form SSA-780, "Certificate of Applicant for Benefits on Behalf of Another," is used as documentation, it must be signed by one of the persons designated in this subsection.)

(b) Capable of handling their own money, but they ask the facility, in writing, to accept this responsibility for them.

(4) It is the facility's responsibility to maintain written authorization requests in a resident's file.

(5) A resident must be given at least a quarterly reporting of all financial transactions affecting their account. The resident's representative payee, guardian and/or other designated agents must be sent a copy of this quarterly report or any other reports related to the resident's account.

(6) Facilities must purchase surety bonds, or otherwise provide assurances or security satisfactory to DSHS, that assures the security of all resident personal funds deposited with them.

(7) Facilities may not require residents to deposit personal funds with them. A facility may hold a resident's personal funds only if the resident or resident's guardian gives written authorization to do so.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0335, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0340 What specific accounting procedures apply to resident trust accounts? (1) A provider must maintain a subsidiary ledger with an account for each resident for whom the provider holds money in trust.

(2) Each account and related supporting information must be:

(a) Maintained at the facility;

(b) Kept current;

(c) Balanced each month; and

(d) Detailed, with supporting verification, showing all money received on behalf of the individual resident and how that money was used.

(3) A provider must make each resident trust account available to DSHS representatives for inspection and audit.

(4) A provider must maintain each resident trust accounts for a minimum of five years.

(5) A provider must notify the DDD regional service office when an individual's account balance is within one hundred dollars of the amount listed on their award letter.

(6) A resident can accumulate funds by:

(a) Not spending their entire clothing and personal incidentals allowance; and

(b) Saving other income DSHS specifically designates as exempt.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0340, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0345 Can residents overdraw their trust account? (1) A resident may not overdraw their account (show a debit balance).

(2) If residents want to spend an amount greater than the balance in their trust account, the facility may loan the residents money from facility funds.

(3) The facility can collect loans to residents by installments from the portion of the resident's allowance remaining at the end of each month.

(4) The facility cannot charge residents interest on these loans.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0345, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0350 Can a resident trust account be charged for Title XIX services? Resident trust accounts cannot be charged for services provided under Title XIX.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0350, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0355 Can a resident trust account be charged for medical services, drugs, therapy and equipment? (1) Any properly made charge to a resident's trust account for medical services must be supported by a written denial from DSHS.

(2) Any request for additional equipment such as a walker, wheelchair or crutches must have a written denial from DSHS before a resident's trust account can be charged.

(3) A request for physical therapy, certain drugs or other medical services must have a written denial from DSHS before a resident's trust account can be charged.

(4) A written denial from DSHS is not required when the pharmacist verifies a drug is not covered by the program (e.g., items on the FDA list of ineffective or possible effective drugs, nonformulary over-the-counter (OTC) medications such as vitamins, nose drops, etc.) The pharmacist's notation that the program does not cover the drugs is sufficient.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0355, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0360 Can providers create petty cash funds for residents? (1) Providers may maintain petty cash funds for residents.

(2) The fund must be an imprest type fund.

(3) The cash for the fund must come from trust money.

(4) The amount of the fund must be reasonable and necessary for the size of the facility and the needs of the residents, but must not exceed five hundred dollars.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0360, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0365 Can providers create checking accounts for residents? (1) A provider must deposit all money, over and above the trust fund petty cash amount,

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intact into a trust fund checking account that is separate and apart from any other bank account(s) of the facility or other facilities.

(2) Deposits of resident allowances must be made intact into the trust checking account within one week from the time payment is received from DSHS, social security administration, or any other payor.

(3) A provider must make any related bankbooks, bank statements, check book, check register, all voided and all canceled checks available to DSHS representatives for audit and inspection. The provider must retain these supporting records and documents for at least five years.

(4) Resident trust money cannot be used to pay checking account service charges.

(5) Each bank's trust account must be reconciled each month to the trust account ledger for each resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0365, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0370 What controls must a provider use to ensure the safety of trust fund money? (1) A provider must not release trust fund money to anyone other than the:

(a) Resident or, with their written consent, their guardian;

(b) Resident's designated agent as appointed by power of attorney; or

(c) Appropriate DSHS personnel designated by the DDD regional services administrator.

(2) A provider must complete a receipt, in duplicate, when money is received. One copy must be given to the person making the payment or deposit and the other copy must remain in the receipt book for easy reference.

(3) All residents must endorse, with their own signature, any checks or state warrants they receive. Only when a resident is incapable of signing their own name may the provider use the resident's "X" mark followed by their printed name and the signature of two witnesses.

(4) When both a general fund account and a trust fund account are kept at the same bank, the trust account portion of any deposit can be deposited directly to the trust account.

(5) A provider must credit a resident's trust account ledger sheet when the resident's allowance is received. This entry must be referenced with the receipt number and must be supported by a copy of the deposit slip (one copy for all deposits made).

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0370, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0375 Can a resident withdraw trust money? Any money held in trust for a resident must be available to them for their personal and incidental needs upon their request or the request of one of the individuals designated in WAC 388-835-0335.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0375, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0380 What happens to resident funds when a change of ownership occurs? (1) When a facility is sold or some other transfer of ownership takes place, the

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former provider must provide the new provider with a written accounting, based upon generally accepted auditing standards, of all resident funds being transferred. The former provider must also obtain a written receipt for the funds from the new provider.

(2) Before any transfer of ownership occurs, the facility must give each resident, or their representative, a written accounting of any personal funds held by the facility.

(3) If there is disagreement regarding the accounting offered by the former provider, the resident retains all rights and remedies provided under state law.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0380, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0385 How are trust fund monies refunded? When a resident is discharged and/or transferred, the balance of their trust account, along with a receipt, will be returned to the individual designated in WAC 388-835-0335 within thirty days of the resident's transfer or discharge.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0385, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0390 How are trust funds liquidated?

(1) In the case of deceased resident, the provider must obtain a receipt from the next-of-kin, guardian, or duly qualified agent when the balance of the trust fund is released. If the next-of-kin, guardian or duly qualified agent cannot be identified, the DDD regional service office must be contacted, in writing within seven days of the resident's death, to assist in the release of the resident's trust fund money. A check or other document showing payment to the next-of-kin, guardian, or duly qualified agent will serve as a receipt.

(2) In situations where the resident leaves the ICF/MR facility without authorization and their whereabouts is unknown, the facility:

(a) Will make a reasonable attempt to locate the missing resident. A "reasonable attempt" includes, but is not limited to, contacting friends, relatives, police, the guardian, and the DDD regional office in the area; and

(b) If the resident cannot be located after ninety days, the facility must notify the department of revenue regarding the existence of "abandoned property" (see chapter 63.29 RCW Uniform Unclaimed Property Act). The facility must deliver to the department of revenue the balance of the resident's trust fund account within twenty days following their notification.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0390, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0395 How must a facility maintain resident property records? (1) A facility must maintain a current, written record for each resident that includes written receipts for all personal property entrusted to the facility by the resident.

(2) All property records must be available to the resident or designated resident representative (see WAC 388-835-0380).

(3) A facility must issue or obtain written receipts when taking possession or disposing of a resident's personal property. The facility must retain copies and/or originals of these receipts.

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(4) A facility must maintain all resident property records so they are available to auditors and in a manner that facilitates the audit process.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0395, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0395, filed 4/20/01, effective 5/21/01.]

ALLOWABLE AND UNALLOWABLE COSTS

WAC 388-835-0400 What are allowable costs? (1)

Allowable costs are documented costs that are necessary, ordinary, related to providing ICF/MR services to ICF/MR residents, and not expressly declared nonallowable by applicable statutes or regulations. Costs are ordinary if they are of the nature and magnitude that a prudent and cost conscious management would pay.

(2) Allowable costs do not include increased costs resulting from transactions or the application of accounting methods which circumvent the principles of the prospective cost-related reimbursement system.

(3) DSHS does not allow increased costs resulting from a series of transactions between the same parties and involving the same assets (e.g., sale and leaseback, successive sales or leases of a single facility or piece of equipment).

(4) When a provider requests a rate adjustment according to WAC 388-835-0900 or 388-835-0905, any cost audited previously and not disallowed is subject to DSHS review and reconsideration according to the criteria in this section.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0400, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0405 What are unallowable costs? (1)

Costs are unallowable if they are not documented, necessary, or ordinary and do not relate to providing services to ICF/MR residents.

(2) Examples of unallowable costs include, but are not limited to, the following:

(a) Costs of items or services not covered by the Medicaid program. Costs of nonprogram items or services will not be allowed even if indirectly reimbursed by DSHS as a result of an authorized reduction in resident contribution.

(b) Costs of services and items provided to ICF/MR residents covered by DSHS's medical care program but not included in ICF/MR services.

(c) Costs associated with a capital expenditure subject to Section 1122 approval (part 100, Title 42 CFR) if DSHS found the expenditure was not consistent with applicable standards, criteria, or plans. If DSHS was not given timely notice of a proposed capital expenditure, all associated costs will not be allowed as of the date the costs were determined to be nonreimbursable under applicable federal regulations.

(d) Costs associated with a construction or acquisition project that requires certificate of need approval according to chapter 70.38 RCW and that approval was not obtained.

(e) Costs associated with outside activities (e.g., costs allocable to the use of a vehicle for personal purposes, or related to the part of a facility leased out for office space).

(f) All salaries or other compensation of officers, directors, stockholders, and others associated with the provider or

home office, except compensation paid for services related to resident care and training.

(g) Costs in excess of limits set in this chapter or costs violating principles contained in this chapter.

(h) Costs resulting from transactions or the application of accounting methods used to circumvent the principles of the prospective cost-related reimbursement system.

(i) Costs applicable to services, facilities, and supplies furnished by a related organization in excess of the lower of cost to the related organization or market meaning the price paid for comparable services, facilities or supplies when purchased in an arms length transaction.

(j) Balances of accounts that cannot be collected (bad debts or uncollectable accounts).

(k) Charity and courtesy allowances.

(l) Cash, assessments, or other contributions to political parties, and cost incurred to improve community or public relations. Dues to charitable organizations, professional organizations and trade associations are allowable costs.

(m) Any portion of trade association dues for legal and consultant fees and costs related to lawsuits or other legal action against DSHS.

(n) Travel expenses for trade association boards of directors in excess of the twelve allowable meetings per calendar year.

(o) Vending machine expenses.

(p) Expenses for barber or beautician services not included in routine care.

(q) Funeral and burial expenses.

(r) Costs of gift shop operations and inventory.

(s) Personal items such as cosmetics, smoking materials, newspapers and magazines, and clothing, except items used in resident activity programs or in ICF/MR programs where clothing is a part of routine care.

(t) Fund-raising expenses except those directly related to the resident activity program.

(u) Penalties and fines.

(v) Expenses related to telephones, televisions, radios, and similar appliances in a resident's private accommodations.

(w) Federal, state, and other income taxes.

(x) Costs of special care services, except where authorized by DSHS.

(y) Expenses for "key-person" insurance and other insurance or retirement plans not available to all employees.

(z) Expenses of profit-sharing plans.

(aa) Expenses related to the purchase and/or use of private or commercial aircraft that exceed what a prudent provider would spend for ordinary and economical transportation when conducting resident care business.

(bb) Personal expenses and allowances of owners or relatives.

(cc) All expenses of maintaining professional licenses or membership in professional organizations.

(dd) Costs related to agreements not to compete.

(ee) Goodwill and the amortization of goodwill.

(ff) Expenses related to vehicles in excess of what a prudent provider would expend for the ordinary and economic provision of transportation needs related to resident care.

(gg) Legal and consultant fees related to a fair hearing against DSHS. Including but not limited to, fees for account-

ing services used to prepare for an administrative judicial review resulting in a final administrative decision favorable to DSHS or where DSHS's decision is allowed to stand.

(hh) Legal and consultant fees related to a lawsuit against DSHS, including suits appealing administrative decisions.

(ii) Lease acquisition costs and other intangibles not related to resident care and training.

(jj) Interest charges assessed by the state of Washington for failure to make timely refund of overpayments and interest expenses incurred for loans obtained to make such refunds.

(kk) Travel expenses outside the states of Idaho, Oregon, and Washington and the Province of British Columbia except travel to and from the home and central office of a chain organization operation outside those areas if the travel is necessary, ordinary, and related to resident care and training.

(ll) Moving expenses of employees when a demonstrated, good-faith effort has not been made to recruit employees within the states of Idaho, Oregon, and Washington and Province of British Columbia.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0405, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0410 Can a provider offset miscellaneous revenues against allowable costs?

(1) A provider must reduce allowable costs whenever the item, service, or activity covered by the costs generate revenue or financial benefits (e.g., purchase discounts or rebates) other than through the provider's normal billing for ICF/MR services.

(2) A provider must not deduct unrestricted grants, gifts, endowments, and interest earned from them from the allowable costs of a nonprofit facility.

(3) When goods or services are sold, the reduction in allowable costs must be the actual cost of the item, service, or activity. If actual cost cannot be accurately determined, the reduction must be the full amount of the revenue received. When financial benefits such as purchase discounts or rebates are received, the reduction must be the amount of the discount or rebate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0410, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0415 Are the costs of meeting required standards allowable costs?

(1) All necessary and ordinary expenses incurred by a provider to meet required standards associated with providing ICF/MR services are allowable costs.

(2) Examples are the cost of:

(a) Meeting licensing and certification standards;

(b) Fulfilling accounting and reporting requirements imposed by this chapter; and

(c) Performing any resident assessment activity required by DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0415, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0420 Are costs associated with related organizations allowable costs?

(1) DSHS allows costs applicable to services, facilities, and supplies furnished to a

provider by a related organization only to the following extent:

(a) The costs do not exceed the lower of the cost to the related organization; or

(b) Market, meaning the price paid for comparable services, facilities, or supplies when purchased in an arm's length transaction.

(2) Private facilities must make all cost documentation regarding related organizations available to the auditors at the time and place the entity's financial records are audited. State facilities must make all cost documentation regarding related organizations available to the auditors at DSHS's offices of accounting services, financial recovery, or budget when the facility is audited.

(3) DSHS disallows all payments to or for the benefit of a related organization where the cost to the related organization cannot be documented.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0420, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0425 Are start-up costs allowable costs? DSHS allows all necessary and ordinary start-up costs in the administration and operations rate component. Start-up costs must be amortized over at least sixty consecutive months beginning with the month the first resident is admitted for care.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0425, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0430 Are organizational costs allowable costs? (1) DSHS allows necessary and ordinary costs directly related to the creation of a provider's corporation or other form of business that are incurred before the admission of the first resident.

(2) DSHS allows these costs in the administration and operation cost area if they are amortized over at least sixty consecutive months beginning with the month in which the first resident is admitted for care.

(3) Examples of allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization and fees paid to states for incorporation.

(4) Organization costs do not include costs relating to the issuance and sale of shares of stock or other securities.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0430, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0435 Are education and training costs allowable costs? (1) DSHS allows ordinary expenses associated with on-the-job and in-service training required for employee orientation and certification when those expenses directly relate to performing an employee's assigned duties.

(2) Ordinary expenses for staff training are allowable costs.

(3) Necessary and ordinary expenses for recreational and social activity training conducted by a provider for volunteers are allowable costs.

(4) Training program expenses for other nonemployees are not allowable costs, except the costs associated with training county-contracted training program employees by an

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ICF/MR as a condition of the ICF/MR's agreement with the county-contracted training program.

(5) DSHS must allow expenses for travel in the states of Idaho, Oregon, and Washington and Province of British Columbia associated with education and training if the expenses meet the requirements of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0435, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0440 Are operating lease costs allowable costs? Facility and/or equipment rental or lease costs associated with an arm's length operating lease are allowable costs.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0440, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0445 Are rental expenses paid to related organizations allowable costs? The expense of renting facilities or equipment from a related organization are allowable to the extent that the rent paid does not exceed the related organization's costs of owning (e.g., depreciation, interest on a mortgage) or leasing the assets. Computing the related organization's cost of owning or leasing the asset must be according to the requirements of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0445, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0450 What is allowable interest? (1) DSHS allows a provider's necessary and ordinary interest costs incurred for working capital loans and capital indebtedness.

(a) "Necessary" means the interest expense must be incurred in connection with a loan satisfying a financial need of the provider and for a purpose related to resident care and training. Interest expense related to a business opportunity or goodwill is unallowable.

(b) "Ordinary" means the interest rate for the loan must not exceed the rate a prudent borrower would pay, in an arm's length transaction, for a comparable loan in the money market at that time.

(c) Interest expense must include amortization of bond discounts and expenses related to the bond issue. The amortization period must be the period from the date the bonds are sold to their maturity date or their date of extinguishment if they are retired before they mature.

(d) Interest expense for assets acquired in a change of ownership after September 30, 1984, is disallowed on any loan principal in excess of the former owner's depreciation base on July 18, 1984.

(2) Interest that is paid to or for the benefit of a related organization is allowed but only to the extent that the actual interest does not exceed the related organization's cost of using the funds.

(3) For construction loans, a provider must capitalize interest expense and loan origination fees incurred during the period of construction. Such costs must be amortized over the life of the constructed asset beginning with the date the first resident is admitted or the date the asset is put into service, whichever occurs first.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0450, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0455 Can a provider offset interest income against allowable costs? Except for nonprofit facilities, a provider must deduct from allowable interest expense all interest income earned from either investing or lending nonrestricted and restricted funds.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0455, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0460 How does DSHS calculate total compensation for owners and relatives? (1) Total compensation means the compensation provided in the employment contract, including benefits. The employment contract can be written, verbal, or inferred from the acts of the parties.

(2) In the absence of a contract, total compensation includes gross salary or wages and fringe benefits (e.g., health insurance) available to all employees.

(3) Total compensation does not include payroll taxes paid by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0460, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0465 How does DSHS define owner or relative compensation? (1) DSHS limits the total compensation of an owner or an owner's relative to the ordinary compensation for necessary services actually performed.

(a) Compensation is ordinary if it is the amount usually paid for comparable services in a comparable facility to an unrelated employee, and does not exceed limits established in this chapter.

(b) A service is necessary if it is related to resident care and training and would have to be performed by another person if the owner or relative did not perform it.

(2) A provider, in maintaining customary time records adequate for audit, must include time records for owners and relatives receiving compensation. These records must document how compensated time was spent performing necessary services.

(3) For purposes of this section, if the provider is a corporation, "owner" includes all corporate officers and directors.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0465, filed 4/20/01, effective 5/21/01.]

CAPITALIZED COSTS AND DEPRECIATION

WAC 388-835-0470 What requirements apply to capitalizing equipment, including furniture and furnishings? A provider must capitalize equipment, including furniture and furnishings according to the following table:

Equipment, including furniture and furnishings	Historical cost	Useful life
For settlement purposes beginning January 1, 1881 and for rate setting purposes beginning July 1, 1982	At least \$500 per item	At least one year from date asset is put into service

[Title 388 WAC—p. 1308]

Equipment, including furniture and furnishings	Historical cost	Useful life
For settlement purposes beginning January 1, 1990 and for rate setting purposes beginning July 1, 1990	At least \$1,000 per item	At least one year from date asset is put into service
For settlement purposes beginning January 1, 1996 and for rate setting purposes beginning July 1, 1996	At least \$500 per item	At least one year

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0470, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0475 What requirements apply to capitalizing buildings, other real property items, components, improvements and leasehold improvements? Buildings and other real property items, components, improvements and leasehold improvements must be capitalized if they are:

- (1) Required or authorized by the lease agreement;
- (2) Cost more than five hundred dollars; and
- (3) Involve at least one of the following:
 - (a) Increase the interior floor space of the structure;
 - (b) Increase or renew paved areas outside the structure that are either adjacent to the structure or provide access to it;
 - (c) Modification to the exterior or interior walls of the structure;
 - (d) Installation of additional heating, cooling, electrical, water-related, or similar fixed equipment;
 - (e) Landscaping or redecorating; or
 - (f) Increasing the structure's useful life by at least two years.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0475, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0480 How are the useful lives of leasehold improvements determined? The useful lives for all leasehold improvements are based upon the American Hospital Association (AHA) guidelines for the applicable asset.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0480, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0485 What are depreciable assets? Depreciable assets are tangible assets that are subject to depreciation and in which a provider has an ownership interest.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0485, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0490 What are some examples of depreciable assets? Some examples of depreciable assets are:

- (1) Buildings, meaning the basic structure or shell and additions to it.
- (2) Equipment such as elevators, heating system, and air conditioning system that are attached to a building and characterized by:

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- (a) An economic useful life of at least three years but shorter than the life of the building to which it is attached;
- (b) Incapable of being removed from the building to which it is attached;
- (c) A unit cost sufficiently large enough to justify ledger control; and
- (d) A physical size and identity that makes control by identification tags possible.

(3) Equipment not attached to buildings.

(4) Land improvements such as paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, wall, etc., where replacement is the responsibility of the provider.

(5) Leasehold improvements and additions made by the lessee belong to the lessor after the lease expires.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0490, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0495 What is "minor equipment"?

Minor equipment includes items such as wastebaskets, bedpans, syringes, catheters, silverware, mops, and buckets.

(2) Minor equipment is generally characterized as:

(a) Not occupying a fixed location and is used by a variety of departments;

(b) Small in size and unit cost;

(c) Subject to inventory control;

(d) A fairly large number of items are in use; and

(e) Possessing a useful life of one to three years.

(3) If properly capitalized (see WAC 388-835-0230), minor equipment is depreciated. If not properly capitalized, minor equipment is expensed when acquired.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0495, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0500 Is land a depreciable asset?

Because the economic useful life of land is considered to be unlimited, land is not a depreciable asset.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0500, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0505 What costs are included in the capitalized cost of land? Examples of costs that are capitalized as land costs include the cost of:

(1) Off-site sewer and water lines;

(2) Public utility charges necessary to service the land;

(3) Government assessments for street paving and sewers;

(4) Permanent roadways and grading of a nondepreciable nature; and

(5) Curbs and sidewalks, the replacement of which is not the responsibility of the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0505, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0510 What is the depreciation base of a tangible asset? (1) The depreciation base of a tangible asset is the asset's historical cost at the time it is acquired by the provider in an arm's length transaction:

(a) Plus the cost of preparing the asset for use;

(b) Less the asset's estimated salvage value, if any, where the straight-line or sum-of-the-years digits methods of depreciation is used;

(c) Less any goodwill; and

(d) Less any accumulated depreciation incurred during periods the asset was used by the provider personally or in another business.

(2) When depreciable assets are acquired from a related organization, the provider's depreciation base cannot exceed the base the related organization had or would have had under a contract with DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0510, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0515 Can an appraisal be used to establish historical cost? (1) If DSHS challenges the historical cost of an asset or if a provider is unable to adequately document the historical cost of an asset, the department may use an appraisal process to establish the asset's fair market value at the time of purchase.

(2) If an appraisal process is used to establish the fair market value of equipment, vendors dealing in that particular type of equipment must perform the appraisals.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0515, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0520 What is the depreciation base of a donated or inherited asset? (1) The depreciation base of donated and/or inherited assets is the lesser of:

(a) Fair market value at the date of donation or death, less goodwill. (Any estimated salvage value must be deducted from fair market value when either the straight-line or sum-of-the-years digits method of depreciation is used); or

(b) The historical cost of the last owner to contract with DSHS, if any.

(2) If the donation or distribution is between related organization, the base must be the lesser of:

(a) Fair market value, less goodwill and, where appropriate, salvage value, or

(b) The depreciation base the related organization used or would have used when contracting with DSHS.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0520, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0525 How is the useful life of a depreciable asset determined? (1) Except for buildings, a provider must not adopt useful lives shorter than the guideline lives contained in the Internal Revenue Service class life ADR system or published by the American Hospital Association. Thirty years is the shortest useful life a provider can adopt for buildings.

(2) Useful life is measured from the date of the most recent arm's length acquisition of the asset.

(3) Building improvements to owned or leased buildings must be depreciated over the remaining useful life of the building or fifteen years, whichever is greater, except for improvements to licensed boarding home facilities required by the Fire Safety Evaluation System (FSES) of the 1984 Life Safety Code. Improvements to these licensed boarding home facilities must be depreciated for at least five years. A pro-

vider must receive DSHS approval before following this exception.

(4) Improvements to leased property that are, according to the lease agreement, the responsibility of the provider must be depreciated over the useful life of the improvement, except for improvements to licensed boarding home facilities required by the Fire safety Evaluation System (FSES) of the 1984 Life Safety Code. Improvements to these licensed boarding home facilities must be depreciated for at least five years. A provider must receive DSHS approval before following this exception.

(5) A provider may change the estimated useful life of an asset to a longer period if necessary.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0525, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0530 What depreciation methods are approved by DSHS? (1) Buildings, building improvements, land improvements, leasehold improvements, and fixed equipment must be depreciated using the straight-line method.

(2) Equipment must be depreciated using the straight-line method, the sum-of-the-years digits method, or the declining balance method at a rate not to exceed one hundred fifty percent of the straight-line rate. Providers electing to use either the sum-of-the-years digits method or the declining balance method may change to the straight-line method without permission of the department.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0530, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0535 What is depreciation expense?

(1) Depreciation expense on tangible assets used to provide ICF/MR services is an allowable cost.

(2) Depreciation expense must be:

(a) Identifiable and recorded in the provider's accounting records; and

(b) Computed using the depreciation base, useful lives and methods specified in this chapter.

(3) If a provider reports annual depreciation expense that includes depreciation on assets unrelated to resident care and training, the annual reported expense must be reduced accordingly.

(4) Once a tangible asset is fully depreciated, no additional depreciation can be claimed unless a new depreciation base is established according to the rules of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0535, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0540 Can providers claim depreciation on assets that are abandoned, retired or disposed of in some other way? (1) Depreciation cannot be claimed on tangible assets that are sold, traded, scrapped, exchanged, stolen, wrecked or destroyed by fire or some other casualty.

(2) Depreciation cannot be claimed on permanently abandoned assets.

(3) If an asset has been retired from active use but is being held for stand-by or emergency service and DSHS has determined that the asset is needed and can be effectively

used in the future, depreciation may be claimed by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0540, filed 4/20/01, effective 5/21/01.]

GAINS AND LOSSES ON RETIRED ASSETS

WAC 388-835-0545 How must providers account for gains and losses on the retirement of tangible assets? For settlement purposes beginning with January 1, 1981 and for rate setting purposes beginning with the July 1, 1982 rate period, the rules in WAC 388-835-0265 through 388-835-0275 apply.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0545, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0550 How are gains and losses calculated when a tangible asset is retired? When a tangible asset is retired, the difference between the assets undepreciated base and any proceeds received from its retirement is considered a gain or loss on retirement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0550, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0555 How must providers account for gains and losses on retired assets that are replaced? If a provider replaces a retired asset, any gain or loss on retirement must be deducted from or added to the cost of the replacement asset, respectively. However, a loss on retirement can only be added to the replacement asset's cost if the provider makes a reasonable effort to recover at least the outstanding book value of the retired asset.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0555, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0560 How must providers account for gains and losses on retired assets that are not replaced?

(1) If a retired asset is not replaced the gain or loss on retirement must be spread over the actual life of the asset up to the date of retirement. However, a loss can only be spread if the provider has made a reasonable effort to recover at least the outstanding book value of the retired asset.

(2) DSHS will calculate any difference between the actual reimbursements paid and the amount of reimbursement that should be paid after the gain or loss is spread. If the difference results from a gain DSHS must recover the difference from the provider. If the difference results from a loss the difference will be added to allowable costs when determining the settlement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0560, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0565 How must providers account for gains and losses on retired assets if they terminate their contract with DSHS? If a retired asset is not replaced and the provider is terminating their contract with DSHS, the gain or loss on retirement must be accounted for according to the requirements in WAC 388-835-0280.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0565, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0570 Can DSHS recover reimbursements for depreciation expense? If a provider terminates their contract without selling or otherwise retiring equipment that was depreciated using an accelerated method, depreciation schedules for this equipment for those periods when the provider participated in the ICF/MR program must be adjusted. DSHS will recover any difference between reimbursement actually paid for depreciation and the reimbursement that would have been paid if the straight-line method had been used.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0570, filed 4/20/01, effective 5/21/01.]

REIMBURSEMENT RATES

WAC 388-835-0575 What requirements apply to calculating ICF/MR reimbursement rates? (1) Medicaid program reimbursement rates established according to this chapter apply only to facilities holding appropriate state licenses and certified to provide ICF/MR services according to state and federal laws and regulations.

(2) All rates must be reasonable and adequate to meet the costs incurred by economically and efficiently operated facilities providing ICF/MR services according to state and federal laws and regulations.

(3) For private facilities:

(a) Final payments must be the lower of the facility's prospective rate or allowable costs.

(b) Prospective rates must be determined according to WAC 388-835-0845, 388-835-0850, 388-835-0860, 388-835-0865, 388-835-0870, 388-835-0875, and 388-835-0880.

(c) Final payments must be determined according to WAC 388-835-0880.

(4) For state facilities:

(a) Final payments must be the facility's allowable costs.

(b) Interim rates must be calculated using the most recent annual reported costs (see WAC 388-835-0845) divided by the total resident days during the reporting period. These costs may be adjusted to incorporate federal, state, or department changes in program standards or services.

(c) Final payments must be determined according to WAC 388-835-0880.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0575, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0575, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0580 What program services are not covered by DSHS prospective reimbursement rates? Medical services that are part of DSHS's medical care program but not included in ICF/MR services are not covered by prospective reimbursement rates. Payments are made directly to the service provider according to WAC 388-835-0835 requirements.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0580, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0585 What requirements apply to prospective reimbursement rates for new providers? (1) A prospective reimbursement rate for a new provider must be established within sixty days after DSHS receives a properly

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completed projected budget from the provider. The effective date of the reimbursement rate must be the same as the effective date of the contract.

(2) The prospective reimbursement rate must be based on the:

(a) Provider's projected cost of operation;

(b) Costs and payment rates of the prior provider, if any; and/or

(c) Costs and payment rates, taking into account applicable lids or maximums, of other providers in comparable circumstances.

(3) If DSHS does not receive a properly completed projected budget at least sixty days before the contract's effective date, a preliminary rate, based on information from former and/or comparable providers, will be prepared by DSHS. This preliminary rate must remain in effect until an initial prospective rate can be set.

(4) If a change of ownership takes place that does not result from an arm's length transaction, the new provider's prospective rates for administration, operations and property costs cannot exceed the former provider's rates. The former provider's rates can be adjusted, if necessary, to reflect changes in economic trends.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0585, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0590 How are reimbursement rates calculated? (1) Each provider's reimbursement rate must be recalculated once each calendar year. The recalculated rate will be implemented prospectively. The recalculated rate will be effective on July 1 of the calendar year in which it was computed. Rates may be recalculated to reflect legislative inflation adjustments or to comply with the requirements of WAC 388-835-0900.

(2) If a provider participated in the ICF/MR program for at least six months during the previous calendar year, their rates must be based on the prior period's allowable costs. If the provider participated in the program for less than six months in the previous calendar year, their rates must be calculated according to WAC 388-835-0840 requirements.

(3) Unless circumstances beyond DSHS's control interfere, all providers submitting correct and complete cost reports by March 31 must receive notification of their new rates by July 1.

(4) When calculating a provider's rate, DSHS must use data from the most recent and complete cost report submitted by the provider and reviewed by DSHS as described in WAC 388-835-0700.

(5) Inflation factor adjustments are based on the Implicit Price Deflator for Personal Consumption from the state of Washington, Economic and Revenue Forecast prepared by the Office of the Forecast Council.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0590, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0595 When does DSHS review a provider's annual cost report? DSHS must review and analyze each annual cost report within six months after it is properly completed and filed with the department.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0595, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0600 What is the purpose of reviewing a provider's annual cost report? DSHS reviews and analyzes annual cost reports to determine if the information contained in them is correct, complete, and reported according to generally accepted accounting principles, the requirements of this chapter and any other applicable rules and instructions issued by the department.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0600, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0605 What is the scope of an annual cost report review? (1) DSHS' review and analysis may include, but is not limited to:

- (a) An examination of prior years reported costs;
- (b) An examination of any cost report review adjustments made in prior years and their final disposition;
- (c) An examination of findings, if any, from prior year cost report field audits; and
- (d) Findings, if any, from the field audit of the cost report currently being reviewed.

(2) If it appears that a provider incorrectly calculated or reported their costs, DSHS may:

- (a) Request additional information from the provider;
- (b) Schedule a special field audit of the provider; or
- (c) Make adjustments to the reported information. If adjustments are made, DSHS must give the provider a schedule of the adjustments including an explanation for each one and the dollar amount associated with each one.

(3) If the provider believes that DSHS adjustments are incorrect, the adjustments must be reviewed according to WAC 388-835-0900. If this review does not satisfactorily resolve the dispute, the adjustment must be further reviewed according to WAC 388-835-0910.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0605, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0610 Can DSHS accumulate cost report information and use it for department purposes? DSHS may accumulate data from properly completed cost reports for:

- (1) Use in exception profiling and establishing rates; and
- (2) Analytical, statistical, or informational purposes that the department considers important.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0610, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0615 What are component rates and cost centers? (1) A provider's overall ICF/MR resident reimbursement rate consists of five component rates within three cost centers.

(2) The five component rates are:

- (a) Resident care and habilitative services;
- (b) Food;
- (c) Administration and operations;
- (d) Property; and
- (e) Return on equity.

(3) The three cost centers are:

- (a) Resident care and habilitation;
- (b) Administration, operations, and property; and
- (c) Return on equity.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0615, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0620 What reimbursement requirements apply to resident care and habilitation cost centers? (1) Resident care and habilitation cost centers at facilities with at least sixteen residents and licensed as a nursing facility, must, according to applicable federal and state regulations, reimburse for resident living services, habilitative and training services, recreation services, and nursing services.

(2) Resident care and habilitation cost centers at facilities with less than sixteen residents and licensed as a boarding home, must, according to applicable federal and state regulations, reimburse for resident living services, habilitative and training services, recreation services, and nursing services. These cost centers must also reimburse for resident care and training staff who perform any of the administration and operations functions specified in WAC 388-835-0870.

(3) A facility's resident care and habilitation cost center rate must be its most recent reported costs per resident day adjusted for inflation.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0620, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0625 What requirements apply to administration, operations and property cost center rates? Administration, operations, and property cost center rates are the sum of three separate rate components:

(1) The food rate component established by WAC 388-835-0865;

(2) The administration and operations rate component established by WAC 388-835-0870; and

(3) The property rate component established by WAC 388-835-0875.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0625, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0630 What is the food rate component? The food rate component reimburses for the necessary and ordinary costs of a resident's bulk and raw food, dietary supplements, beverages with meals and nourishment between meals.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0630, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0635 Is there a limit to the allowable cost for administrative personnel? Compensation for administrative personnel is an allowable cost within the limits contained in this section:

(1) For purposes of this section "compensation" means gross salaries, wages, and the applicable cost of fringe benefits made available to all employees. Compensation does not include payroll taxes paid by the provider.

(2) A licensed administrator's total compensation for actual services rendered to an ICF/MR facility on a full-time basis (at least forty hours per week, including reasonable vacation, holiday, and sick time) is allowable at the lower of:

- (a) Actual compensation received; or

(b) For calendar year 2000, the amount specified in the following table that corresponds to the number of set-up beds in the facility.

Number of set-up beds	Maximum compensation
15 or less	\$42,886
16 to 79	\$47,739
80 to 159	\$52,832
160 and up	\$56,163

(c) The maximum compensation amounts will be adjusted annually for inflation. Inflation factor adjustments are based on the Implicit Price Deflator for Personal Consumption from the state of Washington, Economic and Revenue Forecast prepared by the Office of the Forecast Council.

(d) A licensed administrator's compensation will be allowed only if DSHS is notified in writing within ten days following the start of their employment.

(3) Total compensation of not more than one full-time licensed assistant administrator will be allowed if there are at least eighty set-up beds in the ICF/MR facility. Compensation is allowable at the lower of:

(a) Actual compensation received; or

(b) Seventy-five percent of the amount specified in the above table.

(4) Total compensation of not more than one full-time registered administrator-in-training is allowed at the lower of:

(a) Actual compensation received; or

(b) Sixty percent of the amount specified by DDD in the above table.

(5) The cost of a licensed administrator, assistant administrator, or administrator-in-training is not an allowable expense in ICF/MR facilities with fifteen beds or less. The facility's qualified mental retardation professional (QMRP) will provide administrative services.

(6) A QMRP's total compensation of wages and/or salary is allowable at the lower of:

(a) Actual compensation received; or

(b) The amount specified in DDD in the above table.

(7) If a licensed administrator, licensed assistant administrator, registered administrator-in-training, or QMRP are employed on a less than full-time basis, allowable compensation must be the lower of:

(a) Actual compensation received; or

(b) The maximum amount allowed multiplied by the percentage derived from dividing actual hours worked plus reasonable vacation, holiday and sick time, by two thousand and eighty hours.

(8) A provider must maintain time records for any licensed administrators, assistant administrators, administrators-in-training, or QMRPs they employ.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0635, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0640 Can a provider hire an individual or firm to manage their ICF/MR facility? (1) A provider can enter into an agreement with an individual or firm to manage their ICF/MR facility as the provider's agent, however, the provider must submit a copy of the agreement to DSHS at least sixty days before it becomes effective.

(2007 Ed.)

(2) Copies of any amendments to a management agreement must be received by DSHS at least thirty days before the amendment become effective.

(3) Management fees for periods before DSHS receives a copy of the agreement are not allowable costs.

(4) The department may waive the sixty-day notice requirement to protect the health and safety of facility residents. Any waiver of the sixty-day notice requirement by DSHS must be in writing.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0640, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0645 Are management fees allowable costs? Management fees are allowable costs only when there is:

(1) A written management agreement that:

(a) Creates a principal and/or agent relationship between the provider and the manager; and

(b) Identifies the items, services, and activities that the manager will provide.

(2) Documentation that verifies the management service was performed.

(3) Assurance that the service performed was necessary and did not duplicate any service provided by the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0645, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0650 Are all management fee's allowable? Providers must limit the amount of allowable fees for general management services (including corporate management fees, business entity management fees, board of director fees and overhead and indirect costs associated with providing general management services) to:

(1) The maximum allowable compensation for a licensed administrator and, if the facility has at least eighty set-up beds, an assistant administrator even if one is not employed minus the actual compensation received by the licensed administrator and assistant administrator.

(2) The maximum allowable compensation for a QMRP at a ICF/MR facilities with fifteen beds or fewer, minus the actual compensation received by the QMRP.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0650, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0655 Are management fees involving a related organization allowable costs? (1) A management fee paid to or for the benefit of a related organization is allowable if it does not exceed the lesser of:

(a) The limits set out in WAC 388-835-0400; or

(b) The lower of the related organization's actual cost of providing necessary resident care and training services under the management agreement or the cost of comparable services purchased in an arm's length transaction elsewhere.

(2) If related organization costs are joint facility costs, their measurement must comply with the requirements of WAC 388-835-0400.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0655, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0660 How do overhead and indirect costs relate to allowable costs? (1) For general administrative and management services, costs such as central office costs, owner compensation, and other fees or compensation, including joint facility costs, must include the overhead and indirect costs associated with providing general management services that are not allocated to specific services.

(2) General administrative and management service costs as described in subsection (1) of this section are subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0660, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0665 Are travel and housing expenses of nonresident staff working at a provider's ICF/MR facility allowable costs? (1) All necessary travel and housing expenses of nonresident staff working at a provider's ICF/MR facility are allowable costs if their visit does not exceed three weeks.

(2) If the nonresident staff visit extends beyond three weeks, any travel and housing expenses are subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0665, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0670 Are bonuses paid to a provider's employees allowable costs? (1) Bonuses paid to employees at a provider's ICF/MR facility are compensation.

(2) Bonuses paid to central office employees are management costs that are subject to the management fee limits established in WAC 388-835-0405.

(3) Bonuses paid to other employees not located at an ICF/MR facility and performing managerial services are management costs that are subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0670, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0675 Are fees paid to members of the board of directors or corporations allowable costs? Fees paid to board of director members or corporations operating ICF/MR facilities are management costs subject to the management fee limits established in WAC 388-835-0405.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0675, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0680 How is the administration and operations rate component computed? (1) The administration and operations rate component includes reimbursement for the necessary and ordinary costs of:

- (a) Overall administration and management of the facility;
- (b) Operations and maintenance of the physical plant;
- (c) Resident transportation;
- (d) Dietary service (other than the cost of food and beverages);
- (e) Laundry service;
- (f) Medical and habilitative supplies;
- (g) Taxes; and
- (h) Insurance.

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(2) An ICF/MR facility's administration and operations rate component is the lesser of:

(a) Its most recent reported cost per resident day adjusted for inflation; or

(b) The calculated rate that is at or above eighty-five percent of state and private facilities' most recent reported cost per resident day adjusted for inflation. This ranking must be based on cost reports used to determine rates for facilities with an occupancy level of at least eighty-five percent during the cost report period.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0680, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0685 How is the property rate component computed? (1) The property rate component reimburses an ICF/MR facility for the necessary and ordinary costs of leases, depreciation, and interest.

(2) It is the facility's most recent desk-reviewed cost per resident day.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0685, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0690 Does DSHS pay a return on equity to providers? DSHS pays a return on equity to proprietary providers.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0690, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0695 How is a return on equity calculated? Calculating return on equity is a three-step process.

(1) First, a provider's net equity is calculated using appropriate items from the provider's most recent cost report and relevant Medicare rules and regulations. Note: Goodwill is not included in the calculation of net equity. Also, monthly equity calculations will not be used.

(2) Second, the Medicare rate of return for the twelve-month period ending on the provider's cost report-closing date is multiplied by the provider's net equity.

(3) Finally, the amount calculated in subsection (2) is divided by the provider's annual resident days for the cost report period to determine a return on equity rate per resident day.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0695, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0700 What if a provider's cost report covers a period shorter than twelve months? If a provider's cost report covers less than a twelve-month period, annual resident days are estimated by using the actual resident days reported by the provider. The provider will then be paid a prospective rate per resident day. The prospective rate will either be the rate per resident day calculated in WAC 388-835-0010 or two dollars per resident day whichever is less.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0700, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0705 Are return on equity calculations subject to field audits? (1) All information used to calculate return on equity is subject to field audit.

(2007 Ed.)

(2) A field audit can be used to determine whether the providers reported equity exceeds the equity calculated according to Medicare and the rules of this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0705, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0710 How does DSHS use field audit results? DSHS can use the field audit results to recalculate the provider's return on equity rate for the reported rate period. Any payments received by the provider in excess of the return on equity rate must be refunded to DSHS as part of the settlement procedure established in WAC 388-835-0720.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0710, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0715 Does DSHS place upper limits on the reimbursement rates it pays providers? DSHS limits its reimbursement rates to the following:

(1) Reimbursement rates for providers cannot exceed the provider's customary charge to the general public for the type of service covered by the rate.

(2) Public facilities rendering services for free or for a nominal charge will be reimbursed according to the methods and standards established in this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0715, filed 4/20/01, effective 5/21/01.]

SETTLEMENTS

WAC 388-835-0720 What general requirements apply to settlements between DSHS and providers? (1) Except as otherwise provided in this chapter, settlements must be calculated at the lower of a provider's prospective reimbursement rate or audited allowable costs.

(2) Each provider must complete a proposed preliminary settlement as part of their annual cost report. The due date for the proposed preliminary settlement is the same as the due date for the annual cost report. After reviewing the proposed preliminary settlement, DSHS must issue a preliminary settlement report to the provider.

(3) If a field audit is conducted, DSHS must evaluate the audit findings and issue a final settlement that incorporates the auditor's findings and DSHS's evaluation.

(4) If according to a preliminary or final settlement and the procedures in this chapter, a provider received overpayments from DSHS, they must refund those overpayments to the department. Conversely, DSHS must pay provider for any underpayments for which the department is responsible.

(5) Following a preliminary or final settlement, payment for services must be at the most recent available settlement rate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0720, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0725 What requirements apply to paying overpayments and underpayments? (1) Within thirty days after submitting a preliminary or final settlement report to the provider, DSHS must pay any underpayments it owes.

(2) If a provider received overpayments or payments in error from DSHS, they must refund those payments within

thirty days after receiving the preliminary or final settlement report.

(3) If a provider fails to comply with subsection (2) and the contract has not been terminated, DSHS must deduct the amount the provider owes, plus interest, from the department's current monthly payment due to the provider. The interest rate charged by DSHS on any unpaid balance is one percent per month.

(4) If a provider fails to comply with subsection (2) and the contract has been terminated, DSHS may:

(a) Deduct the amount owed by the provider, plus interest, from any amounts due to the provider from the department. (The interest rate on any unpaid balance is of one percent per month); or

(b) Use whatever legal means is available to recover the overpayment or erroneous payment plus interest on the unpaid balance at the rate of one percent per month.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0725, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0730 What if the amount of overpayment or underpayment is being disputed? (1) A provider does not have to refund any disputed amounts if they, in good faith, disagree with a settlement report and file a timely request for an administrative or judicial hearing.

(2) DSHS cannot withhold any amount owed by a provider, plus interest, from current payments due to the provider if the provider's debt is being administratively reviewed or judicially appealed.

(3) DSHS may recover portions of refunds and assess interest on amounts not specifically disputed by a provider in an administrative hearing or judicial appeal.

(4) If the administrative or judicial remedy sought by the provider is not granted or is partially granted after all appeals are exhausted or terminated by mutual agreement, the provider must refund all amounts owed to DSHS. These amounts, plus interest, must be paid within sixty days following the date of an administrative or judicial decision or the date the dispute process was mutually terminated. Interest accrues on the amount owed from the date a review was requested to the date the debt is repaid.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0730, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0735 What requirements apply to a provider's proposed preliminary settlement? (1) Proposed preliminary settlements submitted by providers must use the prospective rate for the resident care and habilitation cost center at which the provider was paid during the report period, including any resident specific payment adjustments. Resident specific payments must be weighted by the number of paid resident days each rate was in effect and compared to the provider's allowable costs for the cost center divided by total resident days.

(2) A provider's administration, operations, and property cost center settlement rate must be the prospective rate for the report period, including any payment adjustments, weighted by the number of paid resident days each rate was in effect.

(3) A provider's return on equity settlement rate must be the prospective rate for the report period weighted by the number of paid resident days the rate was in effect.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0735, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0740 How must DSHS respond to a provider's proposed preliminary settlement? (1) DSHS has one hundred twenty days after receiving a proposed preliminary settlement to review it for accuracy and either accept or reject it.

(2) If accepted, the proposed preliminary settlement becomes the preliminary settlement report.

(3) If rejected, DSHS must issue a preliminary settlement report by cost center that fully substantiates disallowed costs, refunds, or underpayments due and adjustments to the proposed preliminary settlement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0740, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0745 What recourse does a provider have if DSHS rejects their proposed preliminary settlement? A provider has thirty days after receiving a preliminary settlement report to contest it (see WAC 388-835-0950 and 388-835-0955). After thirty days, if the preliminary settlement report has not been contested, it cannot be reviewed.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0745, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0745, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0750 What requirements apply to final settlements? (1) A final settlement must be by cost center and must fully substantiate all:

- (a) Disallowed costs;
- (b) Refunds;
- (c) Underpayments; or
- (d) Adjustments to cost reports, financial statements, other reports, and schedules submitted by the provider.

(2) A final settlement report must use the prospective rate at which the provider was paid during the report period, including any resident specific payment adjustments made for resident care and training cost center. Resident specific payments must be weighted by the number of paid resident days reported for the period each rate was in effect. DSHS must compare these payments to the provider's audited allowable costs for the period.

(3) A provider's administration operations and property cost center settlement rate is the prospective rate for the period weighted by the number of paid resident days each rate was in effect.

(4) A provider's return of equity rate is the prospective rate for the report period weighted by the number of paid resident days the rate was in effect.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0750, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0755 Can a provider disagree with a final settlement report? A provider has thirty days after receiving a final settlement report to contest it (see WAC 388-835-0950 and 388-835-0955). After thirty days, if the final settlement report has not been contested, it cannot be reviewed.

[Title 388 WAC—p. 1316]

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-835-0755, filed 7/25/02, effective 8/25/02. Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0755, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0760 What if DSHS conducts an audit during the final settlement process? (1) If DSHS conducts an audit, it must issue a final settlement report to the provider after the audit process is completed. Completing the audit process includes exhausting or mutual terminating the reviews and/or appeals of audit findings or determinations.

(2) If a provider, in good faith, is disputing audit findings or determinations through the administrative review or judicial appeal process, DSHS may issue a partial final settlement report to recover overpayments based on audit findings or determinations not being disputed.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0760, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0765 Why is a state facility settlement important? The state facility settlement is determined to establish a state facility's final payment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0765, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0770 How is a state facility settlement calculated? The settlement must be calculated as follows:

(1) If the state facility's allowable costs for the report period are greater than their interim payment, the amount owed to the facility is the allowable cost amount minus the interim payment.

(2) If the state facility's allowable costs for the report period are less than their interim payment, the amount owed by the department is the interim payment minus the allowable cost amount.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0770, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0775 How is a state facility settlement implemented? (1) The settlement is implemented in a two-step process consisting of the facility first submitting a proposed preliminary settlement to DSHS and DSHS responding with a final settlement report that it submits to the state facility.

(2) The proposed preliminary settlement must be:

(a) Submitted to DSHS when the state facility submits their cost report.

(b) Responded to by DSHS within one hundred twenty days after they receive it from the state facility. DSHS must verify the accuracy of the facility's proposal and issue a preliminary settlement substantiating the settlement amount.

(3) The final settlement is the preliminary settlement issued by DSHS if an audit is not conducted.

(4) If an audit is conducted, DSHS must submit a final settlement report to the state facility after the audit process is completed. This report must substantiate all disallowed costs, refunds, underpayments, or adjustments to the provider's financial statements, cost report, and final settlement.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0775, filed 4/20/01, effective 5/21/01.]

(2007 Ed.)

WAC 388-835-0780 Does DSHS have a responsibility to notify each provider regarding prospective reimbursement rates? (1) DSHS must give written notification to each provider regarding DSHS's prospective reimbursement rate.

(2) Unless specified at the time the reimbursement rate is issued, the rate will be effective from the first day of the month the rate is issued until a new rate becomes effective.

(3) If a rate is changed because of a successful provider appeal, the effective date of the new rate is the same as the effective date of the old rate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0780, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0785 Can DSHS increase prospective reimbursement rates? (1) Except for the situations described in subsection (3) and (4) of this section, DSHS prospective reimbursement rates are the maximum provider payment rates for those periods to which they apply.

(2) DSHS does not grant rate adjustments for cost increases that are or were subject to management control or negotiations. Examples include, but are not limited to, all lease cost increases or any cost increases not expressly authorized in subsection (3) and (4).

(3) DSHS does adjust rates for any capitalized additions or replacements made as a condition for licensure or certification.

(4) DSHS does adjust rates for cost increases that must be incurred and cannot be met through the provider's prospective rate. Examples of such cost increases are:

- (a) Program changes required by DSHS;
- (b) Changes in staffing levels or consultants at a facility required by DSHS;
- (c) Changes required by a survey; and
- (d) Changes in revenue assessments required by the state legislature.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0785, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0790 How does a provider request a rate increase? (1) Any provider requesting a rate adjustment must submit a:

(a) Financial analysis showing the increased cost and an estimate of the rate increase needed to cover the increased cost. The estimated rate increase must be computed according to allowable methods;

(b) Written justification for granting the rate increase; and

(c) Certification and documentation that show the staffing changes and/or other improvements started or completed.

(2) Provider's requesting adjustments under WAC 388-835-0900 must submit a written plan identifying the staff they are going to add and the resident needs they have not met because of insufficient staffing.

(3) When reviewing provider requests made under WAC 388-835-0900, DSHS considers:

- (a) If the additional staff requested by a provider is appropriate for meeting resident needs;
- (b) Staffing level comparisons with facilities having similar characteristics;
- (c) The facility's physical layout;
- (d) Supervision and management of current staff;

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(e) Historical trends regarding the facility's underspending for resident care and habilitation;

(f) Number and position of existing staff; and

(g) Other resources available to the provider.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0790, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0795 What requirements apply to providers who receive rate increases? (1) Providers that receive prospective rate increases may be required to submit quarterly reports showing how the additional funds were spent. If required, a quarterly report would begin on the first day of the month following the date the rate increase is granted.

(2) If the additional funds resulting from the rate increase are not spent on DSHS approved changes or improvements approved, DSHS may ask that they be returned immediately.

(3) If a facility gives written notice to DSHS that it intends to close by a specific date and that returning the funds would jeopardize its ability to provide for the health, safety, and welfare of its residents, it may not have to return the additional funds.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0795, filed 4/20/01, effective 5/21/01.]

ERRORS AND OMISSIONS

WAC 388-835-0800 What if DSHS discovers that a prospective rate calculation was affected by an error or omission? (1) DSHS may adjust prospective rates resulting from cost report errors, computational errors or omissions by either DSHS or the provider.

(2) In addition to adjusting the rate, DSHS must notify the provider in writing:

(a) Regarding the nature and substance of each adjustment;

(b) That the effective date of each adjustment is the same as the effective date of the original rate; and

(c) Of any amount due to either DSHS or the provider as a result of an adjustment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0800, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0805 What if a provider discovers an error or omission that affected their cost report? (1) If a provider discovers an error or omission that caused their cost report to be incorrect, the provider must submit amended cost report pages.

(2) Amended cost report pages must be certified and accompanied by a written explanation why the amendment is necessary. Amendments are not accepted by DSHS unless they comply with the requirements in WAC 388-835-0815.

(3) If DSHS concludes that the amendment changes are material, the amended pages must be audited by a field audit.

(4) If DSHS concludes that the amendments are incorrect or unacceptable as a result of the field audit or other information it receives, any rate adjustment based on the amendments is null and void. Any scheduled future rate payment increases resulting from the amendments must be canceled immediately.

[Title 388 WAC—p. 1317]

(5) Any rate adjustment payments must be made according to the repayment provisions in WAC 388-835-0905.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0805, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0810 What other requirements apply to rate adjustments resulting from errors or omissions?

(1) No adjustment can be made to a rate more than:

(a) One hundred twenty days after the field audit narrative and summary is sent to the provider; or

(b) One hundred twenty days after a preliminary settlement becomes a final settlement.

(2) A final settlement that is concluded within the one hundred twenty-day time limits could only be reopened to adjust prospective rates that are based upon errors or omissions.

(3) Only adjustments to prospective rates (and the related computations) resulting from errors or omissions can be reviewed if a timely request is filed according to the provisions of WAC 388-835-0950.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0810, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0815 What requirements apply to repayment of amounts owed due to errors or omissions?

(1) Repayment (or starting repayment) of any amount owed to DSHS by a provider as a result of an error or omission rate adjustment must occur:

(a) Within sixty days after the provider receives a rate adjustment notification from DSHS; or

(b) According to a repayment schedule developed by DSHS.

(2) If a provider does not repay its debt to DSHS when it is due, DSHS may deduct the amount owed from the providers current DSHS payment.

(3) If a provider unsuccessfully contests the rate adjustment (see WAC 388-835-0950, they must repay DSHS (or start repayment) within sixty days after the administrative or judicial proceedings are completed.

(4) If DSHS owes a provider as a result of a rate adjustment, DSHS must pay the provider within thirty days after notifying the provider of the adjustment.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0815, filed 4/20/01, effective 5/21/01.]

PUBLIC REVIEW—PUBLIC DISCLOSURE

WAC 388-835-0820 What role does the public play in setting prospective reimbursement rates? Each year before prospective reimbursement rates are set, DSHS will give all interested members of the public an opportunity to review and comment on the department's proposed rate setting methods and standards.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0820, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0825 What is DSHS' public disclosure responsibility regarding rate setting methodology? Without identifying individual ICF/MR facilities and in compliance with public disclosure statute and rule requirements,

[Title 388 WAC—p. 1318]

DSHS will provide the public with full and complete information regarding its rate setting methodology.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0825, filed 4/20/01, effective 5/21/01.]

BILLING PROCEDURES AND PAYMENTS

WAC 388-835-0830 How does a provider bill DSHS for services provided? (1) A provider must bill DSHS each month, from the first through the last day, for care provided to medical care recipients by completing and returning an IMR statement filed according to department instructions.

(2) A provider cannot bill DSHS for services provided to a resident until they receive a DSHS resident award letter. When the provider receives the award letter, they can bill for services provided since the resident's admission or eligibility date.

(3) A provider cannot bill DSHS for the day of a resident's death, discharge, or transfer from the ICF/MR facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0830, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0835 How does DSHS pay a provider?

(1) DSHS will reimburse a provider for billed service rendered under the ICF/MR contract according to the appropriate rate assigned to the provider.

(2) For each resident, DSHS will pay an amount equal to the appropriate rates multiplied by the number of resident days each rate was in effect, less any amount a resident is required to pay (see WAC 388-835-0940).

(3) A provider must accept DSHS's reimbursement rates as full compensation for all services the provider is obligated to provide under their contract. The provider must not seek or accept additional compensation any contracted services from or on behalf of a resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0835, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0840 Can DSHS withhold provider payments? DSHS cannot withhold a provider payment until the provider is given written notification explaining why the payment is being withheld.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0840, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0845 Can DSHS terminate Medicaid Title XIX payments to providers? DSHS must terminate all Medicaid Title XIX payments to a provider no later than sixty days after a:

(1) Contract expires, is terminated or is not renewed;

(2) Facility license is revoked; or

(3) Facility is decertified as a Title XIX facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0845, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0850 Who is responsible for collecting from residents any amounts they may own for their care?

(1) DSHS will notify a provider of the amount each resident is required to pay for care provided under the contract and the date the payment is due.

(2) The provider is responsible for:

(a) Collecting from the resident; and

(b) Accounting for, according to procedures established by DSHS, any authorized reduction in the resident's contribution.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0850, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0855 What if a resident's circumstances change causing a provider to contribute more to the resident's care? (1) If a provider receives documentation verifying a change in a resident's income or resources that will reduce the resident's ability to contribute to the cost of their care, the provider must report this information in writing to the DDD regional services office within seventy-two hours.

(2) Any necessary corrections should be made in the next ICF/MR statement and a copy of the supporting documentation should be attached.

(3) If a provider receives increased funds for a resident, the normal amount must be allowed for clothing, personal, and incidental expenses and the balance must be applied to the cost of care.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0855, filed 4/20/01, effective 5/21/01.]

RECEIVERSHIP

WAC 388-835-0860 What is the role of a receiver when an ICF/MR facility is placed in receivership? If an ICF/MR facility is providing care to state medical assistance recipients and is placed under receivership, the receiver:

(1) Becomes the Medicaid provider during the receivership period;

(2) Assumes all new provider reporting responsibilities;

(3) Assumes all other new provider responsibilities established in this chapter; and

(4) Is responsible, during the receivership period, for refunding any Medicaid rate payments received that exceed cost of services provided.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0860, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0865 How does DSHS determine prospective reimbursement rates during receivership? When establishing prospective reimbursement rates during receivership, DSHS must consider:

(1) Court ordered compensation, if any, for the receiver.

Receiver compensation may already be available through the:

(a) Return on equity cost center rate, or

(b) Facility administrator salary where the receiver is also the facility's administrator.

(c) In order to satisfy the court order when existing sources of compensation are less than the compensation ordered by the court, DSHS could consider the difference as an additional allowable cost when establishing prospective reimbursement rates.

(2) Start-up costs and costs of repairs, replacements, and additional staff needed for resident health, training, security, and welfare. No additional money will be added to the rate if

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these costs can be covered through the return on equity cost center rate; and

(3) Any other allowable costs contained in this chapter.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0865, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0870 What if the court asks DSHS to recommend a receiver's compensation? If asked for a recommendation regarding receiver compensation by the court, DSHS must consider the:

(1) Range of compensation for private ICF/MR facility managers;

(2) Experience and training of the receiver;

(3) Size, location, and current condition of the facility; and

(4) Additional factors considered appropriate.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0870, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0875 Can DSHS give emergency or transitional financial assistance to a receiver? (1) In response to a court order, DSHS must give up to thirty thousand dollars of emergency or transitional financial assistance to a receiver.

(2) DSHS must recover any emergency or transitional assistance given to a receiver from facility generated revenue that is not obligated for facility operations.

(3) If DSHS has not fully recovered the emergency or transitional assistance when the receivership ends, DSHS may file:

(a) An action against the former licensee or owner to recover what is owed; or

(b) A lien against the facility or the proceeds from the sale of the facility.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0875, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0880 What happens when a receivership ends? When a receivership ends, DSHS may revise the facility's Medicaid reimbursement as follows:

(1) The Medicaid reimbursement rate for the former owner or licensee must be what it was before receivership unless the former owner or licensee requests prospective rate revisions according to the requirements of this chapter.

(2) The Medicaid reimbursement rate for licensed replacement operators must be established according to the rules in this chapter governing prospective reimbursement rates for new providers.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0880, filed 4/20/01, effective 5/21/01.]

DISPUTE RESOLUTION

WAC 388-835-0885 What disputes between providers and DSHS can be resolved through the administrative review process? A provider can use the administrative review process to contest:

(1) An "errors or omissions" reimbursement rate adjustment issued to the provider (see WAC 388-835-0845) or DSHS's refusal to adjust a rate the provider believes is incorrect due to errors or omissions. The provider must request an

administrative review within thirty days of receiving notification that a rate has been adjusted or that DSHS refuses to adjust the rate.

(2) The way in which a DSHS rule, contract provision, or policy statement was applied when calculating the provider's prospective cost related reimbursement system's rate.

(3) An audit finding, other audit determination, a rate review or other settlement determination.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0885, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0890 What disputes cannot be resolved through the administrative review and fair hearing processes? DSHS' administrative review and fair hearing processes cannot be used to challenge the adequacy of any prospective or settlement reimbursement rate or rate component, either individually or collectively.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0890, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0900 How does a provider request an administrative review? (1) A provider challenging an audit or settlement determination has a maximum of thirty days after receiving the finding or decision to file a written request for an administrative review.

(2) Written requests must be filed with the:

(a) Office of Financial Recovery services when the provider challenges an audit finding (adjusting journal entries or AJEs) or other audit determination; or

(b) DDD Director when the provider challenges a rate, desk review, or other settlement determination.

(3) The written request must:

(a) Be signed by the provider or facility administrator;

(b) Identify the specific determination being challenged and the date it was issued;

(c) State, as specifically as possible, the issues and regulations involved and why the provider claims the determination was erroneous; and

(d) Be accompanied by any documentation that will be used to support the provider's position.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0900, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0905 What happens after a provider requests an administrative review? (1) After receiving a provider's request, DSHS must schedule a conference between the provider and appropriate department representatives.

(2) Unless both parties agree, in writing, to a specific later date, the conference must be scheduled at least fourteen days after DSHS notifies the provider that a conference will be held and no later than ninety days after DSHS receives the provider's review request.

(3) The conference may be conducted by telephone unless DSHS or the provider requests, in writing, that it be held in person.

(4) The provider and DSHS representatives must participate in the conference.

(5) Either at the conference or before, the provider must give DSHS any documentation:

(a) Requested by DSHS that the provider is required to maintain for audit purposes under WAC 388-835-0270; and

(b) The provider intends to use to support their position.

(6) At the conference DSHS and the provider must clarify the issues and attempt to resolve them.

(7) If additional documentation is necessary to resolve the issues, a second conference meeting must be scheduled. Unless both parties agree, in writing, to a specific later date, this second conference meeting must be scheduled not later than thirty days after the first session.

(8) Regardless of whether an agreement is reached, DSHS must give the provider a written decision within sixty days after the conference ends.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0905, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0910 What if a provider disagrees with the administrative review decision? (1) If they disagree with the administrative review decision, a provider has a right to request an adjudicative proceeding within thirty days of receiving the decision.

(2) To request an adjudicative proceeding, a provider must:

(a) File a written request with the office of administrative hearings (OAH);

(b) Sign the request or have it signed by the facility administrator;

(c) State as specifically as possible the issues and regulations involved;

(d) State the reasons for disagreeing with the administrative review decision; and

(e) Attach a copy of the contested decision and any documentation the provider will use to support their position.

(3) The adjudicative proceeding must be governed by the Administrative Procedure Act (chapter 34.05 RCW), this chapter, and chapter 388-02 WAC. If any part of this chapter conflict with chapter 388-02 WAC, this chapter prevails.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0910, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0915 Can DSHS withhold an undisputed overpayment amount from a current ICF/MR payment? DSHS is authorized to withhold from an ICF/MR's current payment all amounts found by a preliminary or final settlement to be overpayments if they are not identified by the ICF/MR as overpayments and challenged in an administrative or judicial review.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0915, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0920 Can DSHS withhold a disputed overpayment amount from a current ICF/MR payment? Once administrative and judicial review processes are complete, contested overpayments retained by an ICF/MR may be withheld from the ICF/MR's current payment but only to the extent DSHS's position or claims are upheld.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0920, filed 4/20/01, effective 5/21/01.]

COST OF CARE OF MENTALLY DEFICIENT PERSONS RESIDING IN STATE INSTITUTIONS

WAC 388-835-0925 What is the purpose of this section? The purpose of this chapter is to regulate the costs of care of mentally/physically deficient persons.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0925, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0930 How is the payment for residential facilities set? The department sets the payment for residential facilities by the methodology noted in chapter 388-835 WAC.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0930, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0935 How much of a resident's income is exempt from paying their care? Residents whose total resources are insufficient to pay the actual cost of care must be entitled to a monthly exemption from income in the amount of twenty-five dollars.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0935, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0940 What if the estate of a resident is able to pay all or a portion of their monthly cost? (1) If DSHS finds that the estate of a resident is able to pay all or a portion of their monthly costs for care, support, and treatment, they must serve a written notice of finding of responsibility (NFR) on the:

- (a) Guardian of the resident's estate; or
 - (b) If a guardian has not been appointed, resident's spouse or parent or other person acting in a representative capacity and in possession of the resident's property; and
 - (c) The superintendent of the state school.
- (2) If a resident is an adult and is not under a legal disability, the department must personally serve the NFR on the resident.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0940, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0945 If a resident or guardian is served by DSHS with a NFR when is payment due? If a resident or guardian is served by DSHS with an NFR, payment is due thirty days after receiving the notice.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0945, filed 4/20/01, effective 5/21/01.]

WAC 388-835-0950 May a resident or guardian request a hearing if they disagree with the NFR? If a resident or guardian disagrees with the NFR, they have the right to ask for a hearing under chapter 34.05 RCW. They must file a written hearing request within thirty days of receipt with the secretary of DSHS, ATTN: Determination Officer, P.O. Box 9768, Olympia, WA 98504.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0950, filed 4/20/01, effective 5/21/01.]

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WAC 388-835-0955 What information must be included in the request for a hearing? The request for hearing must include:

- (1) A specific statement of the issues and law involved;
- (2) The grounds for contesting the department decision; and
- (3) A copy of the NFR being contested.

[Statutory Authority: RCW 71A.20.140. 01-10-013, § 388-835-0955, filed 4/20/01, effective 5/21/01.]

Chapter 388-837 WAC RESIDENTIAL HABILITATION CENTER (RHC) ICF/MR PROGRAM

WAC

388-837-9005	What is the purpose of this chapter?
388-837-9015	What does a transfer from one RHC to another RHC mean?
388-837-9020	Do residents have a right to a hearing when transferring from a residential habilitation center (RHC) to another RHC?
388-837-9030	What rights are available to a resident regarding a proposed transfer from one RHC to another RHC?
388-837-9040	What rights are available to a resident regarding a proposed transfer from an RHC to the community, per RCW 71A.20.080?

WAC 388-837-9005 What is the purpose of this chapter? (1) The purpose of this chapter is to establish rules authorized by Title 71A RCW for RHC ICF/MR programs, rules that:

- (a) Regulate the purchase and provision of services in state operated intermediate care facility for the mentally retarded (ICF/MR); and
- (b) Assure adequate ICF/MR care, service, and protection are provided through certification procedures; and
- (c) Establish standards for providing habilitative training, health-related care, supervision, and residential services to eligible persons.

(2) Except where specifically referenced, this chapter supersedes and replaces any and all sections affecting ICF/MR facilities or programs contained in chapter 388-96 WAC.

(3) Except as referenced, definitions in WAC 388-835-0010 apply to this chapter.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9005, filed 7/23/04, effective 8/23/04.]

WAC 388-837-9015 What does a transfer from one RHC to another RHC mean? A transfer means the discharge of a resident from the current RHC in which the resident resides and the admission of that resident to another RHC.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9015, filed 7/23/04, effective 8/23/04.]

WAC 388-837-9020 Do residents have a right to a hearing when transferring from a residential habilitation center (RHC) to another RHC? Notwithstanding hearing rights set forth in WAC 388-825-120 (1)(d), there is no right to an adjudicative proceeding for a resident when the department concludes that the facility where the resident resides cannot provide services due to:

- (1) Decertification of the RHC;
- (2) Revocation of the RHC's certification; or
- (3) An emergency suspension of the RHC's certification;
- (4) Partial closure of the RHC; or
- (5) Closure of the RHC.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9020, filed 7/23/04, effective 8/23/04.]

WAC 388-837-9030 What rights are available to a resident regarding a proposed transfer from one RHC to another RHC? (1) A resident, their guardian, next-of-kin, or responsible party must be notified in writing at least thirty days before any transfer occurs.

(2) The transfer notice must include the reason for the proposed transfer.

(3) A resident, their guardian, next of kin, or responsible party has a right to an informal administrative review before the division director or designee.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9030, filed 7/23/04, effective 8/23/04.]

WAC 388-837-9040 What rights are available to a resident regarding a proposed transfer from an RHC to the community, per RCW 71A.20.080? (1) A resident, or the resident's authorized representative has a right to a hearing regarding the proposed transfer from an RHC to the community, per RCW 71A.20.080 and under chapter 34.05 RCW and chapter 388-02 WAC. DSHS must send a hearing request form with the notice of transfer.

(2) If the resident requests a hearing within the thirty-day time period, DSHS may not transfer the resident until a hearing decision is reached or appeal rights have been exhausted unless the transfer is warranted by the resident's health or safety needs or the welfare of the other residents.

(3) If the secretary or the secretary's designee concludes that the transfer is not appropriate, no further action is to be taken to transfer unless there is a change in the situation or circumstances surrounding the transfer request. If there is a change in the situation or circumstances, the request may be resubmitted.

(4) If the secretary or the secretary's designee affirms the decision to transfer the resident and no petition for judicial review is filed within thirty days, DSHS may proceed with the planned action.

(5) If the secretary or secretary's designee affirms the decision to transfer the resident and a petition for judicial review has been filed, any proposed transfer must be delayed until the appeal process is complete unless a delay jeopardizes the resident's health or safety or the welfare of other residents, or as otherwise provided in RCW 71A.20.080.

[Statutory Authority: Chapter 71A.20 RCW, RCW 71A.12.080, 71A.20.140, 2003 1st sp.s. c 25 § 205. 04-16-018, § 388-837-9040, filed 7/23/04, effective 8/23/04.]

[Title 388 WAC—p. 1322]

Chapter 388-840 WAC

WORK PROGRAMS FOR RESIDENTS OF RESIDENTIAL HABILITATION CENTERS IN THE DIVISION OF DEVELOPMENTAL DISABILITIES (Formerly chapter 275-41 WAC)

WAC

388-840-005	Purpose.
388-840-010	Definition.
388-840-015	Establishment of new work programs.
388-840-020	Protection of residents.
388-840-025	Compensation for persons participating in work programs.

WAC 388-840-005 Purpose. The regulations provide guidelines for the operation of work programs at residential habilitation centers or for programs contracted on behalf of residents of residential habilitation centers within the division of developmental disabilities as required under RCW 43.20A.445.

[99-19-104, recodified as § 388-840-005, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-005, filed 8/9/91, effective 9/9/91.]

WAC 388-840-010 Definition. (1) "Compensate" means the resident's receipt of money for work done at a work program.

(2) "Department" means the Washington state department of social and health services.

(3) "Division" means the developmental disabilities division of the department of social and health services.

(4) "Prevailing wage" means the amount paid to a non-disabled worker in a nearby industry or surrounding community for essentially the same type, quality, and quantity of work or work requiring comparable skills.

(5) "Residential habilitation center (RHC)" means a residential habilitation center operated by the developmental disabilities division.

(6) "Work program" means a directed vocational activity or series of related activities provided on a systematic, organized basis for developing and maintaining individual resident work skills, and providing remuneration to resident employees. Work programs must result in:

- (a) Benefit to the economy of the facility; or
- (b) A contribution to the facility's maintenance; or
- (c) Produce articles or services for sale.

[99-19-104, recodified as § 388-840-010, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-010, filed 8/9/91, effective 9/9/91.]

WAC 388-840-015 Establishment of new work programs. The requirements of RCW 43.20A.445 shall be followed before the department establishes new residential habilitation center work programs.

[99-19-104, recodified as § 388-840-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-015, filed 8/9/91, effective 9/9/91.]

WAC 388-840-020 Protection of residents. (1) When a resident participates in a work program, the resident shall be employed in work and subjected to work conditions where reasonable precautions are taken to ensure the resident's health and safety.

(2007 Ed.)

(2) Resident work programs shall be consistent with the resident's individual habilitation plan objectives.

[99-19-104, recodified as § 388-840-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-020, filed 8/9/91, effective 9/9/91.]

WAC 388-840-025 Compensation for persons participating in work programs. (1) The department shall compensate a person participating in a work program at the prevailing minimum wage except when an appropriate certificate has been obtained by the RHC or contract program in accordance with current regulations and guidelines issued under the Fair Labor Standards Act (29 CFR Ch. V, 525 and 529) as amended.

(2) The department shall not be required to compensate a person participating in the shared domiciliary activities of maintaining the person's own immediate household or residence.

[99-19-104, recodified as § 388-840-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.20.060. 91-17-005 (Order 3230), § 275-41-025, filed 8/9/91, effective 9/9/91.]

Chapter 388-845 WAC

DDD HOME AND COMMUNITY BASED SERVICES WAIVERS

WAC

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388-845-0610

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388-845-1015

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388-845-1210

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WAC 388-845-0001 Definitions. "ADSA" means the aging and disability services administration, an administration within the department of social and health services.

"Aggregate Services" means a combination of services subject to the dollar limitations in the Basic and Basic Plus waivers.

"CAP waiver" means the community alternatives program waiver.

"CARE" means the comprehensive assessment and reporting evaluation.

[Title 388 WAC—p. 1324]

"DDD" means the division of developmental disabilities, a division within the aging and disability services administration of the department of social and health services.

"Department" means the department of social and health services.

"Employment/day program services" means community access, person-to-person, prevocational services or supported employment services subject to the dollar limitations in the Basic and Basic Plus waivers.

"HCBS waivers" means home and community based services waivers.

"ICF/MR" means an intermediate care facility for the mentally retarded.

"Plan of care (POC)" means the primary tool DDD uses to determine and document your needs and to identify services to meet those needs.

"Providers" means an individual or agency who is licensed, certified and/or contracted to provide services to you.

"Respite assessment" means a series of questions about you and your caregiver used to determine the amount of respite care available to you.

"SSI" means Supplemental Security Income, an assistance program administered by the federal Social Security Administration for blind, disabled and aged individuals.

"SSP" means state supplementary payment, a benefit administered by the department intended to augment an individual's SSI.

"State funded services" means services that are funded entirely with state dollars.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0001, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0005 What are home and community based services (HCBS) waivers? (1) Home and community based services (HCBS) waivers are services approved by the Centers For Medicare and Medicaid Services (CMS) under section 1915 (c) of the Social Security Act as an alternative to intermediate care facility for the mentally retarded (ICF/MR) care.

(2) Certain federal regulations are "waived" enabling the provision of services in the home and community to individuals who would otherwise require the services provided in an ICF/MR as defined in chapters 388-835 and 388-837 WAC.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0005, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0010 What is the purpose of HCBS waivers? The purpose of HCBS waivers is to provide services in the community to individuals with ICF/MR level of need to prevent their placement in an ICF/MR.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0010, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0015 What HCBS waivers are provided by the division of developmental disabilities (DDD)? DDD has replaced its community alternatives program (CAP) waiver with four HCBS waivers:

(2007 Ed.)

- (1) Basic waiver;
- (2) Basic Plus waiver;
- (3) CORE waiver; and
- (4) Community protection waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0015, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0020 When were these four HCBS waivers effective? The four DDD HCBS waivers were effective April 1, 2004.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0020, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0025 Does this change in waivers affect the waiver services I am currently receiving? Your services will not be disrupted with this transfer to new waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0025, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0030 Do I meet criteria for HCBS waiver-funded services? You meet criteria for DDD HCBS waiver-funded services if you meet all of the following:

- (1) You have been determined eligible for DDD services per RCW 71A.10.020(3).
- (2) You have been determined to meet ICF/MR level of care per WAC 388-845-0070 through 388-845-0090.
- (3) You meet disability criteria established in the Social Security Act.
- (4) You meet financial eligibility requirements as defined in WAC 388-515-1510.
- (5) You choose to receive services in the community rather than in an ICF/MR facility.
- (6) You have a need for waiver services as identified in your plan of care.
- (7) You are not residing in hospital, jail, prison, nursing facility, ICF/MR, or other institution.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0030, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0035 Am I guaranteed placement on a waiver if I meet waiver criteria? If you are not currently enrolled in a waiver, meeting criteria for the waiver does not guarantee access to or receipt of waiver services.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0035, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0040 Is there a limit to the number of people who can be enrolled in each HCBS waiver? Each waiver has a limit on the number of people who can be served in a waiver year. In addition, DDD has the authority to limit enrollment into the waivers based on availability of funding for new waiver participants.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0040, filed 12/13/05, effective 1/13/06.]

(2007 Ed.)

WAC 388-845-0041 What is DDD's responsibility to provide my services under the waivers administered by DDD? If you are enrolled in an HCBS waiver administered by DDD, DDD must meet your assessed needs for health and welfare.

(1) DDD must address your assessed health and welfare needs in your plan of care, as specified in WAC 388-845-3055.

(2) You have access to DDD paid services that are provided within the scope of your waiver, subject to the limitations in WAC 388-845-0110 and WAC 388-845-0115.

(3) DDD will provide waiver services you need and qualify for within your waiver.

(4) DDD will not deny or limit your waiver services based on a lack of funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0041, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0045 When there is capacity to add people to a waiver, how does DDD determine who will be enrolled? When there is capacity on a waiver and available funding for new waiver participants, DDD may enroll people in a waiver based on the following priority considerations:

(1) First priority will be given to current waiver participants assessed to require a different waiver because their needs have increased and these needs cannot be met within the scope of their current waiver.

(2) DDD may also consider any of the following populations in any order:

(a) Priority populations as identified and funded by the legislature.

(b) Persons DDD has determined to be in immediate risk of ICF/MR admission due to unmet health and safety needs.

(c) Persons identified as a risk to the safety of the community.

(d) Persons currently receiving services through state-only funds.

(e) Persons on an HCBS waiver that provides services in excess of what is needed to meet their identified health and welfare needs.

(f) Persons who were previously on an HCBS waiver since April 2004 and lost waiver eligibility per WAC 388-845-0060(9).

(3) For the Basic waiver only, DDD may consider persons who need the waiver services available in the Basic waiver to maintain them in their family's home.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0045, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0050 How do I request to be enrolled in a waiver? You can contact DDD and request to be enrolled in a waiver at any time.

(1) Your request for waiver enrollment will be documented by DDD in a statewide data base.

(2) When there is capacity available to enroll additional people in a waiver, WAC 388-845-0045 describes how DDD will determine who will be enrolled.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0050, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0051 How will I be notified of the decision by DDD to enroll me in a waiver? DDD will notify you in writing of its decision to enroll you in a waiver or its decision to deny your request to be enrolled in a waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0051, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0055 How do I remain eligible for the waiver? If you are already on a HCBS waiver, you must continue to meet eligibility criteria.

(1) DDD completes a reassessment at least every twelve months to determine if you continue to meet all of the eligibility requirements in WAC 388-845-0030.

(2) You must receive a waiver service at least once in every thirty consecutive days, as specified in WAC 388-513-1320 (3)(b).

(3) Your plan of care, CARE assessment/reassessment and respite assessment/reassessment must be done in person.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0055, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0060 Can my waiver eligibility be terminated? DDD may terminate your waiver eligibility if DDD determines that your health and safety needs cannot be met in your current waiver or for one of the following reasons:

(1) You no longer meet one of the requirements listed in WAC 388-845-0030;

(2) You no longer need waiver services;

(3) You do not use a waiver service at least once in every thirty consecutive days;

(4) You are on the community protection waiver and choose not to be served by a certified residential community protection provider-intensive supported living services (CP-ISLS);

(5) You choose to disenroll from the waiver;

(6) You reside out of state;

(7) You cannot be located or do not make yourself available for the annual waiver reassessment of eligibility;

(8) You refuse to participate with DDD in:

(a) Service planning;

(b) Required quality assurance and program monitoring activities; or

(c) Accepting services agreed to in your plan of care as necessary to meet your health and safety needs.

(9) You are residing in a hospital, jail, prison, nursing facility, ICF/MR, or other institution and remain in residence at least one full calendar month, and are still in residence:

(a) At the end of the twelfth month following the effective date of your current plan of care, as described in WAC 388-845-3060; or

(b) On March 31st, the end of the waiver fiscal year, whichever date occurs first.

(10) Your needs exceed the maximum funding level or scope of services under the Basic or Basic Plus waiver as specified in WAC 388-845-3080; or

(11) Your needs exceed what can be provided under the CORE or community protection waiver as specified in WAC 388-845-3085.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0060, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0065 What happens if I am terminated or choose to disenroll from a waiver? If you are terminated from a waiver or choose to disenroll from a waiver, DDD will notify you.

(1) DDD cannot guarantee continuation of your current services, including Medicaid eligibility.

(2) Your eligibility for nonwaiver state-only funded DDD services is based upon availability of funding and program eligibility for a particular service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0065, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0070 What determines if I need ICF/MR level of care? DDD determines if you need ICF/MR level of care based on your need for waiver services. To reach this decision, DDD uses its department-approved assessment and/or other information specified in WAC 388-845-0085.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0070, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0075 How is a child age twelve or younger assessed for ICF/MR level of care? If you are age twelve or younger, DDD assesses you for ICF/MR level of care using the "child's assessment of ICF/MR level of care—current support needs" form. You must have support needs exceeding what is expected of others of the same age.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0075, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0080 What score indicates ICF/MR level of care if I am age twelve or younger? (1) If you are age five or younger you need major or moderate support in five of nine tasks.

(2) If you are age six through twelve, you need major or moderate support in seven of nine of the tasks in (3) below.

(3) The form indicates certain tasks that require major support and which require moderate or major support.

(a) Major support for:

(i) Dressing and grooming self;

(ii) Toileting self.

(b) Major or moderate support for:

(i) Eating;

(ii) Mobility;

(iii) Communication;

(iv) Making choices and taking responsibility;

(v) Exploring one's environment;

(vi) Supports needed to meet therapy and health needs;

or

(vii) Family/caregiver support required to maintain the child at home.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0080, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0085 If I am age twelve or younger, what if my score on the current needs assessment does not indicate ICF/MR level of care? For children age twelve or younger:

(1) If you do not have a qualifying score for determining ICF/MR level of care using the department approved assessment, you may provide DDD other current information that provides evidence of your need for waiver services.

(2) This additional information may include occupational therapy (OT), physical therapy (PT), psychological, nursing, social work, speech and hearing, or other professional evaluations that reflect current needs.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0085, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0090 How is a person age thirteen or older assessed for ICF/MR level of care? If you are age thirteen or older, DDD assesses you for ICF/MR level of care using the "Assessment of ICF/MR level of care—Current support needs" form.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0090, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0095 What score indicates ICF/MR level of care if I am age thirteen or older? If you are age thirteen or older, you must have a qualifying score of at least forty in responses to twenty questions assessing your residential, school or employment, and social support needs.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0095, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0096 If I am age thirteen or older, what if my score on the current needs assessment does not indicate the need for ICF/MR level of care? If you are age thirteen or older and your current needs assessment does not indicate the need for ICF/MR level of care, you are not eligible for an HCBS waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0096, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0100 What determines which waiver I am assigned to? DDD will assign you to a waiver based on the following criteria:

(1) If you were on the CAP waiver as of March 2004, your initial assignment to the Basic, Basic Plus, CORE, or community protection waiver was based on:

(a) Services you received from DDD in October 2002 through September 2003; and

(b) Services you were authorized to receive in October, November and December 2003.

(2007 Ed.)

(2) If you are new to a waiver since April 1, 2004, assignment is based on your assessment and service plan.

(3) Additional criteria apply to the assignment to the community protection waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0100, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0105 What criteria determine assignment to the community protection waiver? DDD may assign you to the community protection waiver only if you are at least eighteen years of age, not currently residing in a hospital, jail or other institution, and meet the following criteria:

(1) You have been identified by DDD as a person who meets one or more of the following:

(a) You have been convicted of or charged with a crime of sexual violence as defined in chapter 71.09 RCW;

(b) You have been convicted of or charged with acts directed towards strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization, or persons of casual acquaintance with whom no substantial personal relationship exists;

(c) You have been convicted of or charged with a sexually violent offense and/or predatory act, and may constitute a future danger as determined by a qualified professional;

(d) You have not been convicted and/or charged, but you have a history of stalking, sexually violent, predatory and/or opportunistic behavior which demonstrates a likelihood to commit a sexually violent and/or predatory act based on current behaviors that may escalate to violence, as determined by a qualified professional; or

(e) You have committed one or more violent crimes.

(2) You receive or agree to receive residential services from certified residential community protection provider-intensive supported living services (CP-ISLS); and

(3) You comply with the specialized supports and restrictions in your:

(a) Plan of care (POC);

(b) Individual instruction and support plan (IISP); and/or

(c) Treatment plan provided by DDD approved certified individuals and agencies.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0105, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0110 Are there limitations to the waiver services I can receive? There are limitations to waiver services. In addition to the limitations to your access to nonwaiver services cited for specific services in WAC 388-845-0115, the following limitations apply:

(1) A service must be offered in your waiver and authorized in your plan of care.

(2) Mental health stabilization services may be added to your plan of care after the services are provided.

(3) Waiver services are limited to services required to prevent ICF/MR placement.

(4) The cost of your waiver services cannot exceed the average daily cost of care in an ICF/MR.

(5) Waiver services cannot replace or duplicate other available paid or unpaid supports or services.

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(6) Waiver funding cannot be authorized for treatments determined by DSHS to be experimental.

(7) The Basic and Basic Plus waivers have yearly limits on some services and combinations of services. The combination of services is referred to as aggregate services or employment/day program services.

(8) Your choice of qualified providers and services is limited to the most cost effective option that meets your assessed needs.

(9) Services provided out-of-state, other than in recognized bordering cities, are limited to respite care and personal care during vacations.

(a) You may receive services in a recognized out-of-state bordering city on the same basis as in-state services.

(b) The only recognized bordering cities are:

(i) Coeur d'Alene, Moscow, Sandpoint, Priest River and Lewiston, Idaho; and

(ii) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater and Astoria, Oregon.

(10) Other out-of-state waiver services require an approved exception to rule before DDD can authorize payment.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0110, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0115 Does my waiver eligibility limit my access to DDD nonwaiver services? If you are enrolled in a DDD HCBS waiver:

(1) You are not eligible for state-only funding for DDD services; and

(2) You are not eligible for Medicaid personal care.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0115, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0120 Will I continue to receive state supplementary payments (SSP) if I am on the waiver? Your participation in the new waivers does not affect your continued receipt of state supplemental payment from DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0120, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0200 What waiver services are available to me? Each of the four HCBS waivers has a different scope of service and your service plan defines the waiver services available to you.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0200, filed 12/13/05, effective 1/13/06.]

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WAC 388-845-0205 Basic waiver services.

BASIC WAIVER	SERVICES	YEARLY LIMIT
	AGGREGATE SERVICES: Behavior management and consultation Community guide Environmental accessibility adaptations Occupational therapy Physical therapy Specialized medical equipment/ supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation	May not exceed \$1425 per year on any combination of these services
	EMPLOYMENT/DAY PROGRAM SERVICES: Community access Person-to-person Prevocational services Supported employment	May not exceed \$6500 per year
	Sexual deviancy evaluation	Limits are determined by DDD
	Respite care	Limits are determined respite assessment
	Personal care	Limits are determined by CARE assessment
	MENTAL HEALTH STABILIZATION SERVICES: Behavior management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services	Limits are determined by a mental health professional or DDD
	Emergency assistance is only for services contained in the Basic waiver	\$6000 per year; Preauthorization required

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0205, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0210 Basic Plus waiver services.

BASIC PLUS WAIVER	SERVICES	YEARLY LIMIT
	AGGREGATE SERVICES: Behavior management and consultation Community guide Environmental accessibility adaptations Occupational therapy	May not exceed \$6070 per year on any combination of these services

(2007 Ed.)

BASIC PLUS WAIVER	SERVICES	YEARLY LIMIT
	Physical therapy Skilled nursing Specialized medical equipment/supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation	
	EMPLOYMENT/DAY PROGRAM SERVICES: Community access Person-to-person Prevocational services Supported employment	May not exceed \$9500 per year
	Adult foster care (adult family home) Adult residential care (boarding home)	Determined per department rate structure
	MENTAL HEALTH STABILIZATION SERVICES: Behavior management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services	Limits determined by a mental health professional or DDD
	Personal care	Limits determined by the CARE assessment
	Respite care	Limits are determined by respite assessment
	Sexual deviancy evaluation	Limits are determined by DDD
	Emergency assistance in only for services contained in the Basic Plus waiver	\$6000 per year; Preauthorization required

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0210, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0215 CORE waiver services.

CORE WAIVER	SERVICES	YEARLY LIMIT
	Behavior management and consultation Community guide Community transition Environmental accessibility adaptations Occupational therapy Respite care	Determined by the Plan of Care, not to exceed the average cost of an ICF/MR for any combination of services

CORE WAIVER	SERVICES	YEARLY LIMIT
	Sexual deviancy evaluation Skilled nursing Specialized medical equipment/supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation	
	Residential habilitation	
	Community access Person-to-person Prevocational services Supported employment	
	MENTAL HEALTH STABILIZATION SERVICES: Behavior management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services	Limits determined by a mental health professional or DDD
	Personal care	Limited by CARE assessment

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0215, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0220 Community protection waiver services.

COMMUNITY PROTECTION WAIVER	SERVICES	YEARLY LIMIT
	Behavior management and consultation Community transition Environmental accessibility adaptations Occupational therapy Physical therapy Sexual deviancy evaluation Skilled nursing Specialized medical equipment and supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation	Determined by the Plan of Care, not to exceed the average cost of an ICF/MR for any combination of services

COMMUNITY PROTECTION WAIVER	SERVICES	YEARLY LIMIT
	Residential habilitation Person-to-person Prevocational services Supported employment	
	MENTAL HEALTH STABILIZATION SERVICES: Behavioral management and consultation Mental health crisis diversion bed services Skilled nursing Specialized psychiatric services	Limits determined by a mental health professional or DDD

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0220, filed 12/13/05, effective 1/13/06.]

WAIVER SERVICES DEFINITIONS

WAC 388-845-0300 What are adult family home (AFH) services? Per RCW 70.128.010 an adult family home (AFH) is a regular family abode in which a person or persons provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the service. Adult family homes (AFH) may provide residential care to adults in the Basic Plus waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0300, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0305 Who is a qualified provider of AFH services? The provider of AFH services must be licensed and contracted with ADSA as an AFH who has successfully completed the DDD specialty training provided by the department.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0305, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0310 Are there limits to the AFH services I can receive? Adult family homes services are limited by the following:

(1) AFH services are defined and limited per chapter 388-106 WAC and chapter 388-71 WAC governing Medicaid personal care and the comprehensive assessment and reporting evaluation (CARE).

(2) Rates are determined by and limited to department published rates for the level of care generated by CARE.

(3) AFH reimbursement cannot be supplemented by other department funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0310, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0400 What are adult residential care (ARC) services? Adult residential care (ARC) facilities may

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provide residential care to adults. This service is available in the Basic Plus waiver.

(1) An ARC is a licensed boarding home for seven or more unrelated adults.

(2) Services include, but are not limited to, individual and group activities; assistance with arranging transportation; assistance with obtaining and maintaining functional aids and equipment; housework; laundry; self-administration of medications and treatments; therapeutic diets; cuing and providing physical assistance with bathing, eating, dressing, locomotion and toileting; stand-by one person assistance for transferring.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0400, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0405 Who is a qualified provider of ARC services? The provider of ARC services must:

(1) Be a licensed boarding home;
(2) Be contracted with ADSA to provide ARC services; and

(3) Have completed the required and approved DDD specialty training.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0405, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0410 Are there limits to the ARC services I can receive? ARC services are limited by the following:

(1) ARC services are defined and limited by boarding home licensure and rules in chapter 388-78A WAC, and chapter 388-106 WAC and chapter 388-71 WAC governing Medicaid personal care and the comprehensive assessment and reporting evaluation (CARE).

(2) Rates are determined and limited to department published rates for the level of care generated by CARE.

(3) ARC reimbursement cannot be supplemented by other department funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0410, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0500 What is behavior management and consultation? (1) Behavior management and consultation may be provided to persons on any of the four HCBS waivers and include the development and implementation of programs designed to support waiver participants using:

(a) Strategies for effectively relating to caregivers and other people in the waiver participant's life; and

(b) Direct interventions with the person to decrease aggressive, destructive, and sexually inappropriate or other behaviors that compromise their ability to remain in the community (i.e., training, specialized cognitive counseling).

(2) Behavior management and consultation may also be provided as a mental health stabilization service in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0500, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0505 Who is a qualified provider of behavior management and consultation? The provider of behavior management and consultation must be one of the following professionals contracted with DDD and duly licensed, registered or certified to provide this service:

- (1) Marriage and family therapist;
- (2) Mental health counselor;
- (3) Psychologist;
- (4) Sex offender treatment provider;
- (5) Social worker;
- (6) Registered nurse (RN) or licensed practical nurse (LPN);
- (7) Psychiatrist;
- (8) Psychiatric advanced registered nurse practitioner (ARNP);
- (9) Physician assistant working under the supervision of a psychiatrist;
- (10) Registered counselor; or
- (11) Polygrapher.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0505, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0510 Are there limits to the behavior management and consultation I can receive? The following limits apply to your receipt of behavior management and consultation:

- (1) DDD and the treating professional will determine the need and amount of service you will receive, subject to the limitations in subsection (2) below.
- (2) The dollar limitations for aggregate services in your Basic and Basic Plus waiver limit the amount of service unless provided as a mental health stabilization service.
- (3) DDD reserves the right to require a second opinion from a department-selected provider.
- (4) Behavior management and consultation not provided as a mental health stabilization service requires prior approval by DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0510, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0600 What is community access? Community access is a service provided in the community to enhance or maintain the person's competence, integration, physical or mental skills.

- (1) If you are age sixty-two or older, this service is available to assist you to participate in activities, events and organizations in the community in ways similar to others of retirement age.
- (2) This service is available to adults in the Basic, Basic Plus, and CORE waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0600, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0605 Who is a qualified provider of community access? The provider of community access must be a county or an individual or agency contracted with a county or DDD.

(2007 Ed.)

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0605, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0610 Are there limits to community access I can receive? The following limits apply to your receipt of community access:

- (1) You must be age sixty-two or older.
- (2) You cannot be authorized to receive community access services if you receive prevocational services or supported employment services.
- (3) The dollar limitations for employment/day program services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0610, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0700 What is a community guide service? Community guide service increases access to informal community supports. Services are short-term and designed to develop creative, flexible and supportive community resources for individuals with developmental disabilities. This service is available in Basic, Basic Plus and CORE waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0700, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0705 Who is a qualified community guide? Any individual or agency contracted with DDD as a "community guide" is qualified to provide this service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0705, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0710 Are there limitations to the community guide services I can receive? (1) You may not receive community guide services if you are receiving residential habilitation services as defined in WAC 388-845-1500 because your residential provider can meet this need.

- (2) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0710, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0750 What are community transition services? (1) Community transition services are reasonable costs (necessary expenses in the judgment of the state for an individual to establish his or her basic living arrangement) associated with moving from an institutional setting to a community setting and receiving services from a DDD certified residential habilitation services provider as defined in WAC 388-845-1505 and 388-845-1510.

- (2) Community transition services include:
 - (a) Security deposits (not to exceed the equivalent of two month's rent) that are required to obtain a lease on an apartment or home;
 - (b) Essential furnishings such as a bed, a table, chairs, window blinds, eating utensils and food preparation items;

(c) Moving expenses required to occupy and use a community domicile;

(d) Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating); and

(e) Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

(3) Community transition services are available in the CORE and community protection waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0750, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0755 Who are qualified providers of community transition services? (1) Providers of community transition services for individuals in the CORE waiver must meet the requirements as a provider of residential habilitation services contained in WAC 388-845-1505.

(2) Providers of community transition services for individuals in the community protection waiver must meet the requirements as a provider of residential habilitation services contained in WAC 388-845-1510.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0755, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0760 Are there limitations to community transition services I can receive? (1) Community transition services do not include:

(a) Diversional or recreational items such as televisions, cable TV access, VCRs, MP3, CD or DVD players; and

(b) Computers whose use is primarily diversional or recreational.

(2) Community transition services are available only to individuals that are moving from an institution to a community setting and are enrolled in either the CORE or community protection waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0760, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0800 What is emergency assistance?

Emergency assistance is a temporary increase to the yearly dollar limit specified in the Basic and Basic Plus waiver when additional waiver services are required to prevent ICF/MR placement. These additional services are limited to the services provided in your waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0800, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0805 Who is a qualified provider of emergency assistance? The provider of the service you need to meet your emergency must meet the provider qualifications for that service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0805, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0810 How do I qualify for emergency assistance? You qualify for emergency assistance only if you

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have used all of your waiver funding and your current situation meets one of the following criteria:

(1) You involuntarily lose your present residence for any reason either temporary or permanent;

(2) You lose your present caregiver for any reason, including death;

(3) There are changes in your caregiver's mental or physical status resulting in the caregiver's inability to perform effectively for the individual; or

(4) There are significant changes in your emotional or physical condition that requires a temporary increase in the amount of a waiver service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0810, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0820 Are there limits to my use of emergency assistance? All of the following limitations apply to your use of emergency assistance:

(1) Prior authorization is required based on a reassessment of your plan of care to determine the need for emergency services;

(2) Payment authorizations are reviewed every thirty days and cannot exceed six thousand dollars per twelve months based on the effective date of your current plan of care (POC);

(3) Emergency services are limited to the scope of services in your waiver;

(4) Emergency assistance may be used for interim services until:

(a) The emergency situation has been resolved; or

(b) You are transferred to alternative supports that meet your assessed needs; or

(c) You are transferred to an alternate waiver that provides the service you need.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0820, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0900 What are environmental accessibility adaptations? (1) Environmental accessibility adaptations are available in all of the HCBS waivers and provide the physical adaptations to the home required by the individual's plan of care needed to:

(a) Ensure the health, welfare and safety of the individual; or

(b) Enable the individual who would otherwise require institutionalization to function with greater independence in the home.

(2) Environmental accessibility adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installing specialized electrical and/or plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0900, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0905 Who is a qualified provider for building these environmental accessibility adaptations? The provider making these environmental accessibility adaptations must be a registered contractor per chapter 18.27 RCW and contracted with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0905, filed 12/13/05, effective 1/13/06.]

WAC 388-845-0910 What limitations apply to environmental accessibility adaptations? The following service limitations apply to environmental accessibility adaptations:

- (1) Prior approval by DDD is required.
- (2) Environmental accessibility adaptations or improvements to the home are excluded if they are of general utility without direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.
- (3) Environmental accessibility adaptations cannot add to the total square footage of the home.
- (4) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0910, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1000 What are extended state plan services? Extended state plan services refer to physical therapy; occupational therapy; and speech, hearing and language services available to you under Medicaid without regard to your waiver status. They are "extended" services when the waiver pays for more services than is provided under the state Medicaid plan. These services are available under all four HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1010 Who is a qualified provider of extended state plan services? Providers of extended state plan services must be certified, registered or licensed therapists as required by law and contracted with DDD for the therapy they are providing.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1010, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1015 Are there limits to the extended state plan services I can receive? (1) Additional therapy may be authorized as a waiver service only after you have accessed what is available to you under Medicaid and any other private health insurance plan;

(2) The department does not pay for treatment determined by DSHS to be experimental;

(3) The department and the treating professional determine the need for and amount of service you can receive:

(a) The department reserves the right to require a second opinion from a department-selected provider.

(b) The department will require evidence that you have accessed your full benefits through Medicaid and private insurance before authorizing this waiver service.

(2007 Ed.)

(4) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1015, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1100 What are mental health crisis diversion bed services? Mental health crisis diversion bed services are temporary residential and behavioral services that may be provided in a client's home or licensed or certified setting. These services are available to eligible clients who are at risk of serious decline of mental functioning and who have been determined to be at risk of psychiatric hospitalization. These services are available in all four HCBS waivers administered by DDD as mental health stabilization services in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1100, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1105 Who is a qualified provider of mental health crisis diversion bed services? Providers of mental health crisis diversion bed services must be:

- (1) DDD certified residential agencies per chapter 388-101 WAC; or
- (2) Other department licensed or certified agencies.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1105, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1110 What are the limits of mental health crisis diversion bed services? (1) Mental health crisis diversion bed services are intermittent and temporary. The duration and amount of services you need to stabilize your crisis is determined by a mental health professional and/or DDD.

(2) These services are available in all four HCBS waivers administered by DDD as mental health stabilization services in accordance with WAC 388-845-1150 through 388-845-1160.

(3) The costs of mental health crisis diversion bed services do not count toward the dollar limits for aggregate services in the Basic and Basic Plus waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1110, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1150 What are mental health stabilization services? Mental health stabilization services assist persons who are experiencing a mental health crisis. These services are available in all four waivers to adults determined by mental health professionals or DDD to be at risk of institutionalization in a psychiatric hospital without one of more of the following services:

- (1) Behavior management and consultation;
- (2) Skilled nursing services;
- (3) Specialized psychiatric services; or
- (4) Mental health crisis diversion bed services.

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[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1150, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1155 Who are qualified providers of mental health stabilization services? Providers of these mental health stabilization services are listed in the rules in this chapter governing the specific services listed in WAC 388-845-1150.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1155, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1160 Are there limitations to the mental health stabilization services that I can receive? (1) Mental health stabilization services are intermittent and temporary. The duration and amount of services you need to stabilize your crisis is determined by a mental health professional and/or DDD.

(2) The costs of mental health stabilization services do not count toward the dollar limitations for aggregate services in the Basic and Basic Plus waiver.

(3) Mental health stabilization services require prior approval by DDD or its designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1160, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1200 What is a "person-to-person" service? "Person-to-person" is a day program service intended to assist participants to progress toward employment goals through individualized planning, skill instruction, information and referral, and one to one relationship building. This service may be provided in addition to community access, prevocational services, or supported employment. This service is available to adults in all four HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1200, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1205 Who is a qualified provider of person-to-person services? The provider of "person-to-person" services must be a county or an individual or agency contracted with a county or DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1205, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1210 Are there limits to the person-to-person service I can receive? (1) You must be age twenty-one and graduated from high school or age twenty-two or older to receive person-to-person services.

(2) The dollar limitations for employment/day program services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1210, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1300 What are personal care services? Personal care services are the provision of assistance with personal care tasks as defined in WAC 388-106-0010,

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personal care services. These services are available in the Basic, Basic Plus, and CORE waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1300, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1305 Who are the qualified providers of personal care services? (1) Qualified providers of personal care services may be individuals or licensed homecare agencies contracted with DDD.

(2) All individual providers and homecare agency providers must meet provider qualifications for in-home caregivers in WAC 388-71-0500 through 388-71-0556.

(3) Providers of personal care services for adults must comply with the training requirements in these rules governing Medicaid personal care providers in WAC 388-71-05670 through 388-71-05799.

(4) Natural, step, or adoptive parents can be the personal care provider of their adult child age eighteen or older.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1305, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1310 Are there limits to the personal care services I can receive? (1) You must meet the programmatic eligibility for Medicaid personal care in chapters 388-106 and 388-71 WAC governing Medicaid personal care (MPC) using the current department approved assessment form: Comprehensive assessment reporting evaluation (CARE) or children's comprehensive assessment.

(2) The maximum hours of personal care you may receive are determined by the approved department assessment for Medicaid personal care services.

(a) Provider rates are limited to the department established hourly rates for in-home Medicaid personal care.

(b) Homecare agencies must be licensed through the department of health and contracted with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1310, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1400 What are prevocational services? Prevocational services prepare an adult for paid or unpaid employment through the teaching of such concepts as compliance, attendance, task completion, problem solving and safety. These services are available in all four HCBS waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1400, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1405 Who are the qualified providers of prevocational services? Providers of prevocational services must be a county or an individual or agency contracted with a county or DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1405, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1410 Are there limits to the prevocational services I can receive? The following limitations apply to your receipt of prevocational services:

(1) You must be age twenty-one and graduated from high school or age twenty-two or older.

(2) You are not expected to be competitively employed within one year (excluding supported employment programs).

(3) You cannot be authorized to receive prevocational services if you receive community access services or supported employment services.

(4) The dollar limitations for employment/day program services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1410, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1500 What are residential habilitation services? Residential habilitation services (RHS) are available in the CORE and community protection waivers.

(1) Residential habilitation services include assistance:

(a) With personal care and supervision; and

(b) To learn, improve or retain social and adaptive skills necessary for living in the community.

(2) Residential habilitation services may provide instruction and support addressing one or more of the following outcomes:

(a) Health and safety;

(b) Personal power and choice;

(c) Competence and self-reliance;

(d) Positive recognition by self and others;

(e) Positive relationships; and

(f) Integration into the physical and social life of the community.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1500, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1505 Who are qualified providers of residential habilitation services for the CORE waiver? Providers of residential habilitation services for participants in the CORE waiver must be one of the following:

(1) Individuals contracted with DDD to provide residential support as a "companion home" provider;

(2) Individuals contracted with DDD to provide training as an "alternative living provider";

(3) Agencies contracted with DDD and certified per chapter 388-101 WAC;

(4) State-operated living alternatives (SOLA);

(5) Licensed and contracted group care homes, group training homes, foster homes, child placing agencies, staffed residential homes or adult residential rehabilitation centers per WAC 246-325-0012.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1505, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1510 Who are qualified providers of residential habilitation services for the community protection waiver? Providers of residential habilitation services

for participants of the community protection waiver are limited to state operated living alternatives (SOLA) and supported living providers who are contracted with DDD and certified under chapter 388-101 WAC as a residential community protection provider intensive supported living services (CP-ISLS).

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1510, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1515 Are there limits to the residential habilitation services I can receive? (1) You may only receive one type of residential habilitation service at a time.

(2) None of the following can be paid for under the CORE or community protection waiver:

(a) Room and board;

(b) The cost of building maintenance, upkeep, improvement, modifications or adaptations required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code;

(c) Activities or supervision already being paid for by another source;

(d) Services provided in your parent's home unless you are receiving alternative living services for a maximum of six months to transition you from your parent's home into your own home.

(3) The following persons cannot be paid providers for your service:

(a) Your spouse;

(b) Your natural, step, or adoptive parents if you are a child age seventeen or younger;

(c) Your natural, step, or adoptive parent unless your parent is certified as a residential agency per chapter 388-101 WAC or is employed by a certified or licensed agency qualified to provide residential habilitation services.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1515, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1600 What is respite care? Respite care is intended to provide short-term intermittent relief for persons normally providing care for waiver individuals. This service is available in the Basic, Basic Plus, and CORE waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1600, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1605 Who is eligible to receive respite care? The person providing your care is eligible to receive respite care if you are in the Basic, Basic Plus or CORE waiver and:

(1) You live in a private home with an unpaid caregiver; or

(2) You live with a paid caregiver who is:

(a) A natural, step or adoptive parent;

(b) A contracted companion home provider; or

(c) A licensed children's foster home provider.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1605, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1606 Can DDD approve an exception to the requirements in WAC 388-845-1605? DDD may approve an exception to WAC 388-845-1605 above only through June 30, 2006 if all of the following conditions exist:

- (1) Your live-in caregiver is a relative as defined in WAC 388-825-345(2);
- (2) You were living with this caregiver in January 2005;
- (3) Your relative caregiver was receiving payment from the department as your caregiver in January 2005; and
- (4) You were enrolled in the Basic, Basic Plus, or CORE waiver in January 2005.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1606, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1610 Where can respite care be provided? Respite care can be provided in the following location(s):

- (1) Individual's home or place of residence;
- (2) Relative's home;
- (3) Licensed children's foster home;
- (4) Licensed, contracted and DDD certified group home;
- (5) State operated living alternative (SOLA) and other DDD certified supported living settings;
- (6) Licensed boarding home contracted as an adult residential center;
- (7) Adult residential rehabilitation center;
- (8) Licensed and contracted adult family home;
- (9) Children's licensed group home, licensed staffed residential home, or licensed childcare center;
- (10) Other community settings such as camp, senior center, or adult day care center.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1610, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1615 Who are qualified providers of respite care? Providers of respite care can be any of the following individuals or agencies contracted with DDD for respite care:

- (1) Individuals meeting the provider qualifications under chapter 388-825 WAC;
- (2) Homecare/home health agencies, licensed under chapter 246-335 WAC, Part 1;
- (3) Licensed and contracted group homes, foster homes, child placing agencies, staffed residential homes and foster group care homes;
- (4) Licensed and contracted adult family home;
- (5) Licensed and contracted adult residential care facility;
- (6) Licensed and contracted adult residential rehabilitation center under WAC 246-325-012;
- (7) Licensed childcare center under chapter 388-295 WAC;
- (8) Licensed child daycare center under chapter 388-295 WAC;
- (9) Adult daycare centers contracted with DDD;
- (10) Certified provider per chapter 388-101 WAC when respite is provided within the DDD contract for certified residential services; or

[Title 388 WAC—p. 1336]

(11) Other DDD contracted providers such as community center, senior center, parks and recreation, summer programs, adult day care.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1615, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1620 Are there limits to the respite care I can receive? The following limitations apply to the respite care you can receive:

(1) If you are in the Basic or Basic Plus waiver, a respite care assessment will determine how much respite you can receive per WAC 388-845-3005 through 388-845-3050.

(2) If you are in the CORE waiver, the plan of care (POC), not the respite assessment, will determine the amount of respite care you can receive.

(3) Prior approval by DDD is required to exceed fourteen days per month.

(4) Respite cannot replace:

- (a) Daycare while a parent or guardian is at work; and/or
- (b) Personal care hours available to you. When determining your unmet need, DDD will first consider the personal care hours available to you.

(5) Respite providers have the following limitations and requirements:

(a) If respite is provided in a private home, the home must be licensed unless it is the client's home or the home of a relative of specified degree per WAC 388-825-345;

(b) The respite provider cannot be the spouse of the caregiver receiving respite if the spouse and the caregiver reside in the same residence; and

(c) If you receive respite from a provider who requires licensure, the respite services are limited to those age-specific services contained in the provider's license.

(6) Your caregiver cannot provide paid respite services for you or other persons during your respite care hours.

(7) If you require respite from a licensed practical nurse (LPN) or a registered nurse (RN), services may be authorized as skilled nursing services per WAC 388-845-1700 using an LPN or RN. If you are in the Basic Plus waiver, skilled nursing services are limited to the dollar limits of your aggregate services per WAC 388-845-0210. The dollar limit governing aggregate services does not apply to skilled nursing services provided as part of mental health stabilization services per WAC 388-845-1100(2).

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1620, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1650 What are sexual deviation evaluations? Sexual deviation evaluations are professional evaluations of sexual deviancy to determine the need for psychological, medical or therapeutic services. Sexual deviancy evaluations are available in all four waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1650, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1655 Who is a qualified provider of sexual deviation evaluations? The provider of sexual deviation evaluations must:

(1) Be a certified sexual offender treatment provider (SOTP); and

(2) Meet the standards contained in WAC 246-930-030 (education required prior to examination) and WAC 246-930-040 (professional experience required prior to examination).

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1655, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1660 Are there limitations to the sexual deviation evaluations I can receive? (1) The evaluations must meet the standards contained in WAC 246-930-320.

(2) The costs of sexual deviation evaluations do not count toward the dollar limits for aggregate services in the Basic or Basic Plus waivers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1660, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1700 What is skilled nursing? (1) Skilled nursing is continuous, intermittent, or part time nursing services. These services are available in the Basic Plus, CORE, and community protection waivers.

(2) Services include nurse delegation services provided by a registered nurse, including the initial visit, follow-up instruction, and/or supervisory visits.

(3) These services are available in all four HCBS waivers administered by DDD as mental health stabilization services in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1700, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1705 Who is a qualified provider of skilled nursing services? The provider of skilled nursing services must be a licensed practical nurse (LPN) or registered nurse (RN) acting within the scope of the Nurse Practice Act chapter 246-845 WAC and contracted with DDD to provide this service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1705, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1710 Are there limitations to the skilled nursing services I can receive? The following limitations apply to your receipt of skilled nursing services:

(1) Skilled nursing services require prior approval by DDD.

(2) The department and the treating professional determine the need for and amount of service.

(3) The department reserves the right to require a second opinion by a department-selected provider.

(4) Skilled nursing services provided as a mental health stabilization service require prior approval by DDD or its designee.

(5) The dollar limitation for aggregate services in your Basic Plus waiver limit the amount of skilled nursing services unless provided as a mental health stabilization service.

(2007 Ed.)

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1710, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1800 What are specialized medical equipment and supplies? (1) Specialized medical equipment and supplies are services to help individuals with their activities of daily living or to better participate in their environment. These services are available in all four HCBS waivers.

(2) Included are devices, controls, appliances, and items necessary for life support; ancillary supplies and equipment necessary to the proper functioning of such items; and durable and nondurable medical equipment not available through Medicaid under the Medicaid state plan.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1800, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1805 Who are the qualified providers of specialized medical equipment and supplies? The provider of specialized medical equipment and supplies must be a medical equipment supplier contracted with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1805, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1810 Are there limitations to my receipt of specialized medical equipment and supplies? The following limitations apply to your receipt of specialized medical equipment and supplies:

(1) Prior approval by the department is required for each authorization.

(2) The department reserves the right to require a second opinion by a department-selected provider.

(3) Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the Medicaid state plan.

(4) Items must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability.

(5) Medications, prescribed or nonprescribed, and vitamins are excluded.

(6) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1810, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1900 What are specialized psychiatric services? (1) Specialized psychiatric services are specific to the individual needs of persons with developmental disabilities who are experiencing mental health symptoms. These services are available in all four HCBS waivers.

(2) Service may be any of the following:

(a) Psychiatric evaluation,

(b) Medication evaluation and monitoring,

(c) Psychiatric consultation.

(3) These services are also available as a mental health stabilization service in accordance with WAC 388-845-1150 through 388-845-1160.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1900, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1905 Who are qualified providers of specialized psychiatric services? Providers of specialized psychiatric services must be one of the following licensed or registered, and contracted healthcare professionals:

- (1) Psychiatrist;
- (2) Psychiatric advanced registered nurse practitioner (ARNP); or
- (3) Physician assistant working under the supervision of a psychiatrist.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1905, filed 12/13/05, effective 1/13/06.]

WAC 388-845-1910 Are there limitations to the specialized psychiatric services I can receive? (1) Specialized psychiatric services are excluded if they are available through other Medicaid programs.

(2) The dollar limitations for aggregate service in your Basic and Basic Plus waiver limit the amount of specialized psychiatric services unless provided as a mental health stabilization service.

(3) Specialized psychiatric services provided as a mental health stabilization service require prior approval by DDD or its designee.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-1910, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2000 What is staff/family consultation and training? (1) Staff/family consultation and training is professional assistance to families or direct service providers to help them better meet the needs of the waiver person. This service is available in all four HCBS waivers.

(2) Consultation and training is provided to families, direct staff, or personal care providers to meet the specific needs of the waiver participant as outlined in the individual's plan of care, including:

- (a) Health and medication monitoring;
- (b) Positioning and transfer;
- (c) Basic and advanced instructional techniques;
- (d) Positive behavior support; and
- (e) Augmentative communication systems.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training? To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDD:

- (1) Audiologist;
- (2) Licensed practical nurse;
- (3) Marriage and family therapist;
- (4) Mental health counselor;
- (5) Occupational therapist;
- (6) Physical therapist;
- (7) Registered nurse;

- (8) Sex offender treatment provider;
- (9) Speech/language pathologist;
- (10) Social worker;
- (11) Psychologist;
- (12) Certified American sign language instructor;
- (13) Nutritionist;
- (14) Registered counselor; or
- (15) Certified dietician.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2005, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2010 Are there limitations to the staff/family consultation and training I can receive? (1) Expenses to the family or provider for room and board or attendance, including registration, at conferences are excluded as a service under staff/family consultation and training.

(2) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2010, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2100 What is supported employment? Supported employment provides intensive ongoing individual or group support in a work setting to adults with developmental disabilities. This service is available in all four HCBS waivers.

(1) Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

(2) Supported employment is conducted in a variety of settings; particularly work sites in which persons without disabilities are employed.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2100, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2105 Who is a qualified provider of supported employment? A supported employment provider must be a county, or agencies or individuals contracted with a county or DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2105, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2110 Are there limits to the supported employment I can receive? The following limitations apply to your receipt of supported employment:

(1) You must be age twenty-one and graduated from high school or age twenty-two or older.

(2) Payment will be made only for the adaptations, supervision, training, and support with the activities of daily living you require as a result of your disabilities.

(3) Payment is excluded for the supervisory activities rendered as a normal part of the business setting.

(4) You cannot be authorized to receive supported employment services if you receive community access services or prevocational services.

(5) The dollar limitations for employment/day program services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2110, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2200 What are transportation services? Transportation services provide reimbursement to a provider when the transportation is required and specified in the waiver plan of care. This service is available in all four HCBS waivers.

(1) Transportation provides the person access to waiver services, specified by the plan of care.

(2) Whenever possible, the person must use family, neighbors, friends, or community agencies that can provide this service without charge.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2200, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2205 Who is qualified to provide transportation services? The provider of transportation services can be an individual or agency contracted with DDD.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2205, filed 12/13/05, effective 1/13/06.]

WAC 388-845-2210 Are there limitations to the transportation services I can receive? The following limitations apply to transportation services:

(1) Transportation to/from medical or medically related appointments is a Medicaid transportation service and is to be considered and used first.

(2) Transportation is offered in addition to medical transportation but cannot replace Medicaid transportation services.

(3) Transportation is limited to travel to and from a waiver service.

(4) Transportation does not include the purchase of a bus pass.

(5) Reimbursement for provider mileage requires prior approval by DDD and is paid according to contract.

(6) This service does not cover the purchase or lease of vehicles.

(7) Reimbursement for provider travel time is not included in this service.

(8) Reimbursement to the provider is limited to transportation that occurs when you are with the provider.

(9) You are not eligible for transportation services if the cost and responsibility for transportation is already included in your waiver provider's contract and payment.

(10) The dollar limitations for aggregate services in your Basic or Basic Plus waiver limit the amount of service you may receive.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-2210, filed 12/13/05, effective 1/13/06.]

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ASSESSMENT AND PLAN OF CARE

WAC 388-845-3000 What is the process for determining the services I need? Your service needs are determined through the ICF-MR level of care assessment and the service planning process.

(1) You receive an initial and annual assessment of your needs using a department-approved form.

(a) The ICF-MR level of care assessment identifies your need for waiver services.

(b) The "comprehensive assessment reporting evaluation (CARE)" will determine your eligibility and amount of personal care services.

(c) If you are in the Basic or Basic Plus waiver, a DDD respite assessment will determine the amount of respite care available to you.

(2) From the assessment, DDD develops your waiver plan of care (POC) with you and/or your legal representative and others who are involved in your life such as your parent or guardian, advocate and service providers.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3005 What is the waiver respite assessment? The waiver respite assessment is a series of questions about you and your primary caregiver that will determine the amount of respite care available to you.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3005, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3010 Who must have a waiver respite assessment? (1) If you are in the Basic or Basic Plus waiver and are interested in receiving respite care, and are eligible for respite care per WAC 388-845-1605, your personal care needs must first be assessed by CARE.

(2) A respite assessment will then determine the amount of respite care available to you.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3010, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3015 How is the waiver respite assessment administered? The waiver respite assessment is administered by department staff during an in-person interview with you if you choose to be present, and at least one other person with knowledge of you, such as your primary caregiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3015, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3020 Who can be the respondent for the waiver respite assessment? The respondent for your waiver respite assessment must be an adult who is well acquainted with you and can provide the information needed to complete the assessment, such as your primary caregiver.

(1) You cannot be the respondent for your own respite assessment.

(2) The department may select and interview additional respondents as needed to get complete and accurate information.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3020, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3025 How often is this waiver respite assessment completed? Your waiver respite assessment must be completed at the time of your CARE assessment/reassessment.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3025, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3030 What items are assessed to determine my respite allocation? The waiver respite assessment documents information about you and your caregiver. Information must reflect what is currently happening, not what may occur in the future or what has occurred more than thirty days ago. The information documented includes:

- (1) The level of monitoring you require, above and beyond what is typically required for persons of similar age;
- (2) Circumstances in your primary caregiver's life that may impact his/her care giving ability;
- (3) The effect of your disability on other household members;
- (4) Your primary caregiver's care giving responsibilities for others;
- (5) How many parents, legal representatives and/or primary caregivers live in the same household as you;
- (6) Availability of others to provide your care; and
- (7) Your disability related emotional or behavior issues and how that affects your caregiver; the frequency and severity of these issues; and what a caregiver does to help you manage these behaviors.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3030, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3035 How is the waiver respite assessment scored? The responses to the waiver respite assessment are converted to a respite lid.

(1) The respite lid represents the maximum number of respite hours you are authorized to receive in a twelve-month period.

(2) You may use as many respite hours as you need, up to your assessed respite lid.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3035, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3040 When will the new respite assessment go into effect? The new respite assessment will be effective at the time of your next CARE assessment/reassessment.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3040, filed 12/13/05, effective 1/13/06.]

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WAC 388-845-3045 How will I know the results of my respite assessment? Your respite care allocation will be written into your plan of care as a separate, authorized service.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3045, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3050 What is the effective date of my respite allocation? Your respite care allocation is effective when your respite assessment is completed and authorized in your annual or amended POC.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3050, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3055 What is a waiver plan of care (POC)? (1) The plan of care is the primary tool DDD uses to determine and document your needs and to identify the services to meet those needs.

(2) Your plan must include:

(a) The services that you and DDD have agreed are necessary for you to receive in order to address your health and welfare needs as specified in WAC 388-845-3000;

(b) Both paid and unpaid services you receive or need;

(c) How often you will receive each waiver service; how long you will need it; and who will provide it; and

(d) Your signature on the plan indicating your agreement.

(3) You may choose any qualified provider for the service, who meets all of the following:

(a) Is able to meet your needs within the scope of their contract, licensure and certification;

(b) Is reasonably available;

(c) Meets provider qualifications in chapters 388-845 and 388-825 WAC for contracting; and

(d) Agrees to provide the service at department rates.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3055, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3060 When is my plan of care effective? Your plan of care is effective the date DDD signs and approves it.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3060, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3065 How long is my plan effective? Your plan of care is effective through the last day of the twelfth month following the effective date.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3065, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3070 What happens if I do not sign my plan of care? If DDD is unable to obtain the necessary signature on the plan of care from you or your legal representative, DDD will take one or more of the following actions:

(1) DDD will continue providing services as identified in your most current POC for up to thirty days from the date you

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were notified of the plan to implement your most current POC.

(2) After thirty days, unless you file an appeal, DDD will assume consent and implement the new POC without your signature or the signature of your legal representative.

(3) You will be provided written notification and appeal rights to this action to implement the new POC.

(4) Your appeal rights are in WAC 388-825-120 through 388-825-165.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3070, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3075 What if my needs change? You may request a review of your plan of care at any time by calling your case manager. If there is a significant change in your condition or circumstances, DDD must reassess your plan of care with you and amend the plan to reflect any significant changes. This reassessment does not affect the end date of your annual plan of care.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3075, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3080 What if my needs exceed the maximum yearly funding limit or the scope of services under the Basic or Basic Plus waiver? (1) If you are on the Basic or Basic Plus waiver and your assessed need for services exceeds the maximum permitted, DDD will make the following efforts to meet your health and welfare needs:

(a) Identify more available natural supports;

(b) Initiate an exception to rule to access available non-waiver services not included in the Basic or Basic Plus waiver other than natural supports;

(c) Authorize emergency services up to six thousand dollars per year if your needs meet the definition of emergency services in WAC 388-845-0800.

(2) If emergency services and other efforts are not sufficient to meet your needs, you will be offered:

(a) An opportunity to apply for an alternate waiver that has the services you need;

(b) Priority for placement on the alternative waiver when there is capacity to add people to that waiver;

(c) Placement in an ICF/MR.

(3) If none of the options in subsections (1) and (2) above is successful in meeting your health and welfare needs, DDD may terminate your waiver eligibility.

(4) If you are terminated from a waiver, you will remain eligible for nonwaiver DDD services but access to state-only funded DDD services is limited by availability of funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3080, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3085 What if my needs exceed what can be provided under the CORE or community protection waiver? (1) If you are on the CORE or community protection waiver and your assessed need for services exceeds the scope of services provided under your waiver, DDD will make the following efforts to meet your health and welfare needs:

(a) Identify more available natural supports;

(b) Initiate an exception to rule to access available non-waiver services not included in the CORE or community protection waiver other than natural supports;

(c) Offer you the opportunity to apply for an alternate waiver that has the services you need, subject to WAC 388-845-0045;

(d) Offer you placement in an ICF/MR.

(2) If none of the above options is successful in meeting your health and welfare needs, DDD may terminate your waiver eligibility.

(3) If you are terminated from a waiver, you will remain eligible for nonwaiver DDD services but access to state-only funded DDD services is limited by availability of funding.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3085, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3090 What if my identified health and welfare needs are less than what is provided in my current waiver? If your identified health and welfare needs are less than what is provided in your current waiver, DDD may terminate you from your current waiver and enroll you in a waiver that meets but does not exceed your assessed need for waiver services.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3090, filed 12/13/05, effective 1/13/06.]

WAC 388-845-3095 Will I have to pay toward the cost of waiver services? (1) Depending on your SSI status, Medicaid status, income and resources, you may be required to participate towards the cost of your care. DDD determines what amount, if any, you pay.

(2) If you live in a licensed facility, you participate from your earned and unearned income per rules in WAC 388-515-1510:

(a) If you have nonexempt income that exceeds the cost of your waiver services, you may keep the difference.

(b) If you are eligible for SSI, you pay only for room and board.

(c) If you are not eligible for SSI, you may be required to participate towards the cost of your waiver services in addition to your facility room and board rate.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-3095, filed 12/13/05, effective 1/13/06.]

WAC 388-845-4000 What are my appeal rights under the waiver? You have appeal rights under WAC 388-825-120 to the following decisions:

(1) Any denial, reductions, or termination of a service.

(2) A denial or termination of your choice of a qualified provider.

(3) Your termination from waiver eligibility.

(4) Denial of your request to receive ICF/MR services instead of waiver services.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-4000, filed 12/13/05, effective 1/13/06.]

WAC 388-845-4005 Can I appeal a denial of my request to be enrolled in a waiver? You do not have an appeal right to a denial to be enrolled in a waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-4005, filed 12/13/05, effective 1/13/06.]

WAC 388-845-4010 How do I appeal a department action? (1) Your rights to appeal a department decision are in RCW 71A.10.050 and WAC 388-825-120 and are limited to an applicant, recipient, or former recipient of services from the division of developmental disabilities.

(2) If you want to appeal a department action, you must request an appeal within ninety days from receipt of the department notice of the action you are disputing.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-4010, filed 12/13/05, effective 1/13/06.]

WAC 388-845-4015 Will my services continue during an appeal? Services may continue according to the provisions contained in WAC 388-825-145.

[Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-4015, filed 12/13/05, effective 1/13/06.]

Chapter 388-850 WAC COUNTY PLAN FOR DEVELOPMENTAL DISABILITIES

(Formerly chapter 275-25 WAC)

WAC

388-850-010	Definitions.
388-850-015	Exemptions.
388-850-020	Plan development and submission.
388-850-025	Program operation—General provisions.
388-850-030	Appeal procedure.
388-850-035	Services—Developmental disabilities.
388-850-040	Rights—Health and safety assured.
388-850-045	Funding formula—Developmental disabilities.
388-850-050	Client rights—Notification of client.

WAC 388-850-010 Definitions. (1) All terms used in this chapter not defined herein shall have the same meaning as indicated in the act.

(2) "Act" means local funds for community services chapter 71.20 RCW, State services chapter 71A.12 RCW, and Local services chapter 71A.14 RCW as now existing or hereafter amended.

(3) "County" means each county or two or more counties acting jointly.

(4) "Department" means the department of social and health services.

(5) "Exemption" means the department's approval of a written request for an exception to a rule in this chapter.

(6) "Indian" shall mean any:

(a) Person enrolled in or eligible for enrollment in a recognized Indian tribe; any person determined to be or eligible to be found to be an Indian by the secretary of the interior; and any Eskimo, Aleut or other Alaskan native;

(b) Canadian Indian person who is a member of a treaty tribe, Metis community, or other nonstatus Indian community from Canada;

(c) Unenrolled Indian person considered an Indian by a federally or nonfederally recognized Indian tribe or by an urban Indian/Alaska community organization.

(7) "Plan" means the application a county submits to the secretary for review and approval under the act(s); or revision of an existing plan.

(8) "Population" means the most recent estimate of the aggregate number of persons located in the designated county as computed by the office of financial management.

(9) "Secretary" means the secretary of the department or such employee or such unit of the department as the secretary may designate.

[99-19-104, recodified as § 388-850-010, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234. 93-15-013 (Order 3591), § 275-25-010, filed 7/8/93, effective 8/8/93. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-010, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-010, filed 1/12/83; Order 1142, § 275-25-010, filed 8/12/76. Formerly chapters 275-12, 275-13 and 275-29 WAC.]

WAC 388-850-015 Exemptions. (1) The department may approve an exemption to a specific rule in this chapter as defined under WAC 388-850-010(5) provided an:

(a) Assessment of the exemption request ensures granting the exemption shall not undermine the legislative intent of Title 71A RCW; and

(b) Evaluation of the exemption request shows granting the exemption shall not adversely affect the quality of the services, supervision, health, and safety of department-served persons.

(2) Agencies and individual providers shall retain a copy of each department-approved exemption.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-850-015, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-850-015, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-015, filed 8/9/91, effective 9/9/91.]

WAC 388-850-020 Plan development and submission. (1) All dates in this section refer to the twenty-four-month period prior to the start of the state fiscal biennium.

(2) Before July 1, in the odd year of each biennium, the department shall negotiate with and submit to counties the biennial plan guidelines.

(3) Before July 1, the department shall submit to counties needs assessment data, and before December 31, updated needs assessment data in the odd year of each biennium.

(4) Before April 1, of the even year of each biennium, each county shall submit to the department a written plan for developmental disabilities services for the subsequent state fiscal biennium. The county's written plan shall be in the form and manner prescribed by the department in the written guidelines.

(5) Within sixty days of receipt of the county's written plan, the department shall acknowledge receipt, review the plan, and notify the county of errors and omissions in meeting minimum plan requirements.

(6) Within thirty days after receipt, each county shall submit a response to the department's review when errors and omissions have been identified within the review.

(7) Before December 15 of the even year of each biennium, the department shall announce the amount of funds included in the department's biennial budget request to each county. The department shall announce the actual amount of funds appropriated and available to each county as soon as possible after final passage of the Biennial Appropriations Act.

(8) Each county shall submit to the department a contract proposal within sixty days of the announcement by the department of the actual amount of funds appropriated and available.

(9) The department may modify deadlines for submission of county plans and responses to reviews or contract proposals when, in the department's judgment, the modification enables the county to improve the program or planning process.

(10) The department may authorize the county to continue providing services in accordance with the previous plan and contract, and reimburse at the average level of the previous contract, in order to continue services until the new contract is executed.

[99-19-104, recodified as § 388-850-020, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030 and 71A.16.020. 92-09-115 (Order 3373), § 275-25-020, filed 4/21/92, effective 5/21/92. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-020, filed 1/12/83. Statutory Authority: RCW 69.54.040, 78-08-086 (Order 1322), § 275-25-020, filed 7/28/78; Order 1142, § 275-25-020, filed 8/12/76.]

WAC 388-850-025 Program operation—General provisions. (1) The provisions of this section shall apply to all programs operated under authority of the acts.

(2) The county and all contractors and subcontractors must comply with all applicable law or rule governing the department's approval of payment of funds for the programs. Verification may be in the manner and to the extent requested by the secretary.

(3) State funds shall not be paid to a county for costs of services provided by the county or other person or organization who or which was not licensed, certified, and approved as required by law or by rule whether or not the plan was approved by the secretary.

(4) The secretary may impose such reasonable fiscal and program reporting requirements as the secretary deems necessary for effective program management.

(5) Funding.

(a) The department and county shall negotiate and execute a contract before the department provides reimbursement for services under contract, except as provided under WAC 388-850-020(10).

(b) Payments to counties shall be made on the basis of vouchers submitted to the department for costs incurred under the contract. The department shall specify the form and content of the vouchers.

(c) The secretary may make advance payments to counties, where such payments would facilitate sound program management. The secretary shall withhold advance payments from counties failing to meet the requirements of WAC 388-850-020 until such requirements are met. Any county failing to meet the requirements of WAC 388-850-020 after advance payments have been made shall repay said advance payment

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within thirty days of notice by the department that the county is not in compliance.

(d) If the department receives evidence a county or subcontractor performing under the contract is:

- (i) Not in compliance with applicable state law or rule; or
- (ii) Not in substantial compliance with the contract; or
- (iii) Unable or unwilling to provide such records or data

as the secretary may require, then the secretary may withhold all or part of subsequent monthly disbursement to the county until such time as satisfactory evidence of corrective action is forthcoming. Such withholding or denial of funds shall be subject to appeal under the Administrative Procedure Act (chapter 34.05 RCW).

(6) **Subcontracting.** A county may subcontract for the performance of any of the services specified in the contract. The county's subcontracts shall include:

(a) A precise and definitive work statement including a description of the services provided;

(b) The subcontractor's specific agreement to abide by the acts and the rules;

(c) Specific authority for the secretary and the state auditor to inspect all records and other material the secretary deems pertinent to the subcontract; and agreements by the subcontractor that such records will be made available for inspection;

(d) Specific authority for the secretary to make periodic inspection of the subcontractor's program or premises in order to evaluate performance under the contract between the department and the county; and

(e) Specific agreement by the subcontractor to provide such program and fiscal data as the secretary may require.

(7) **Records: Maintenance.** Client records shall be maintained for every client for whom services are provided and shall document:

- (a) Client demographic data;
- (b) Diagnosis or problem statement;
- (c) Treatment or service plan; and
- (d) Treatment or services provided including medications prescribed.

(8) Liability.

(a) The promulgation of these rules or anything contained in these rules shall not be construed as affecting the relative status or civil rights or liabilities between:

- (i) The county and community agency; or
- (ii) Any other person, partnership, corporation, association, or other organization performing services under a contract or required herein and their employees, persons receiving services, or the public.

(b) The use or implied use herein of the word "duty" or "responsibility" or both shall not import or imply liability other than provided for by the statutes or general laws of the state of Washington, to any person for injuries due to negligence predicated upon failure to perform on the part of an applicant, or a board established under the acts, or an agency, or said agency's employees, or persons performing services on said agency's behalf.

(c) Failure to comply with any compulsory rules shall be cause for the department to refuse to provide the county and community agency funds under the contract.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-850-025,

filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-850-025, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.030. 91-17-005 (Order 3230), § 275-25-030, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-030, filed 1/12/83; Order 1142, § 275-25-030, filed 8/12/76.]

WAC 388-850-030 Appeal procedure. (1) Any agency making application to participate in a county program operated under authority of the act(s), which is dissatisfied with the disposition of its application, or the community board(s) as defined in the act(s) or the community social services board, which is dissatisfied with any aspect of the plan, may appeal for a hearing before the county governing body. The county governing body shall review the appeal and notify the agency or board of its disposition within thirty days after the appeal has been received.

(2) A county which is dissatisfied with the department's disposition of its plan may request an administrative review.

(3) All requests for administrative reviews shall:

(a) Be made in writing to the appropriate program office within the department;

(b) Specify the date of the decision being appealed;

(c) Specify clearly the issue to be resolved by the review;

(d) Be signed by, and include the address of the county or its representative;

(e) Be made within thirty days of notification of the decision which is being appealed.

(4) An administrative review and redetermination shall be provided by the department within thirty days of the submission of the request for review, with written confirmation of the findings and the reasons for the findings to be forwarded to the county as soon as possible.

(5) Any county dissatisfied with the finding of an administrative review or who chooses not to request an administrative review may initiate proceedings pursuant to the Administrative Procedure Act (chapter 34.05 RCW).

[99-19-104, recodified as § 388-850-030, filed 9/20/99, effective 9/20/99. Statutory Authority: Chapters 70.96A and 34.05 RCW and P.L. 102-234. 93-15-013 (Order 3591), § 275-25-040, filed 7/8/93, effective 8/8/93; Order 1142, § 275-25-040, filed 8/12/76.]

WAC 388-850-035 Services—Developmental disabilities. (1) A county may purchase and provide services listed under chapter 71A.14 RCW.

(2) The department shall pay a county for department authorized services provided to an eligible developmentally disabled person.

(3) A county may purchase or provide authorized services. Authorized services may include, but are not limited to:

- (a) Early childhood intervention services;
- (b) Employment services;
- (c) Community access services;
- (d) Residential services;
- (e) Individual evaluation;
- (f) Program evaluation;
- (g) County planning and administration; and
- (h) Consultation and staff development.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-850-035, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-850-035, filed 12/29/03, effective 1/29/04. 99-19-104, recodified as § 388-850-035, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW

71A.14.030. 91-17-005 (Order 3230), § 275-25-520, filed 8/9/91, effective 9/9/91. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-25-520, filed 3/1/82. Statutory Authority: RCW 71.20.030, 71.20.050, and 71.20.070. 78-04-002 (Order 1278), § 275-25-520, filed 3/2/78; Order 1142, § 275-25-520, filed 8/12/76.]

WAC 388-850-040 Rights—Health and safety assured. A county, when contracting for specific services, must assure that client rights and client health and safety are protected.

[99-19-104, recodified as § 388-850-040, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71.20.070, 72.33.125 and 72.33.850. 82-06-034 (Order 1771), § 275-25-527, filed 3/1/82.]

WAC 388-850-045 Funding formula—Developmental disabilities. (1) For the purposes of this section, "county" shall mean the legal subdivision of the state, regardless of any agreement with another county to provide developmental disabilities services jointly.

(2) The allocation of funds to counties shall be based on the following criteria:

(a) Each county shall receive a base amount of funds. The amount shall be based on the prior biennial allocation, including any funds from budget provisos from the prior biennium, and subject to the availability of state and federal funds;

(b) The distribution of any additional funds provided by the legislature or other sources shall be based on a distribution formula which best meets the needs of the population to be served as follows:

(i) On a basis which takes into consideration minimum grant amounts, requirements of clients residing in an ICF/MR or clients on one of the division's Title XIX home and community-based waivers, and the general population of the county, and special education enrollment as well as the population eligible for county-funded developmental disabilities services;

(ii) On a basis that takes into consideration the population numbers of minority groups residing within the county;

(iii) A biennial adjustment shall be made after these factors are considered; and

(iv) Counties not receiving any portion of additional funds pursuant to this formula shall not have their base allocation reduced due to application of this formula.

(c) Funding appropriated through legislative proviso, including vendor rate increases, shall be distributed to the population directed by the legislature utilizing a formula as directed by the legislature or using a formula specific to that population or distributed to identified people;

(d) The ability of the community to provide funds for the developmental disability program provided in chapter 71A.14 RCW may be considered with any or all of the above.

(3) A county may utilize seven or less percent of the county's allocated funds for county administrative expenses. A county may utilize more than seven percent for county administration with approval of the division director. A county electing to provide all services directly, in addition to county administration, is exempt from this requirement.

(4) The department may withhold five or less percent of allocated funds for new programs, for statewide priority programs, and for emergency needs.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, 71A.14.040, and Title 71A RCW. 05-11-015, § 388-850-045, filed 5/9/05, effective 6/9/05. Statutory Authority: RCW 71A.12.030, 71A.10.020 and 2002 c 371. 04-02-014, § 388-850-045, filed 12/29/03, effective 1/29/04. 99-19-104, recodified as § 388-850-045, filed 9/20/99, effective 9/20/99. Statutory Authority: RCW 71A.14.040. 92-13-032 (Order 3404), § 275-25-530, filed 6/10/92, effective 7/11/92. Statutory Authority: RCW 71A.14.030. 91-17-005 and 91-17-025 (Orders 3230 and 3230A), § 275-25-530, filed 8/9/91 and 8/14/91, effective 9/9/91 and 9/14/91. Statutory Authority: RCW 69.54.040 and 71.24.190. 83-03-011 (Order 1936), § 275-25-530, filed 1/12/83; Order 1142, § 275-25-530, filed 8/12/76.]

WAC 388-850-050 Client rights—Notification of client. (1) All agencies providing services under the act shall post a statement of client rights. Such statement shall inform the client of the client's right to:

- (a) Be treated with dignity;
- (b) Be protected from invasion of privacy;
- (c) Have information about him/her treated confidentially;
- (d) Actively participate in the development or modification of his/her treatment program;
- (e) Be provided treatment in accordance with accepted quality-of-care standards and which is responsive to his/her best interests and particular needs;
- (f) Review his/her treatment records with the therapist at least bimonthly: Provided, That information confidential to other individuals shall not be reviewed by the client;
- (g) Be fully informed regarding fees to be charged and methods for payment.

(2) Clients shall be informed of their rights pursuant to WAC 388-865-0515 upon admission to inpatient service.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-850-050, filed 7/25/02, effective 8/25/02. 99-19-104, recodified as § 388-850-050, filed 9/20/99, effective 9/20/99; Order 1142, § 275-25-755, filed 8/12/76.]

Chapter 388-853 WAC

COSTS OF CARE OF MENTALLY DEFICIENT PERSONS RESIDING IN STATE INSTITUTIONS

(Formerly chapter 275-20 WAC)

WAC

388-853-010	Authority.
388-853-030	Schedule of per capita cost.
388-853-035	Exempt income.
388-853-080	Notice and finding of responsibility—Appeal procedure.

WAC 388-853-010 Authority. The following rules regarding costs of care of mentally/physically deficient persons are hereby adopted under the authority of chapter 72.01 RCW.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-853-010, filed 7/25/02, effective 8/25/02. 00-17-151, recodified as § 388-853-010, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-20-010, filed 2/17/78; Order 2, § 275-20-010, filed 2/23/68.]

WAC 388-853-030 Schedule of per capita cost. Resident charges will be established in accordance with the methodology promulgated under chapter 388-835 WAC.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-853-030, (2007 Ed.)

filed 7/25/02, effective 8/25/02. 00-17-151, recodified as § 388-853-030, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 72.33.660. 84-18-022 (Order 2144), § 275-20-030, filed 8/29/84. Statutory Authority: RCW 72.33.600. 83-18-028 (Order 2018), § 275-20-030, filed 8/31/83; 82-20-022 (Order 1885), § 275-20-030, filed 9/29/82; 81-17-025 (Order 1690), § 275-20-030, filed 8/12/81; 81-06-004 (Order 1611), § 275-20-030, filed 2/19/81; 80-12-011 (Order 1535), § 275-20-030, filed 8/25/80; 80-02-060 (Order 1480), § 275-20-030, filed 1/18/80; 79-08-044 (Order 1418), § 275-20-030, filed 7/19/79; 78-10-057 (Order 1341), § 275-20-030, filed 9/22/78. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-20-030, filed 2/17/78; Order 1191, § 275-20-030, filed 2/18/77; Order 1071, § 275-20-030, filed 12/2/75; Order 982, § 275-20-030, filed 11/14/74, effective 1/1/75; Order 903, § 275-20-030, filed 1/29/74; Order 808, § 275-20-030, filed 6/15/73, effective 8/1/73; Order 15, § 275-20-030, filed 5/11/71; Order 2, § 275-20-030, filed 2/23/68.]

WAC 388-853-035 Exempt income. Residents whose total resources are insufficient to pay the actual cost of care shall be entitled to a monthly exemption from income in the amount of twenty-five dollars or such amount as specified in chapter 388-835 WAC.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-853-035, filed 7/25/02, effective 8/25/02. 00-17-151, recodified as § 388-853-035, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-20-035, filed 2/17/78.]

WAC 388-853-080 Notice and finding of responsibility—Appeal procedure. (1) When the department determines that the estate of a resident of a state residential habilitation center is able to pay all or a portion of the monthly charges for care, support, and treatment, the department shall serve a notice and finding of responsibility (NFR) on the:

- (a) Guardian of the resident's estate; or
- (b) If a guardian has not been appointed, resident's spouse or parent or other person acting in a representative capacity and in possession of the resident's property, and the superintendent of the state school.

(2) When a resident is an adult and is not under a legal disability, the department shall personally serve the NFR on the resident.

(3) The NFR shall state the amount which the department determines the resident's estate is able to pay per month. The amount shall not exceed the monthly charges fixed under RCW 43.20B.420.

(4) The resident's or guardian's responsibility for payment to the department shall commence twenty-eight days after service of the NFR.

(5) The right to an adjudicative proceeding contesting the NFR is contained in RCW 43.20B.430.

(a) A financially responsible person wishing to contest the NFR shall, within twenty-eight days of receipt of the NFR:

(i) File a written application for an adjudicative proceeding showing proof of receipt with the Secretary, DSHS, Attn: Determination Officer, P.O. Box 9768, Olympia, WA 98504; and

- (ii) Include in or with the application:
 - (A) A specific statement of the issues and law involved;
 - (B) The grounds for contesting the department decision; and
 - (C) A copy of the NFR being contested.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 43.20B.430,

this chapter, and chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision in this chapter governs.

[Statutory Authority: RCW 71A.16.010, 71A.16.030, 71A.12.030, chapter 71A.20 RCW, RCW 72.01.090, and 72.33.125. 02-16-014, § 388-853-080, filed 7/25/02, effective 8/25/02. 00-17-151, recodified as § 388-853-080, filed 8/22/00, effective 8/22/00. Statutory Authority: RCW 71.05.560. 90-21-030 (Order 3083), § 275-20-080, filed 10/9/90, effective 11/9/90. Statutory Authority: RCW 34.05.220 (1)(a) and 43.20B.420. 90-04-074 (Order 2997), § 275-20-080, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 72.33.660. 79-08-044 (Order 1418), § 275-20-080, filed 7/19/79.]

Chapter 388-855 WAC

LIABILITY FOR COSTS OF CARE AND HOSPITALIZATION OF THE MENTALLY ILL

(Formerly chapter 275-16 WAC)

WAC

388-855-0010	Authority.
388-855-0015	Definitions.
388-855-0030	Schedule of charges.
388-855-0035	Available assets of estate of patients and responsible relatives.
388-855-0045	Exempt income.
388-855-0055	Notice and finding of responsibility (NFR)—Appeal procedure.
388-855-0065	Determination of liability.
388-855-0075	Unusual and exceptional circumstances.
388-855-0085	Other pertinent factors.
388-855-0095	Failure to cooperate with department.
388-855-0105	Petition for review.

WAC 388-855-0010 Authority. The following rules regarding hospitalization charges are hereby adopted under the authority of Title 71 RCW.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0010, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412], 81-08-020 (Order 1627), § 275-16-010, filed 3/25/81. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 275-16-010, filed 2/17/78; Order 1, § 275-16-010, filed 2/23/68; Emergency Rules (part), filed 1/26/68, 10/24/67, and 8/2/67.]

WAC 388-855-0015 Definitions. "Adjusted charges" are those [charges levied upon] [amounts charged to] a patient who is or has been confined to a state hospital for the mentally ill, either by voluntary or involuntary admission, and their estates and responsible relatives, which are less than the actual cost of hospitalization as reflected in the schedule of charges herein and which has been established by the issuance of a notice of finding of responsibility.

"Adjusted gross income" is that gross income of the estate of the patient and responsible relatives less any deductions, contributions or payments mandated by law including, but not necessarily limited to, income tax and social security.

"Dependent" means any spouse, minor son or daughter, or permanently disabled son or daughter, of the patient living in the patient's household. If the patient is a minor, then the same definitions shall apply in determining the dependency of members of the parent's household. If a minor son or daughter is not living in the patient's household, that son or daughter shall not be considered a dependent unless the patient is in fact contributing more than fifty percent of that child's support in accordance with a court order or court-recognized agreement.

"Department" means the department of social and health services.

"Determination officer" is that duly appointed and qualified claims investigator who is delegated authority by the secretary to conduct or cause to have conducted an investigation of the financial condition of the estate of the patient and responsible relatives; to evaluate the results of such investigations; to make determinations of the ability to pay hospitalization charges from such investigations and evaluations; and to issue notices of findings of responsibility to the responsible parties.

"Estate of patient and responsible relative" means the total assets available to the patient and his responsible relatives to reimburse the department for hospitalization charges incurred by the patient in a state hospital for the mentally ill in accordance with these regulations.

"Gross income" means the total assets available to the estate of the patient and responsible relatives expressed in terms of their cash equivalent on a monthly basis. The total assets available to the estate of the patient and responsible relatives are converted to a monthly cash equivalent figure by dividing those assets by twelve months. Gross income includes all of the following calculated prior to any mandatory deductions; gross wages for service; net earnings from self-employment; and all other assets divided by twelve months.

"Responsible relative" includes the spouse of a patient, or the parent of a patient who is under eighteen years of age.

"Secretary" means the secretary of the department of social and health services.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0015, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412], 81-08-020 (Order 1627), § 275-16-015, filed 3/25/81.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-855-0030 Schedule of charges. Under RCW 43.20B.325, the department shall base hospitalization charges for patients in state hospitals on the actual operating costs of such hospitals. The department shall require patient's hospitalization charges due and payable on or before the tenth day of each calendar month for services rendered to department patients during the preceding month. A schedule of each hospital's charge rates will be computed under this section based on actual operating costs of the hospital for the previous year. The schedule will be prepared by the secretary's designee, from financial and statistical information contained in hospital records. The schedule will be updated at least annually. All changes under this section shall be prepared in advance of the effective date. Each hospital will make available the schedule of current charge rates upon request.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, recodified as § 388-855-0030, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.325. 94-16-048 (Order 3764), § 275-16-030, filed 7/27/94, effective 8/27/94; 93-22-031 (Order 3659), § 275-16-030, filed 10/27/93, effective 11/27/93; 92-17-007 (Order 3434), § 275-16-030, filed 8/6/92, effective 9/6/92; 92-09-118 (Order 3376), § 275-16-030, filed 4/21/92, effective 5/22/92. Statutory Authority: RCW 43.20B.335. 91-21-122 (Order 3267), § 275-16-030, filed 10/23/91, effective 11/23/91; 91-17-

064 (Order 3235), § 275-16-030, filed 8/20/91, effective 9/20/91; 91-08-014 (Order 3155), § 275-16-030, filed 3/26/91, effective 4/26/91. Statutory Authority: RCW 43.20B.335 and 71.05.560. 90-18-004 (Order 3061), § 275-16-030, filed 8/23/90, effective 9/23/90. Statutory Authority: RCW 71.02.412. 89-22-128 (Order 2890), § 275-16-030, filed 11/1/89, effective 12/2/89. Statutory Authority: RCW 43.20B.335. 88-21-095 (Order 2715), § 275-16-030, filed 10/19/88. Statutory Authority: RCW 71.02.412. 87-19-026 (Order 2531), § 275-16-030, filed 9/10/87; 86-17-075 (Order 2414), § 275-16-030, filed 8/19/86; 85-17-038 (Order 2273), § 275-16-030, filed 8/15/85; 84-17-011 (Order 2131), § 275-16-030, filed 8/3/84; 83-18-029 (Order 2019), § 275-16-030, filed 8/31/83; 82-17-070 (Order 1866), § 275-16-030, filed 8/18/82; 80-06-087 (Order 1508), § 275-16-030, filed 5/28/80. Statutory Authority: RCW 72.01.090. 79-03-019 (Order 1372), § 275-16-030, filed 2/21/79; 78-03-029 (Order 1270), § 275-16-030, filed 2/17/78; Order 1190, § 275-16-030, filed 2/18/77; Order 1086, § 275-16-030, filed 1/15/76; Order 1002, § 275-16-030, filed 1/14/75; Order 947, § 275-16-030, filed 6/26/74; Order 812, § 275-16-030, filed 6/28/73; Order 14, § 275-16-030, filed 5/11/71; Order 6, § 275-16-030, filed 1/10/69; Order 1, § 275-16-030, filed 2/23/68; Emergency Rules (part), filed 1/26/68, 10/24/67, 8/2/67, and 7/28/67.]

WAC 388-855-0035 Available assets of estate of patients and responsible relatives. (1) The department will include, but not necessarily be limited to, in their determination of the assets of the estates of present and former patients of state hospitals for the mentally ill and their responsible relatives, cash, stocks, bonds, savings, security interests, insurance benefits, guardianship funds, trust funds, governmental benefits, pension benefits and personal property.

(2) Real property shall also be an available asset to the estate: Provided, That the patient's home shall not be considered an available asset if that property is owned by the estate and serves as the principal dwelling and actual residence of the patient, the patient's spouse, and/or minor children and disabled sons or daughters: Provided further, That if the home is not being used for residential purposes by the patient, the patient's spouse, and/or minor children and disabled sons or daughters, and in the opinion of two physicians, there is no reasonable expectancy that the patient will be able to return to the home during the remainder of his life, the home shall be considered an asset available to the estate.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0035, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-035, filed 3/25/81.]

WAC 388-855-0045 Exempt income. Patients whose total resources are insufficient to pay for the actual cost of care shall be entitled to a monthly exemption from income in the amount of forty-one dollars and sixty-two cents or such amount as specified in WAC 388-478-0040.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0045, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 78-03-029 (Order 1270), § 388-16-045 (codified as WAC 275-16-045), filed 2/17/78.]

WAC 388-855-0055 Notice and finding of responsibility (NFR)—Appeal procedure. (1) The determination officer's assessment of the ability and liability of a person or of the person's estate to pay hospitalization charges shall be issued in the form of a notice and finding of responsibility (NFR) as prescribed by RCW 43.20B.340.

(2) When the NFR is for full hospitalization charges as specified under WAC 388-855-0030, the department shall:

(a) Inform the financially responsible person of the current charges; and

(b) Periodically recompute the financially responsible person's charges.

(3) When the NFR is for adjusted charges, the department shall:

(a) Express the charges in a daily or monthly rate; and

(b) Set aside charges for ancillary services.

(4) The right to an adjudicative proceeding to contest the NFR is contained in RCW 43.20B.340.

(a) A financially responsible person wishing to contest the NFR shall, within twenty-eight days of receipt of the NFR:

(i) File a written application for an adjudicative proceeding showing proof of receipt with the Secretary, DSHS, Attn: Determination Officer, P.O. Box 9768, Olympia, WA 98504; and

(ii) Include in or with the application:

(A) A specific statement of the issues and law involved;

(B) The grounds for contesting the department decision; and

(C) A copy of the contested NFR.

(b) The proceeding shall be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 43.20B.340, this chapter, and chapter 388-02 WAC. If any provision in this chapter conflicts with chapter 388-02 WAC, the provision in this chapter governs.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090. 01-01-007, amended and recodified as § 388-855-0055, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 71.05.560. 90-21-030 (Order 3083), § 275-16-055, filed 10/9/90, effective 11/9/90. Statutory Authority: RCW 34.05.220 (1)(a) and 43.20B.335. 90-04-075 (Order 3001), § 275-16-055, filed 2/5/90, effective 3/1/90. Statutory Authority: RCW 81.02.412 [71.02.412]. 81-08-020 (Order 1627), § 275-16-055, filed 3/25/81.]

WAC 388-855-0065 Determination of liability. (1) In determining the ability of the estate of the patient and responsible relative to pay hospitalization charges, first priority shall be given to any third party benefits which might be available. The availability of third party benefits, such as medical insurance, health insurance, Medicare, Medicaid, CHAMPUS, CHAMPVA, shall be considered as an available asset of the estate and shall justify a finding for actual costs of hospitalization during such period as the coverage is in effect.

(2) In the absence of third party benefits, charges shall be based upon the available assets of the estate giving consideration to any unusual and exceptional circumstances and other pertinent factors. No financial determination of the ability of the estate to pay hospitalization charges shall conflict with the eligibility requirements for Medicaid for those patients who are eligible or potentially eligible for such benefits.

(3) The ability of the estate to pay adjusted charges will be determined by applying the following formula:

$$X = (Z - E)F$$

$$\text{Where } Z = (A - Y - N - R) \div D$$

$$Z = \text{available income per family member}$$

$$X = \text{adjusted charges (daily)}$$

$$A = \text{gross income}$$

$$Y = \text{mandatory deductions}$$

$$N = \text{allowance for unusual and exceptional circumstances}$$

- R = allowance for other pertinent factors
- D = number of dependents
- E = exempt income
- F = a factor which converts the monthly figures to a daily rate (.0328767).

All calculations are expressed in monthly terms except the final adjusted charge which is converted to a daily rate. All final figures are rounded out to the nearest cent.

(4) The adjusted gross income (A-Y) is determined by first developing the gross income of the estate of the patient and the responsible relative. Gross income (A) includes not only gross wages for services rendered, and/or net earnings from self-employment, but all other available assets which have been divided by twelve months to convert them to a monthly cash equivalent figure. All mandatory deductions (Y), such as income tax and social security, are deducted from the gross income to arrive at the adjusted gross income.

(5) Approved allowances for unusual and exceptional circumstances (N) and for other pertinent factors (R) are then subtracted from the adjusted gross income.

(6) The available income (A-Y-N-R) is then divided by the number of dependents in the household of the patient (D) to determine the available income per family member.

(7) Exempt income (E) as defined in WAC 388-855-0045 is then subtracted from the available income per family member to arrive at the monthly adjusted charges.

(8) The monthly adjusted charges are multiplied by the factor of .0328767 which converts the monthly figure to a daily rate.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090, 01-01-007, amended and recodified as § 388-855-0065, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412], 81-08-020 (Order 1627), § 275-16-065, filed 3/25/81.]

WAC 388-855-0075 Unusual and exceptional circumstances. Unusual and exceptional circumstances for these purposes will cover those expenses other than usual or common; rare and extraordinary; that are of a medical nature and *must* be supplied to the patient for his health, medical or physical well being. Such expenses do not include those expenses that are reimbursable from insurance benefits or can be reasonably obtained from welfare agencies, health maintenance organizations, free clinics, or other free private or governmental sources. The existence and necessity of such unusual and exceptional circumstances must be attested to in writing, by the institution superintendent, that those expenses resulting therefrom are an integral part of the patient's treatment plan and that allowance for such circumstances is necessary for the medical and/or mental well-being of the patient. Upon such written certification, the resources necessary to meet the unusual and exceptional circumstances will not be considered as an asset available to the estate of the patient and responsible relatives for these purposes: Provided, That any such attestation by the institution superintendent must conform with the eligibility criteria of Medicaid if the patient is eligible or potentially eligible for such benefits.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090, 01-01-007, recodified as § 388-855-0075, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412], 81-08-020 (Order 1627), § 275-16-075, filed 3/25/81.]

WAC 388-855-0085 Other pertinent factors. The determination officer may consider the following other pertinent factors in determining the ability of the estate of the patient and responsible relatives to pay.

(1) The determination officer may consider those factors related to the well-being, education and training, child support obligations set by court order or by administrative finding under chapter 74.20A RCW, and/or rehabilitation of the patient and the patient's immediate family, to whom the patient owes a duty of support. The patient and/or responsible relatives shall show the existence and the necessity for the pertinent factors as defined. Upon such a showing, the determination officer may consider such resources necessary to reasonably provide for such pertinent factors as assets not available to the estate of the patient and responsible relatives.

(2) Consistent with RCW 43.20B.335, the determination officer shall consider a judgment owed by the patient to any victim of an act that would have resulted in criminal conviction of the patient but for a finding of the patient's criminal insanity. A victim shall include an estate's personal representative who has obtained judgment for wrongful death against the criminally insane patient.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090, 01-01-007, amended and recodified as § 388-855-0085, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.335, 96-18-090, § 275-16-085, filed 9/4/96, effective 10/5/96, 81.02.412 [71.02.412]. Statutory Authority: RCW 81-08-020 (Order 1627), § 275-16-085, filed 3/25/81.]

WAC 388-855-0095 Failure to cooperate with department. Any patient, former patient, guardian, or other responsible party or parties who, after diligent effort by the department, has been shown to have failed to cooperate with the financial investigation by the department; or fails to comply with, or ignores, departmental correspondence; or supplies false or misleading information; or willfully conceals assets or potential assets; will be subject to a determination by the department that the estate of the patient and responsible relatives has the ability to pay full hospitalization charges: Provided, That no person adjudged incompetent by a court of this state at the time of said investigation shall be penalized by his or her actions: Provided further, That such a finding of liability to pay full hospitalization charges shall in no way diminish the responsible party's right to appeal such a finding of responsibility.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090, 01-01-007, recodified as § 388-855-0095, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 81.02.412 [71.02.412], 81-08-020 (Order 1627), § 275-16-095, filed 3/25/81.]

WAC 388-855-0105 Petition for review. (1) After a finding of responsibility becomes final in accordance with RCW 43.20B.340, the responsible party may petition for a review of such findings to the secretary. The petitioner must show a substantial change in the financial ability of the estate to pay the charges in a petition for review. The burden of proof of a change in financial ability rests with the petitioner.

(2) A petition for review shall be in writing and to the following address:

Secretary, DSHS
Attn: Determination Officer
P.O. Box 9768 MS HJ-21
Olympia, WA 98504

(3) The determination officer, upon receipt of the petition for review, may conduct or cause to have conducted such investigation as may be necessary to verify the alleged changes in financial status or to determine any other facts which would bear upon the financial ability of the estate to pay.

(4) Based upon the review of the facts, the determination officer may modify or vacate the NFR under the provisions of RCW 43.20B.350.

(5) The NFR will not be modified or vacated, if such modification or vacation inflicts or causes the loss of Medicaid eligibility; jeopardizes the eligibility for other third-party benefits; or has the potential end result of diminishing or jeopardizing the recovery of hospitalization cost by the department without a clear showing of real benefit, financial or otherwise, to the patient and/or responsible relatives.

(6) Nothing herein is intended to preclude the reinvestigation and/or review of the finding of responsibility by the department of its own volition.

[Statutory Authority: RCW 43.20B.335, 43.20B.325, 72.01.090, 01-01-007, recodified as § 388-855-0105, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 43.20B.335, 90-23-071 (Order 3096), § 275-16-105, filed 11/20/90, effective 12/21/90. Statutory Authority: RCW 81.02.412 [71.02.412], 81-08-020 (Order 1627), § 275-16-105, filed 3/25/81.]

Chapter 388-865 WAC

COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

WAC

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388-865-0201	Allocation of funds to RSN/PHPs. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0201, filed 5/31/01, effective 7/1/01.] Repealed by 06-18-057, filed 8/31/06, effective 10/1/06. Statutory Authority: RCW 71.24.035 and chapter 71.24 RCW.	388-865-0540	Fees for evaluation and treatment facility certification. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0540, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.
388-865-0203	Allocation formula for state hospital beds. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0203, filed 5/31/01, effective 7/1/01.] Repealed by 06-18-057, filed 8/31/06, effective 10/1/06. Statutory Authority: RCW 71.24.035 and chapter 71.24 RCW.	388-865-0550	Rights of all consumers who receive community inpatient services. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0550, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.
388-865-0340	Consumer disenrollment. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0340, filed 5/31/01, effective 7/1/01.] Repealed by 05-17-154, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 71.24.035.	388-865-0555	Rights of consumers receiving involuntary inpatient services. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0555, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.
388-865-0501	Certification based on deemed status. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0501, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.	388-865-0557	Rights related to antipsychotic medication. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0557, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.
388-865-0502	Single bed certification. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0502, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.	388-865-0560	Rights of consumers who receive emergency and inpatient services voluntarily. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0560, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.
388-865-0504	Exception to rule—Long-term certification. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0504, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.	388-865-0565	Petition for the right to possess a firearm. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0565, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.
388-865-0505	Evaluation and treatment facility certification—Minimum standards. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0505, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.	<p>SECTION ONE—COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS</p> <p>WAC 388-865-0100 Purpose. Chapter 388-865 of the Washington Administrative Code implements chapters 71.05, 71.24, and 71.34 RCW, and the mental health Title XIX Section 1915 (b) Medicaid waiver provisions.</p> <p>[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0100, filed 5/31/01, effective 7/1/01.]</p> <p>WAC 388-865-0105 What the mental health division does and how it is organized. (1) The department of social and health services is designated by the legislature as the state mental health authority, and has designated the mental health division to administer the state mental health program.</p> <p>(2) To request an organizational chart, contact the mental health division at 1-888-713-6010 or (360) 902-8070, or write to the Mental Health Division Director, P.O. Box 45320, Olympia, WA 98504.</p> <p>(3) Local services are administered by regional support networks (RSN), whose telephone number is located in the local telephone directory and can also be obtained by calling the mental health division at the above telephone number.</p> <p>[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0105, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0105, filed 5/31/01, effective 7/1/01.]</p>	
388-865-0510	Standards for administration. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0510, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.		
388-865-0515	Admission and intake evaluation. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0515, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.		
388-865-0525	Clinical record. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0525, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.		
388-865-0530	Competency requirements for staff. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0530, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.		
388-865-0535	The process for gaining certification and renewal of certification. [Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0535, filed 5/31/01, effective 7/1/01.] Repealed by 04-07-014, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW.		

WAC 388-865-0107 Peer counselor certification. The mental health division certifies consumers to provide peer support services.

(1) In order to be certified as a peer counselor, all applicants must meet the following requirements:

(a) Be a self-identified consumer of mental health services, as defined;

(b) Maintain registration as a counselor under chapter 18.19 RCW;

(c) Complete specialized training provided or contracted by the mental health division; and

(d) Successfully pass an examination administered by the mental health division or an authorized contractor.

(2) The training requirement specified in (2)(c) of this subsection is waived for consumers who were trained prior to October 1, 2004 by trainers approved by the mental health division, provided that all of the other requirements are met by January 31, 2005.

(3) A consumer whose request for certification is denied has the right to contest this decision by submitting a written request to the mental health division within twenty-eight calendar days of the date of notification:

(a) The request should include the consumer's name, address, and telephone number and a brief explanation of the issue and resolution being requested;

(b) The consumer also has the right to use the state administrative hearing process as described in chapter 388-02 WAC;

(c) A consumer who completes the administrative hearing process may request reconsideration in accordance with chapter 388-02 WAC but does not have recourse to review by the DSHS board of appeals.

[Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037, 05-17-156, § 388-865-0107, filed 8/22/05, effective 9/22/05.]

WAC 388-865-0110 Access to records of registration. The mental health division, regional support networks, mental health prepaid health plans, and service providers must ensure that information about the fact that a consumer has or is receiving mental health services is not shared or released except as specified under RCW 71.05.390 and other laws and regulations about confidentiality as noted below in WAC 388-865-0115.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0110, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0115 Access to clinical records. There are numerous federal and state rules and regulations on the subjects of confidentiality and access to consumer clinical records. Many of the rules are located in chapter 70.02 RCW, RCW 71.05.390, 71.05.400, 71.05.410, 71.05.420, 71.05.430, 71.05.440, 71.05.445, 71.05.610 through 71.05.680, 71.34.160, 71.34.162, 71.34.170, 71.34.200, 71.34.210, 71.34.220, 71.34.225, 13.50.100(4)(b), and 42 C.F.R. 431 and 438, and 42 C.F.R. Part 2 of the Code of Federal Regulations and are not repeated in these rules.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0115, filed 5/31/01, effective 7/1/01.]

(2007 Ed.)

WAC 388-865-0120 Waiver of a minimum standard of this chapter. (1) A regional support network, mental health prepaid health plan, service provider or applicant subject to the rules in this chapter may request a waiver of any sections or subsections of these rules by submitting a request in writing to the director of the mental health division. The request must include:

(a) The name and address of the entity that is making the request;

(b) The specific section or subsection of these rules for which a waiver is being requested;

(c) The reason why the waiver is necessary, or the method the entity will use to meet the desired outcome of the section or subsection in a more effective and efficient manner;

(d) A description of the plan and timetable to achieve compliance with the minimum standard or to implement, test, and report results of an improved way to meet the intent of the section or subsection. In no case will the mental health division write a waiver of minimum standards for more than the time period of the entity's current license and/or certificate.

(2) For agencies contracting with a regional support network or mental health prepaid health plan, a statement by the regional support network or mental health prepaid health plan recommending mental health division approval of the request, including:

(a) Recommendations, if any, from the quality review team or ombuds staff; and

(b) A description of how consumers will be notified of changes made as a result of the exception.

(3) The mental health division makes a determination on the waiver request within thirty days from date of receipt. The review will consider the impact on accountability, accessibility, efficiency, consumer satisfaction, and quality of care and any violations of the request with state or federal law.

(4) When granting the request, the mental health division issues a notice to the person making the request, and the involved regional support network if the regional support network is not the applicant, that includes:

(a) The section or subsection waived;

(b) The conditions of acceptance;

(c) The time frame for which the waiver is approved;

(d) Notification that the agreement may be reviewed by the mental health division and renewed, if requested.

(5) When denying the request, the mental health division includes the reason for the decision in the notice sent to the person making the request.

(6) The mental health division does not waive any requirement that is part of statute.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0120, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0150 Definitions. "Adult" means a person on or after their eighteenth birthday. For persons eligible for the Medicaid program, adult means a person on or after his/her twenty-first birthday.

"Certified peer counselor" is defined as a consumer of mental health services who has met the registration, experience, and training requirements, has satisfactorily passed the

examination, and has been issued a certificate by the mental health division as specified in WAC 388-865-0107.

"Child" means a person who has not reached his/her eighteenth birthday. For persons eligible for the Medicaid program, child means a person who has not reached his/her twenty-first birthday.

"Clinical services" means those direct age and culturally appropriate consumer services which either:

- (1) Assess a consumer's condition, abilities or problems;
- (2) Provide therapeutic interventions which are designed to ameliorate psychiatric symptoms and improve a consumer's functioning.

"Consumer" means a person who has applied for, is eligible for or who has received mental health services. For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

"Consultation" means the clinical review and development of recommendations regarding the job responsibilities, activities, or decisions of, clinical staff, contracted employees, volunteers, or students by persons with appropriate knowledge and experience to make recommendations.

"Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

"Ethnic minority" or **"racial/ethnic groups"** means, for the purposes of this chapter, any of the following general population groups:

- (1) African American;
- (2) An American Indian or Alaskan native, which includes:
 - (a) A person who is a member or considered to be a member in a federally recognized tribe;
 - (b) A person determined eligible to be found Indian by the secretary of interior, and
 - (c) An Eskimo, Aleut, or other Alaskan native.
- (d) A Canadian Indian, meaning a person of a treaty tribe, Metis community, or nonstatus Indian community from Canada.
- (e) An unenrolled Indian meaning a person considered Indian by a federally or nonfederally recognized Indian tribe or off reservation Indian/Alaskan native community organization.
- (3) Asian/Pacific Islander; or
- (4) Hispanic.

"Medical necessity" or **"medically necessary"** - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less

costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Mental health division" means the mental health division of the Washington state department of social and health services (DSHS). DSHS has designated the mental health division as the state mental health authority to administer the state and Medicaid funded mental health program authorized by chapters 71.05, 71.24, and 71.34 RCW.

"Mental health professional" means:

(1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;

(2) A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

(3) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;

(4) A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

(5) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.

"Mental health specialist" means:

(1) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(2) A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:

(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age or older; and

(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age or older, under the supervision of a geriatric mental health specialist.

(3) An **"ethnic minority mental health specialist"** is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority consumers.

(4) A **"disability mental health specialist"** is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, **"disabled"** means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(a) If the consumer is deaf, the specialist must be a mental health professional with:

(i) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for consumers with developmental disabilities must be a mental health professional who:

(i) Has at least one year's experience working with people with developmental disabilities; or

(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

"Older person" means an adult who is sixty years of age or older.

"Regional Support Network (RSN)" means a county, a combination of counties, or a private nonprofit entity that administers and provides publicly funded mental health services for a designated geographic area within the state.

"Service recipient" means for the purposes of a mental health prepaid health plan, a consumer eligible for the Title XIX Medicaid program.

"Substantial hardship" means that a consumer will not be billed for emergency involuntary treatment if he or she meets the eligibility standards of the psychiatric indigent inpatient program that is administered by the DSHS economic services administration.

"Supervision" means monitoring of the administrative, clinical, or clerical work performance of staff, students, volunteers, or contracted employees by persons with the authority to give direction and require change.

"Underserved" means consumers who are:

- (1) Minorities;
- (2) Children;
- (3) Older adults;
- (4) Disabled; or
- (5) Low-income persons.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0150, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037, 05-17-156, § 388-865-0150, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.800, and 2003 1st sp.s. c 25. 03-24-030, § 388-865-0150, filed 11/24/03, effective 12/25/03. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0150, filed 5/31/01, effective 7/1/01.]

SECTION TWO—REGIONAL SUPPORT NETWORKS

WAC 388-865-0200 Regional support networks. The mental health division contracts with certified regional support

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networks to administer all mental health services activities or programs within their jurisdiction using available resources. The regional support network must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To gain and maintain certification, the regional support network must comply with all applicable federal, state and local laws and regulations, and all of the minimum standards of this section. The community mental health program administered by the regional support network includes the following programs:

(1) Administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapters 71.05 and 71.34 RCW;

(2) Resource management program as defined in RCW 71.24.025(15) and this section;

(3) Community support services as defined in RCW 71.24.025(7);

(4) Residential and housing services as defined in RCW 71.24.025(14);

(5) Ombuds services;

(6) Quality review teams;

(7) Inpatient services as defined in chapters 71.05 and 71.34 RCW; and

(8) Services operated or staffed by consumers, former consumers, family members of consumers, or other advocates. If the service is clinical, the service must comply with the requirements for licensed services. Consumer or advocate run services may include, but are not limited to:

(a) Consumer and/or advocate operated businesses;

(b) Consumer and/or advocate operated and managed clubhouses;

(c) Advocacy and referral services;

(d) Consumer and/or advocate operated household assistance programs;

(e) Self-help and peer support groups;

(f) Ombuds service; and

(g) Other services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0200, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0205 Initial certification of a regional support network. An entity is initially certified if it is selected to be a regional support network for a designated geographic area through a Request for Proposal process. In order to gain certification as a regional support network under circumstances other than through a Request for Proposal, an entity must submit to the department:

(1) A statement of intent to become a regional support network;

(2) A preliminary operating plan which meets departmental guidelines and complies with the requirements of RCW 71.24.045 and 71.24.300.

(3) If the entity proposes to serve more than one county or the designated geographic area includes a tribal authority, the entity must also include a joint operating agreement that includes the following:

(a) Identification of a single authority with final responsibility for all available resources and performance of the

contract with the department consistent with chapters 71.05, 71.24, and 71.34 RCW;

(b) Assignment of all responsibilities required by RCW 71.24.300; and

(c) Participation of tribal authorities in the agreement at the request of the tribal authorities.

(4) Within thirty days of the submission the department will provide a written response either:

(a) Certifying the regional support network; or

(b) Denying certification because the requirements are not met.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0205, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0205, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0210 Renewal of regional support network certification. At least biennially the mental health division reviews the compliance of each regional support network with the statutes, applicable rules and regulations, applicable standards, and state minimum standards as defined in this chapter:

(1) If the regional support network is in compliance with the statutes, applicable rules and regulations, applicable standards, and state minimum standards, the mental health division provides the regional support network with a written certificate of compliance.

(2) If the regional support network is not in compliance with the statutes, applicable rules and regulations, the mental health division will provide the regional support network written notice of the deficiencies. In order to maintain certification, the regional support network must develop a plan of corrective action approved by the mental health division.

(3) If the regional support network fails to develop an approved plan of corrective action or does not complete implementation of the plan within the time frames specified, the mental health division may initiate procedures to suspend, revoke, limit, or restrict certification consistent with the provisions of RCW 71.24.035 (7) through (11) and of 43.20A.-205. The mental health division sends a written decision to revoke, suspend, or modify the former certification, with the reasons for the decision and informing the regional support network of its right to an administrative hearing.

(4) The mental health division may suspend or revoke the certification of a regional support network immediately if the mental health division determines that deficiencies imminently jeopardize the health and safety of consumers.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0210, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0215 Consumer eligibility and payment for services. (1) Within available resources as defined in RCW 71.24.025(2), the regional support network must serve consumers in the following order of priority as defined in RCW 71.24.035 (5)(b):

(a) Acutely mentally ill persons;

(b) Chronically mentally ill adults and severely emotionally disturbed children;

(c) Seriously disturbed persons.

[Title 388 WAC—p. 1354]

(2) Consumers eligible for the Title XIX Medicaid program are entitled to receive covered medically necessary services from a mental health prepaid health plan without charge to the consumer;

(3) The consumer or the parent(s) of a child who has not reached their eighteenth birthday, the legal guardian, or the estate of the consumer is responsible for payment for services provided. The consumer may apply to the following entities for payment assistance:

(a) DSHS for medical assistance;

(b) The community support provider for payment responsibility based on a sliding fee scale; or

(c) The regional support network for authorization of payment for involuntary evaluation and treatment services for consumers who would experience a substantial hardship as defined in WAC 388-865-0150.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0215, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0217 Psychiatric indigent inpatient program. (1) The psychiatric indigent inpatient (PII) program is a state funded, limited casualty (LCP) program specifically for mental health clients identified in need of inpatient psychiatric care by the regional support network (RSN).

(2) The psychiatric indigent inpatient (PII) program pays only for emergent voluntary inpatient psychiatric care in community hospitals within the state of Washington. Psychiatric indigent inpatient (PII) does not cover ancillary charges for physician, transportation, pharmacy or other costs associated with an inpatient psychiatric hospitalization.

(3) To be eligible for the psychiatric indigent inpatient (PII) program, a client is subject to the following conditions and limitations:

(a) The client must have a voluntary inpatient psychiatric admission authorized by a regional support network (RSN) in the month of application or within the three months immediately preceding the month of application.

(b) Consumers applying for the psychiatric indigent inpatient (PII) program are subject to the income and resource rules for TANF and TANF-related clients in chapters 388-450 and 388-470 WAC.

(c) If a client's income and/or resources exceed the standard for medically needy (MN), as described in WAC 388-478-0070, the client must spend down the excess amount as described in WAC 388-519-0110 for the client to be eligible for the psychiatric indigent inpatient (PII) program. Spend-down is a client financial obligation for medical expenses. The department deducts the spenddown from payments to providers (see WAC 388-502-0100).

(d) A client who is voluntarily admitted must have incurred an emergency medical expense requirement (EMER) of two thousand dollars over a twelve-month period. EMER is a client financial obligation. The department deducts the EMER from payments to providers (see WAC 388-502-0100).

(i) Qualifying emergency medical expense requirement (EMER) expenses are psychiatric inpatient services in a community hospital.

(ii) The emergency medical expense requirement (EMER) period lasts for twelve calendar months, beginning

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on the first day of the month of certification for psychiatric indigent inpatient (PII) and continuing through the last day of the twelfth month.

(e) A client is limited to a single three-month period of psychiatric indigent inpatient (PII) eligibility per twelve-month emergency medical expense requirement (EMER) period.

(4) Clients are not eligible for the psychiatric indigent inpatient (PII) program if they:

(a) Are eligible for, or receiving, any other cash or medical program; or

(b) Entered Washington state specifically to obtain medical care; or

(c) Are inmates of a federal or state prison; or

(d) Are committed under the Involuntary Treatment Act (ITA).

[Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 06-13-042, § 388-865-0217, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.800, and 2003 1st sp.s. c 25. 03-24-030, § 388-865-0217, filed 11/24/03, effective 12/25/03.]

WAC 388-865-0220 Standards for administration.

The regional support network must demonstrate that it meets the requirements of chapters 71.05, 71.24, and 71.34 RCW, and ensures the effectiveness and cost effectiveness of community mental health services in an age and culturally competent manner. The regional support network must:

(1) Establish a governing board that includes, where applicable, representation from tribal authorities, consistent with RCW 71.24.300;

(2) For multicounty regional support networks, function as described in the regional support network joint operating agreement;

(3) Ensure the protection of consumer and family rights as described in this chapter, and chapters 71.05 and 71.34 RCW; and other applicable statutes for consumers involved in multiservice systems;

(4) Collaborate with and make reasonable efforts to obtain and use resources in the community to maximize services to consumers;

(5) Educate the community regarding mental illness to diminish stigma;

(6) Maintain agreement(s) with sufficient numbers of certified involuntary inpatient evaluation and treatment facilities to ensure that persons eligible for regional support network services have access to inpatient care;

(7) Develop publicized forums in which to seek and include input about service needs and priorities from community stakeholders, including:

(a) Consumers;

(b) Family members and consumer advocates;

(c) Culturally diverse communities including consumers who have limited English proficiency;

(d) Service providers;

(e) Social service agencies;

(f) Organizations representing persons with a disability;

(g) Tribal authorities; and

(h) Underserved groups.

(8) Maintain job descriptions for regional support staff with qualifications for each position with the education, experience, or skills relevant to job requirements; and

(9) Provide orientation and ongoing training to regional support network staff in the skills pertinent to the position and the treatment population, including age and culturally competent consultation with consumers, families, and community members.

(10) Identify trends and address service gaps;

(11) The regional support network must provide an updated two-year plan biennially to the mental health division for approval consistent with the provisions of RCW 71.24.300(1). The biennial plan must be submitted to the regional support network governing board for approval and to the advisory board for review and comment.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0220, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0221 Public awareness of mental health services. The regional support network or its designee must provide public information on the availability of mental health services. The regional support network must:

(1) Maintain listings of services in telephone directories and other public places such as libraries, community services offices, juvenile justice facilities, of the service area. The regional support network or its designee must prominently display listings for crisis services in telephone directories;

(2) Publish and disseminate brochures and other materials or methods for describing services and hours of operation that are appropriate for all individuals, including those who may be visually impaired, limited English proficient, or unable to read;

(3) Post and make information available to consumers regarding the ombuds service consistent with WAC 388-865-0250, and local advocacy organizations that may assist consumers in understanding their rights.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0221, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0222 Advisory board. The regional support network must promote active engagement with persons with mental disorders, their families and services providers by soliciting and using their input to improve its services. The regional support network must appoint an advisory board that:

(1) Is broadly representative of the demographic character of the region and the ethnicity and broader cultural aspects of consumers served;

(2) Is composed of at least fifty-one percent:

(a) Current consumers or past consumers of public mental health services, including those who are youths, older adults, or who have a disability; and

(b) Family, foster family members, or care givers of consumers, including parents of emotionally disturbed children.

(3) Independently reviews and provides comments to the regional support network governing board on plans, budgets, and policies developed by the regional support network to implement the requirements of this section, chapters 71.05,

71.24, 71.34 RCW and applicable federal law and regulations.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0222, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0225 Resource management. The regional support network must establish mechanisms which maximize access to and use of age and culturally competent mental health services, and ensure eligible consumers receive appropriate levels of care. The regional support network must:

(1) Authorize admission, transfers and discharges for eligible consumers into and out of the following services:

- (a) Community support services;
- (b) Residential services; and
- (c) Inpatient evaluation and treatment services.

(2) Ensure that services are provided according to the consumer's individualized service plan;

(3) Not require preauthorization of emergency services and transportation for emergency services that are required by an eligible consumer;

(4) Identify in the agreement with the mental health division any of these duties it has delegated to a subcontractor.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0225, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0229 Inpatient services. The regional support network must develop and implement age and culturally competent services that are consistent with chapters 71.24, 71.05, and 71.34 RCW. The regional support network must:

(1) For voluntary inpatient services: Develop and implement formal agreements with inpatient services funded by the regional support network regarding:

- (a) Referrals;
- (b) Admissions; and
- (c) Discharges.

(2) For involuntary evaluation and treatment services:

(a) Maintain agreements with sufficient numbers of certified involuntary evaluation and treatment facilities to ensure that consumers eligible for regional support network services have access to involuntary inpatient care. The agreements must address regional support network responsibility for discharge planning;

(b) Determine which service providers on whose behalf the regional support network will apply on behalf of for certification by the mental health division;

(c) Ensure that all service providers or its subcontractors that provide evaluation and treatment services are currently certified by the mental health division and licensed by the department of health;

(d) Ensure periodic reviews of the evaluation and treatment service facilities consistent with regional support network procedures and notify the appropriate authorities if it believes that a facility is not in compliance with applicable statutes, rules and regulations.

(3) Authorize admissions, transfers and discharges into and out of inpatient evaluation and treatment services for eligible consumers including:

(a) State psychiatric hospitals:

- (i) Western state hospital;
- (ii) Eastern state hospital;
- (iii) Child study and treatment center.

(b) Community hospitals;

(c) Residential inpatient evaluation and treatment facilities licensed by the department of health as adult residential rehabilitation centers; and

(d) Children's long-term inpatient program.

(4) Receive prior approval from the mental health division in the form of a single bed certification for services to be provided to consumers on a ninety- or one hundred eighty-day community inpatient involuntary commitment order consistent with the exception criteria in WAC 388-865-0502; and

(5) Identify in the agreement with the mental health division any of these duties it has delegated to a subcontractor.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0229, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0230 Community support services.

The regional support network must develop and coordinate age and culturally competent community support services that are consistent with chapters 71.24, 71.05, and 71.34 RCW:

(1) Provide the following services directly, or contract with sufficient numbers and variety of licensed and/or certified service providers to ensure that persons eligible for regional support network services have access to at least the following services:

- (a) Emergency crisis intervention services;
- (b) Case management services;
- (c) Psychiatric treatment including medication supervision;
- (d) Counseling and psychotherapy services;
- (e) Day treatment services as defined in RCW 71.24.300(5) and 71.24.035(7);
- (f) Consumer employment services as defined in RCW 71.24.035 (5)(e); and
- (g) Peer support services.

(2) Conduct prescreening determinations for providing community support services for persons with mental illness who are being considered for placement in nursing homes (RCW 71.24.025(7) and 71.24.025(9)); and

(3) Complete screening for persons with mental illness who are being considered for admission to residential services funded by the regional support network (RCW 71.24.025 and 71.24.025(9)).

[Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037. 05-17-156, § 388-865-0230, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0230, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0235 Residential and housing services. The regional support network must ensure:

(1) Active promotion of consumer access to, and choice in, safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.

(2) Provision of services to families of eligible children and to eligible consumers who are homeless or at imminent

risk of becoming homeless as defined in Public Law 100-77, through outreach, engagement and coordination or linkage of services with shelter and housing.

(3) The availability of community support services, with an emphasis supporting consumers in their own home or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in RCW 71.24.025 (7) and (14); and 71.24.025(14).

(4) That eligible consumers in residential facilities receive mental health services consistent with their individual service plan, and are advised of their rights, including long-term care rights (chapter 70.129 RCW).

(5) If supervised residential services are needed they are provided only in licensed facilities:

(a) An adult family home that is licensed under chapter 388-76 WAC.

(b) A boarding home facility that is licensed under chapter 388-78A WAC.

(c) An adult residential rehabilitative center facility that is licensed under chapter 246-325 WAC.

(6) The active search of comprehensive resources to meet the housing needs of consumers.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0235, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0240 Consumer employment services.

The regional support network must coordinate with rehabilitation and employment services to assure that consumers wanting to work are provided with employment services consistent with WAC 388-865-0464.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0240, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0245 Administration of the Involuntary Treatment Act. The regional support network must establish policies and procedures for administration of the involuntary treatment program, including investigation, detention, transportation, court related and other services required by chapters 71.05 and 71.34 RCW. This includes:

(1) Designating mental health professionals to perform the duties of involuntary investigation and detention in accordance with the requirements of chapters 71.05 and 71.34 RCW.

(2) Documenting consumer compliance with the conditions of less restrictive alternative court orders by:

(a) Ensuring periodic evaluation of each committed consumer for release from or continuation of an involuntary treatment order. Evaluations must be recorded in the clinical record, and must occur at least monthly for ninety and one hundred eighty-day commitments.

(b) Notifying the designated mental health professional if noncompliance with the less restrictive order impairs the individual sufficiently to warrant detention or evaluation for detention and petitioning for revocation of the less restrictive alternative court order.

(3) Ensuring that when a peace officer or designated mental health professional escorts a consumer to a facility, the designated mental health professional must take reason-

able precautions to safeguard the consumer's property including:

(a) Safeguarding the consumer's property in the immediate vicinity of the point of apprehension;

(b) Safeguarding belongings not in the immediate vicinity if there may be possible danger to those belongings;

(c) Taking reasonable precautions to lock and otherwise secure the consumer's home or other property as soon as possible after the consumer's initial detention.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0245, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0245, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0250 Ombuds services. The regional support network must provide unencumbered access to and maintain the independence of the ombuds service as set forth in this section and in the agreement between mental health division and the regional support network. The mental health division and the regional support network must include representatives of consumer and family advocate organizations when revising the terms of the agreement regarding the requirements of this section. Ombuds members must be current consumers of the mental health system, past consumers or family members. The regional support network must maintain an ombuds service that:

(1) Is responsive to the age and demographic character of the region and assists and advocates for consumers with resolving complaints and grievances at the lowest possible level;

(2) Is independent of service providers;

(3) Receives and investigates consumer, family member, and other interested party complaints and grievances;

(4) Is accessible to consumers, including a toll-free, independent phone line for access;

(5) Is able to access service sites and records relating to the consumer with appropriate releases so that it can reach out to consumers, and resolve complaints and/or grievances;

(6) Receives training and adheres to confidentiality consistent with this chapter and chapters 71.05, 71.24, and 70.02 RCW;

(7) Continues to be available to investigate, advocate and assist the consumer through the grievance and administrative hearing processes;

(8) Involves other persons, at the consumer's request;

(9) Assists consumers in the pursuit of formal resolution of complaints;

(10) If necessary, continues to assist the consumer through the fair hearing processes;

(11) Coordinates and collaborates with allied systems' advocacy and ombuds services to improve the effectiveness of advocacy and to reduce duplication of effort for shared clients;

(12) Provides information on grievance experience to the regional support network and mental health division quality management process; and

(13) Provides reports and formalized recommendations at least biennially to the mental health division and regional support network advisory and governing boards, quality

review team, local consumer and family advocacy groups, and provider network.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0250, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0255 Consumer grievance process.

The regional support network must develop a process for reviewing consumer complaints and grievances. A complaint is defined as a verbal statement of dissatisfaction with some aspect of mental health services. A grievance is a written request that a complaint be heard and adjudicated, usually undertaken after attempted resolution of a complaint fails. The process must be submitted to the mental health division for written approval and incorporation into the agreement between the regional support network and the mental health division. The process must:

- (1) Be age, culturally and linguistically competent;
- (2) Ensure acknowledgment of receipt of the grievance the following working day. This acknowledgment may be by telephone, with written acknowledgment mailed within five working days;
- (3) Ensure that grievances are investigated and resolved within thirty days. This time frame can be extended by mutual written agreement, not to exceed ninety days;
- (4) Be published and made available to all current or potential users of publicly funded mental health services and advocates in language that is clear and understandable to the individual;
- (5) Encourage resolution of complaints at the lowest level possible;
- (6) Include a formal process for dispute resolution;
- (7) Include referral of the consumer to the ombuds service for assistance at all levels of the grievance and fair hearing processes;
- (8) Allow the participation of other people, at the grievant's choice;
- (9) Ensure that the consumer is mailed a written response within thirty days from the date a written grievance is received by the regional support network;
- (10) Ensure that grievances are resolved even if the consumer is no longer receiving services;
- (11) Continue to provide mental health services to the grievant during the grievance and fair hearing process;
- (12) Ensure that full records of all grievances are kept for five years after the completion of the grievance process in confidential files separate from the grievant's clinical record. These records must not be disclosed without the consumer's written permission, except as necessary to resolve the grievance or to DSHS if a fair hearing is requested;
- (13) Provide for follow-up by the regional support network to assure that there is no retaliation against consumers who have filed a grievance;
- (14) Make information about grievances available to the regional support network;
- (15) Inform consumers of their right to file an administrative hearing with DSHS without first accessing the contractor's grievance process. Consumers must utilize the regional support network grievance process prior to requesting disenrollment;

[Title 388 WAC—p. 1358]

(16) Inform consumers of their right to use the DSHS prehearing and administrative hearing processes as described in chapter 388-02 WAC. Consumers have this right when:

- (a) The consumer believes there has been a violation of DSHS rule;
- (b) The regional support network did not provide a written response within thirty days from the date a written request was received;
- (c) The regional support network, mental health prepaid health plan, the department of social and health services, or a provider denies services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0255, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0260 Mental health professionals and specialists. The regional support network must assure sufficient numbers of mental health professionals and specialists are available in the service area to meet the needs of eligible consumers. The regional support network must:

- (1) Document efforts to acquire the services of the required mental health professionals and specialists;
- (2) Ensure development of a training program using in-service training or outside resources to assist service providers to acquire necessary skills and experience to serve the needs of the consumer population;
- (3) If more than five hundred persons in the total population in the regional support network geographic area report in the U.S. census that they belong to racial/ethnic groups as defined in WAC 388-865-0150, the regional support network must contract or otherwise establish a working relationship with the required specialists to:
 - (a) Provide all or part of the treatment services for these populations; or
 - (b) Supervise or provide consultation to staff members providing treatment services to these populations.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0260, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0265 Mental health professional—Exception. The regional support network may request an exception of the requirements of a mental health professional for a person with less than a masters degree level of training. The mental health division may grant an exception of the minimum requirements on a time-limited basis and only with a demonstrated need for an exception under the following conditions:

- (1) The regional support network has made a written request for an exception including:
 - (a) Demonstration of the need for an exception;
 - (b) The name of the person for whom an exception is being requested;
 - (c) The functions which the person will be performing;
 - (d) A statement from the regional support network that the person is qualified to perform the required functions based on verification of required education and training, including:
 - (i) Bachelor of Arts or Sciences degree from an accredited college or university;

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(ii) Course work or training in making diagnoses, assessments, and developing treatment plans; and

(iii) Documentation of at least five years of direct treatment of persons with mental illness under the supervision of a mental health professional.

(2) The regional support network assures that periodic supervisory evaluations of the individual's job performance are conducted;

(3) The regional support network submits a plan of action to assure the individual will become qualified no later than two years from the date of exception. The regional support network may apply for renewal of the exception. The exception may not be transferred to another regional support network or to use for an individual other than the one named in the exception;

(4) If compliance with this rule causes a disproportionate economic impact on a small business as defined in the Regulatory Fairness Act, chapter 19.85 RCW, and the business does not contract with a regional support network, the small business may request the exception directly from the mental health division.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0265, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0270 Financial management. The regional support network must be able to demonstrate that it ensures the effectiveness and cost effectiveness of community mental health services. The regional support network must:

(1) Spend funds received by the mental health division in accordance with its contract and to meet the requirements of chapters 71.05, 71.24, 71.34 RCW, and the State Appropriations Act;

(2) Use accounting procedures that are consistent with applicable state and federal requirements and generally accepted accounting principles (GAAP), with the following additional requirements:

(a) Include as assets all property, equipment, vehicles, buildings, capital reserve funds, operating reserve funds, risk reserve funds, or self-insurance funds.

(b) Interest accrued on funds stated in this section must be accounted for and kept for use by the regional support network.

(c) Property, equipment, vehicles, and buildings must be properly inventoried with a physical inventory conducted at least every two years.

(d) Proceeds from the disposal of any assets must be retained by the regional support network for purposes of subsection (1) of this section.

(3) Comply with the 1974 county maintenance of effort requirement for administration of the Involuntary Treatment Act (chapter 71.05 RCW) and 1990 county maintenance of effort requirement for community programs for adults consistent with RCW 71.24.160, and in the case of children, no state funds shall replace local funds from any source used to finance administrative costs for involuntary commitment procedures conducted prior to January 1, 1985 (chapter 71.34 RCW);

(4) Maintain accounting procedures to ensure that accrued interest and excess reserve balances are returned to

the regional support network for use in the public mental health system.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0270, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0275 Management information system. The regional support network must be able to demonstrate that it collects and manages information that shows the effectiveness and cost effectiveness of mental health services. The regional support network must:

(1) Operate an information system and ensure that information about consumers who receive publicly funded mental health services is reported to the state mental health information system according to mental health division guidelines.

(2) Ensure that the information reported is:

(a) Sufficient to produce accurate regional support network reports; and

(b) Adequate to locate case managers in the event that a consumer requires treatment by a service provider that would not normally have access to treatment information about the consumer.

(3) Ensure that information about consumers is shared or released between service providers only in compliance with state statutes (see chapters 70.02, 71.05, and 71.34 RCW) and this chapter. Information about consumers and their individualized crisis plans must be available:

(a) Twenty-four hours a day, seven days a week to designated mental health professionals and inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and

(b) To the state and regional support network staff as required for management information and program review.

(4) Maintain on file a statement signed by regional support network, county or service provider staff having access to the mental health information systems acknowledging that they understand the rules on confidentiality and will follow the rules.

(5) Take appropriate action if a subcontractor or regional support network employee willfully releases confidential information, as required by chapter 71.05 RCW.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0275, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0275, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0280 Quality management process.

The regional support network must implement a process for continuous quality improvement in the delivery of culturally competent mental health services. The regional support network must submit a quality management plan as part of the written biennial plan to the mental health division for approval. All changes to the quality management plan must be submitted to the mental health division for approval prior to implementation. The plan must include:

(1) Roles, structures, functions and interrelationships of all the elements of the quality management process, including but not limited to the regional support network governing board, clinical and management staff, advisory board, ombuds service, and quality review teams.

(2) Procedures to ensure that quality management activities are effectively and efficiently carried out with clear management and clinical accountability, including methods to:

- (a) Collect, analyze and display information regarding:
 - (i) The capacity to manage resources and services, including financial and cost information and compliance with statutes, regulations and agreements;
 - (ii) System performance indicators;
 - (iii) Quality and intensity of services;
 - (iv) Incorporation of feedback from consumers, allied service systems, community providers, ombuds and quality review team;
 - (v) Clinical care and service utilization including consumer outcome measures; and
 - (vi) Recommendations and strategies for system and clinical care improvements, including information from exit interviews of consumers and practitioners.
- (b) Monitor management information system data integrity;
- (c) Monitor complaints, grievances and adverse incidents for adults and children;
- (d) Monitor contracts with contractors and to notify the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements;
- (e) Immediately investigate and report allegations of fraud and abuse of the contractor or subcontractor to the mental health division;
- (f) Monitor delegated administrative activities;
- (g) Identify necessary improvements;
- (h) Interpret and communicate practice guidelines to practitioners;
- (i) Implement change;
- (j) Evaluate and report results;
- (k) Demonstrate use of all corrective actions to improve the system;
- (l) Consider system improvements based on recommendations from all on-site monitoring, evaluation and accreditation/certification reviews;
- (m) Review update, and make the plan available to community stakeholders.

(3) Targeted improvement activities, including:

- (a) Performance measures that are objective, measurable, and based on current knowledge/best practice including at least those defined by the mental health division in the agreement with the regional support network;
- (b) An analysis of consumer care covering a representative sample of at least ten percent of consumers or five hundred consumers, whichever is smaller;
- (c) Efficient use of human resources; and
- (d) Efficient business practices.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0280, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0282 Quality review teams. The regional support network must establish and maintain unencumbered access to and maintain the independence of a quality review team as set forth in this section and in the agreement between mental health division and the regional support network. The quality review team must include current con-

sumers of the mental health system, past consumers or family members. The regional support network must assure that quality review teams:

(1) Fairly and independently review the performance of the regional support network and service providers to evaluate systemic customer service issues as measured by objective indicators of consumer outcomes in rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, including:

- (a) Quality of care;
- (b) The degree to which services are consumer-focused/directed and are age and culturally competent;
- (c) The availability of alternatives to hospitalization, cross-system coordination and range of treatment options; and
- (d) The adequacy of the regional support network's cross system linkages including, but not limited to schools, state and local hospitals, jails and shelters.

(2) Have the authority to enter and monitor any agency providing services for area regional support network consumers, including state and community hospitals, freestanding evaluation and treatment facilities, and community support service providers;

(3) Meet with interested consumers and family members, allied service providers, including state or community psychiatric hospitals, regional support network contracted service providers, and persons that represent the age and ethnic diversity of the regional support network to:

(a) Determine if services are accessible and address the needs of consumers based on sampled individual recipient's perception of services using a standard interview protocol developed by the mental health division. The protocol will query the sampled individuals regarding ease of accessing services, the degree to which services address medically necessary needs (acceptability), and the benefit of the service received; and

(b) Work with interested consumers, service providers, the regional support network, and DSHS to resolve identified problems.

(4) Provide reports and formalized recommendations at least biennially to the mental health division, the mental health advisory committee and the regional support network advisory and governing boards and ensure that input from the quality review team is integrated into the overall regional support network quality management process, ombuds services, local consumer and family advocacy groups, and provider network; and

(5) Receive training and adhere to confidentiality standards.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0282, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0284 Standards for contractors and subcontractors. The regional support network must not subcontract for clinical services to be provided using state funds unless the subcontractor is licensed and/or certified by the mental health division for those services or is personally licensed by the department of health as defined in chapter 48.43, 18.57, 18.71, 18.83, or 18.79 RCW. The regional support network must:

(1) Require and maintain documentation that contractors and subcontractors are licensed, certified, or registered in accordance with state or federal laws;

(2) Follow applicable requirements of the regional support network agreement with the mental health division;

(3) Demonstrate that it monitors contracts with contractors and notifies the mental health division of observations and information indicating that providers may not be in compliance with licensing or certification requirements; and

(4) Terminate its contract with a provider if the mental health division notifies the regional support network of a provider's failure to attain or maintain licensure or certification, if applicable.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0284, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0286 Coordination with a mental health prepaid health plan. If the regional support network is not also a mental health prepaid health plan, the regional support network must ensure continuity of services between itself and the mental health prepaid health plan by maintaining a working agreement about coordination for at least the following services:

- (1) Community support services;
- (2) Inpatient evaluation and treatment services;
- (3) Residential services;
- (4) Transportation services;
- (5) Consumer employment services;
- (6) Administration of involuntary treatment investigation and detention services; and
- (7) Immediate crisis response after presidential declaration of a disaster.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0286, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0288 Regional support networks as a service provider. A regional support network may operate as a community support service provider under the following circumstances:

- (1) Meeting the criteria specified in RCW 71.24.037 and 71.24.045;
- (2) Maintaining a current license as a community support service provider from the mental health division.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0288, filed 5/31/01, effective 7/1/01.]

SECTION THREE—MENTAL HEALTH PREPAID HEALTH PLANS

WAC 388-865-0300 Mental health prepaid health plans. A mental health prepaid health plan is an entity that contracts with the mental health division to administer mental health services for people who are eligible for the Title XIX Medicaid program. The mental health prepaid health plan must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. To be eligible for a contract as a mental health prepaid health plan, the entity must:

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(1) Provide documentation of a population base of forty-one thousand six hundred Medicaid eligible persons (covered lives) within the service area or receive approval from the mental health division based on submittal of an actuarially sound risk management profile;

(2) Maintain certification as a regional support network or licensure by the Washington state office of the insurance commissioner as a health care service contractor under chapter 48.44 RCW.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0300, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0305 Regional support network contracting as a mental health prepaid health plan. A regional support network contracting with the mental health division as a mental health prepaid health plan must comply with all requirements for a regional support network and the additional requirements for a prepaid health plan.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0305, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0310 Mental health prepaid health plans—Minimum standards. To be eligible for a contract, a mental health prepaid health plan must comply with all applicable federal, state, and local statutes and regulations and meet all of the minimum standards of WAC 388-865-300 through 388-865-355. The mental health prepaid health plan must:

- (1) Provide medically necessary mental health services that are age and culturally competent for all Medicaid recipients in the service area within a capitated rate;
- (2) Provide outreach to consumers, including homeless persons and families as defined in Public Law 100-77, and home-bound individuals;
- (3) Demonstrate working partnerships with tribal authorities for the delivery of services that blend with tribal values, beliefs and culture;
- (4) Develop and maintain written subcontracts that clearly recognize that legal responsibility for administration of the service delivery system remains with the mental health prepaid health plan, as identified in the agreement with the mental health division;
- (5) Retain responsibility to ensure that applicable standards of state and federal statute and regulations and this chapter are met even when it delegates duties to subcontractors;
- (6) Ensure the protection of consumer and family rights as described in chapters 71.05 and 71.34 RCW;
- (7) Ensure compliance with the following standards:
 - (a) WAC 388-865-0220, Standards for administration;
 - (b) WAC 388-865-0225, Resource management program;
 - (c) WAC 388-865-0229, Inpatient services and treatment services;
 - (d) WAC 388-865-0230, Community support services;
 - (e) WAC 388-865-0250, Ombuds services;
 - (f) WAC 388-865-0255, Consumer grievance process;
 - (g) WAC 388-865-0260, Mental health professionals or specialists;

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(h) WAC 388-865-0265, Mental health professional—Exception;

(i) WAC 388-865-0270, Financial management;

(j) WAC 388-865-0275, Management information system;

(k) WAC 388-865-0280, Quality management process;

(l) WAC 388-865-0282, Quality review teams; and

(m) WAC 388-865-0284, Standards for contractors and subcontractors.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0310, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0315 Governing body. The mental health prepaid health plan must establish a governing body responsible for oversight of the mental health prepaid health plan. The governing body must:

(1) Be free from conflict of interest and all appearance of conflict of interest between personal, professional and fiduciary interests of a governing body member and the best interests of the prepaid health plan and the consumers it serves.

(2) Have rules about:

(a) When a conflict of interest becomes evident;

(b) Not voting or joining a discussion when a conflict of interest is present; and

(c) When the body can assign the matter to others, such as staff or advisory bodies.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0315, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0320 Utilization management. Utilization management is the way the mental health prepaid health plan authorizes or denies mental health services, monitors services, and follows the level of care guidelines. To demonstrate the impact on enrollee access to care of adequate quality, a mental health prepaid health plan must provide utilization management of the community mental health rehabilitation services (42 C.F.R. 440) that is independent of service providers. This process must:

(1) Provide effective and efficient management of resources;

(2) Assure capacity sufficient to deliver appropriate quality and intensity of services to enrolled consumers without a wait list consistent with the agreement with the mental health division;

(3) Plan, coordinate, and authorize community support services;

(4) Ensure that services are provided according to the individual service plan;

(5) Ensure assessment and monitoring processes are in place by which service delivery capacity responds to changing needs of the community and enrolled consumers;

(6) Develop, implement, and enforce written level of care guidelines for admission, placements, transfers and discharges into and out of services. The guidelines must address:

(a) A clear process for the mental health prepaid health plan's role in the decision-making process about admission and continuing stay at various levels is available in language

that is clearly understood by all parties involved in an individual consumer's care, including laypersons;

(b) Criteria for admission into various levels of care, including community support, inpatient and residential services that are clear and concrete;

(c) Methods to ensure that services are individualized to meet the needs for all Medicaid consumers served, including consumers of different ages, cultures, languages, civil commitment status, physical abilities, and unique service needs; and

(d) To the extent authorization of care at any level of care or at continuing stay determinations is delegated, the mental health prepaid health plan retains a sufficiently strong and regular oversight role to assure those decisions are being made appropriately.

(7) Collect data that measures the effectiveness of the criteria in ensuring that all eligible people get services that are appropriate to his/her needs;

(8) Report to the mental health division any knowledge it gains that the mental health prepaid health plan or service provider is not in compliance with all state and federal laws and regulations.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0320, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0325 Risk management. The mental health prepaid health plan must:

(1) Assume the financial risk of providing community mental health outpatient rehabilitation services, community hospital services and operation of a capitated mental health managed care system for the Medicaid eligible persons in the service area;

(2) Maintain a risk reserve of annual premium payments as defined by chapter 48.44 RCW or the actuarial analysis submitted with the formal request for waiver for mental health approved by the Health Care Financing Administration. All other mental health reserves and undesignated fund balances shall be limited to no more than ten percent of annual revenues supporting the prepaid health plan's mental health program;

(3) Demonstrate solvency and manage all fiscal matters within the managed care system, including:

(a) Current pro forma;

(b) Financial reports;

(c) Balance sheets;

(d) Revenue and expenditure; and

(e) An analysis of reserve account(s) and fund balance(s) information including a detailed composition of capital, operating, and risk reserves and or fund balances.

(4) Maintain policies for each reserve account and have a process for collecting and disbursing reserves to pay for costs incurred by the mental health prepaid health plan;

(5) Demonstrate capacity to process claims for members of the contracted provider network and any emergency service providers accessed by consumers while out of the mental health prepaid health plan service area within sixty days using methods consistent with generally accepted accounting practices;

(6) Comply with the requirements of section 1128 (b) of the Social Security Act, which prohibits making payments

directly or indirectly to physicians or other providers as an inducement to reduce or limit services provided to consumers;

(7) In accordance with the Medicaid section 1915b waiver, the mental health prepaid health plan is required to pay for psychiatric inpatient services in community hospitals either through a direct contract with community hospitals or through an agreement with the department. In the event that the mental health prepaid health plan chooses to use the department as its fiscal agent, the plan agrees to abide by all policies, rules, payment requirements, and levels promulgated by the medical assistance administration. If the plan chooses to direct contract, the plan is responsible for executing contracts for sufficient hospital capacity pursuant to a plan approved by the mental health division.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0325, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0330 Marketing/education of mental health services. The mental health prepaid health plan must demonstrate that it provides information to eligible persons so that they are aware of available mental health services and how to access them. The mental health prepaid health plan must:

(1) Develop and submit marketing/education plan(s) and procedures to the mental health division within the time frames in the agreement with the mental health division for approval prior to issuance. The plan shall, at a minimum, include information on the following:

- (a) Consumer rights and responsibilities;
 - (b) The service recipient's right to disenroll;
 - (c) Cross-system linkages;
 - (d) Access to mental health services for diverse populations, including other languages than English;
 - (e) Use of media;
 - (f) Stigma reduction;
 - (g) Subcontractor participation/involvement;
 - (h) Plan for evaluation of marketing strategy;
 - (i) Procedures and materials, and any revisions thereof;
- and

(j) Maintain listings of mental health services with toll-free numbers in the telephone and other public directories of the service area.

(2) Describe services and hours of operations through brochures and other materials and other methods of advertising;

(3) Assure that the materials and methods are effective in reaching people who may be visually impaired, have limited comprehension of written or spoken English, or who are unable to read. At a minimum, all written materials generally available to service recipients shall be translated to the most commonly used languages in the service area;

(4) Post and otherwise make information available to consumers about ombuds services and local advocacy organizations that may assist consumers in understanding their rights;

(5) Ensure distribution of written educational material(s) to consumers, allied systems and local community resources including:

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(a) Annual brochure(s) containing educational material on major mental illnesses and the range of options for treatment, supports available in the system, including medication and formal psychotherapies, as well as alternative approaches that may be appropriate to age, culture and preference of the service recipient;

(b) Information regarding the scope of available benefits (e.g., inpatient, outpatient, residential, employment, community support);

(c) Service locations, crisis response services; and

(d) Service recipients' responsibilities with respect to out-of-area emergency services; unauthorized care; noncovered services; complaint process, grievance procedures; and other information necessary to assist in gaining access.

(6) Ensure marketing plans, procedures and materials are accurate and do not mislead, confuse or defraud the service recipient.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0330, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0335 Consumer enrollment. (1) DSHS enrolls a Medicaid recipient in a mental health prepaid inpatient health plan when the person resides in the contracted service area of the prepaid inpatient health plan. The assigned prepaid inpatient health plan is responsible to provide outpatient medically necessary state Medicaid plan approved services to Medicaid service recipients in the contracted service area and to assure inpatient medically necessary state Medicaid plan approved services are received;

(2) An enrolled Medicaid service recipient who requests or receives medically necessary nonemergency community mental health rehabilitation services may request and receive such service from the assigned mental health prepaid inpatient health plan through authorized providers only;

(3) An enrolled Medicaid service recipient is automatically transferred from the assigned prepaid inpatient health plan when the recipient moves from the contracted service area of one mental health prepaid inpatient health plan to the contracted service area of another;

(4) Services to Medicaid recipients may be provided through alternative means if currently contracted authorized providers are not able to provide those services when:

(a) The services are state Medicaid plan approved services and are medically necessary for the Medicaid service recipient; and

(b) Services are or should be available to other Medicaid service recipients in the local mental health prepaid inpatient health plan; and

(c) The Medicaid service recipient has made reasonable attempts to utilize services through authorized providers; or

(d) The Medicaid service recipient has received a choice of providers and has made an informed decision to request medically necessary services through a provider outside the prepaid inpatient health plan provider network that has cultural or linguistic expertise or both needed to meet medical necessity that are not sufficient within the provider network; or

(e) The Medicaid service recipient has utilized the prepaid inpatient health plan grievance or appeal process and the state administrative hearing process, and a decision has been

made in favor of the Medicaid service recipient that Medicaid plan approved services continue to be medically necessary.

[Statutory Authority: RCW 71.24.035, 05-17-154, § 388-865-0335, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0335, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0345 Choice of primary care provider. The mental health prepaid health plan must ensure that each consumer who is receiving nonemergency community mental health rehabilitation services has a primary care provider who is responsible to carry out the individualized service plan. The mental health prepaid health plan must allow consumers, parents of consumers under the age of thirteen, and guardians of consumers of all ages to select a primary care provider from the available primary care provider staff within the mental health prepaid health plan.

(1) For an enrolled client with an assigned case manager, the case manager is the primary care provider;

(2) If the consumer does not make a choice, the mental health prepaid health plan or its designee must assign a primary care provider no later than fifteen working days after the consumer requests services;

(3) The mental health prepaid health plan or its designee must allow a consumer to change primary care providers in the first ninety days of enrollment with the mental health prepaid health plan and once during a twelve-month period for any reason;

(4) Any additional change of primary care provider during the twelve-month period may be made with documented justification at the consumer's request by:

(a) Notifying the mental health prepaid health plan (or its designee) of his/her request for a change, and the name of the new primary care provider; and

(b) Identifying the reason for the desired change.

(5) A consumer whose request to change primary care providers is denied may submit a grievance with the plan, or request an administrative hearing.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0345, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0350 Mental health screening for children. The mental health prepaid health plan is responsible for conducting mental health screening and treatment for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program. This includes:

(1) Providing resource management services for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program as specified in contract with the mental health division;

(2) Developing and maintaining an oversight committee for the coordination of the early and periodic screening, diagnosis and treatment program. The oversight committee must include representation from parents of Medicaid-eligible children.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0350, filed 5/31/01, effective 7/1/01.]

[Title 388 WAC—p. 1364]

WAC 388-865-0355 Consumer request for a second opinion. An enrolled consumer in a mental health prepaid health plan must have the right to a second opinion by another participating staff in the enrolled consumer's assigned mental health prepaid health plan:

(1) When the enrolled consumer needs more information about the medical necessity of the treatment recommended by the mental health prepaid health plan; or

(2) If the enrolled consumer believes the mental health prepaid health plan primary care provider is not authorizing medically necessary community mental health rehabilitation services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0355, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0360 Monitoring of mental health prepaid health plans. The mental health division will conduct an annual on-site medical audit and an administrative audit at least every two years for purposes of assessing the quality of care and conformance with the minimum standards of this section and the Title XIX Medicaid 1915(b) mental health waiver requirements. The monitoring will include a review of:

(1) The mental health prepaid health plan's conformance to monitoring its service provider network in accordance with the quality management plan approved by the mental health division that includes processes established under the Medicaid waiver for mental health services;

(2) Any direct services provided by the mental health prepaid health plan;

(3) Other provisions within the code of federal regulations for managed care entities, which may include access, quality of care, marketing, record keeping, utilization management and disenrollment functions.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0360, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0363 Coordination with the regional support network. If the mental health prepaid health plan is not also a regional support network, the mental health prepaid health plan must ensure continuity of services between itself and the regional support network by maintaining a working agreement about coordination for at least the following services:

- (1) Residential services;
- (2) Transportation services;
- (3) Consumer employment services;
- (4) Administration of involuntary treatment investigation and detention services; and
- (5) Immediate crisis response after presidential declaration of a disaster.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335, 01-12-047, § 388-865-0363, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0365 Suspension, revocation, limitation or restriction of a contract. The mental health division may suspend, revoke, limit or restrict a mental health prepaid health plan contract or refuse to grant a contract for failure to

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conform to applicable state and federal rules and regulations or for violation of health or safety considerations.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0365, filed 5/31/01, effective 7/1/01.]

SECTION FOUR—COMMUNITY SUPPORT SERVICE PROVIDERS

WAC 388-865-0400 Community support service providers. The mental health division licenses and certifies community support service providers. To gain and maintain licensure or certification, a provider must meet applicable local, state and federal statutes and regulations as well as the requirements of WAC 388-865-400 [388-865-0400] through 388-865-450 [388-865-0450] as applicable to services offered. The license or certificate lists service components the provider is authorized to provide to publicly funded consumers and must be prominently posted in the provider reception area. In addition, the provider must meet minimum standards of the specific service components for which licensure is being sought:

- (1) Emergency crisis intervention services;
- (2) Case management services;
- (3) Psychiatric treatment, including medication supervision;
- (4) Counseling and psychotherapy services;
- (5) Day treatment services;
- (6) Consumer employment services; and/or
- (7) Peer support services.

[Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037. 05-17-156, § 388-865-0400, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.-335. 01-12-047, § 388-865-0400, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0405 Competency requirements for staff. The licensed service provider must ensure that staff are qualified for the position they hold and have the education, experience, or skills to perform the job requirements. The provider must maintain documentation that:

- (1) All staff have a current Washington state department of health license or certificate or registration as may be required for their position;
- (2) Washington state patrol background checks are conducted for employees in contact with consumers consistent with RCW 43.43.830;
- (3) Mental health services are provided by a mental health professional, or under the clinical supervision of a mental health professional;
- (4) Staff performing mental health services (not including crisis telephone) must have access to consultation with a psychiatrist or a physician with at least one year's experience in the direct treatment of persons who have a mental or emotional disorder;
- (5) Mental health services to children, older adults, ethnic minorities or persons with disabilities must be provided by, under the supervision of, or with consultation from the appropriate mental health specialist(s) when the consumer:
 - (a) Is a child as defined in WAC 866-865-0150;
 - (b) Is or becomes an older person as defined in WAC 388-865-0150;

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(c) Is a member of a racial/ethnic group as defined in WAC 866-865-0105 and as reported:

- (i) In the consumer's demographic data; or
- (ii) By the consumer or others who provide active support to the consumer; or
- (iii) Through other means.
- (d) Is disabled as defined in WAC 388-865-0150 and as reported:

- (i) In the consumer's demographic data; or
- (ii) By the consumer or others who provide active support to the consumer; or
- (iii) Through other means.

(6) Staff receive regular supervision and an annual performance evaluation; and

(7) An individualized annual training plan must be implemented for each direct service staff person and supervisor in the skills he or she needs for his/her job description and the population served.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0405, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0410 Consumer rights. (1) The provider must document that consumers, prospective consumers, or legally responsible others are informed of consumer rights at admission to community support services in a manner that is understandable to the individual. Consumer rights must be written in alternative format for consumers who are blind or deaf, and must also be translated to the most commonly used languages in the service area consistent with WA 388-865-0260(3);

(2) The provider must post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of telephone only services (e.g., crisis lines) must post the statement of consumer rights in a location visible to staff and volunteers during working hours;

(3) The provider must develop a statement of consumer rights that incorporates the following statement or a variation approved by the mental health division: "You have the right to:

- (a) Be treated with respect, dignity and privacy;
- (b) Develop a plan of care and services which meets your unique needs;
- (c) The services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;
- (d) Refuse any proposed treatment, consistent with the requirements in chapters 71.05 and 71.34 RCW;
- (e) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;
- (f) Be free of any sexual exploitation or harassment;
- (g) Review your clinical record and be given an opportunity to make amendments or corrections;
- (h) Receive an explanation of all medications prescribed, including expected effect and possible side effects;
- (i) Confidentiality, as described in chapters 70.02, 71.05, and 71.34 RCW and regulations;
- (j) All research concerning consumers whose cost of care is publicly funded must be done in accordance with all appli-

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cable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC;

(k) Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;

(l) Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;

(m) If you are Medicaid eligible, receive all service which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from a provider within the regional support network about what services are medically necessary;

(n) Lodge a complaint with the ombuds, regional support network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The ombuds may, at your request, assist you in filing a grievance. The ombuds' phone number is: _____."

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0410, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0415 Access to services. The community support service provider must document and otherwise ensure that eligible consumers have access to age and culturally competent services when and where those services are needed. The provider must:

(1) Identify and reduce barriers to people getting the services where and when they need them;

(2) Comply with the Americans with Disabilities Act and the Washington State Antidiscrimination Act, chapter 49.60 RCW;

(3) Assure that services are timely, appropriate and sensitive to the age, culture, language, gender and physical condition of the consumer;

(4) Provide alternative service delivery models to make services more available to underserved persons as defined in WAC 388-865-0150;

(5) Provide access to telecommunication devices or services and certified interpreters for deaf or hearing impaired consumers and limited English proficient consumers;

(6) Bring services to the consumer or locate services at sites where transportation is available to consumers; and

(7) Ensure compliance with all state and federal nondiscrimination laws, rules and plans.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0415, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0420 Intake evaluation. The community support service provider must complete an intake evaluation in collaboration with the consumer within fourteen days of admission to service. If seeking this information presents a barrier to service, the item may be left incomplete provided that the reasons are documented in the clinical record. The following must be documented in the consumer's intake evaluation:

(1) A consent for treatment or copy of detention or involuntary treatment order;

(2) Consumer strengths, needs and desired outcomes in their own words. At the consumer's request also include the input of people who provide active support to the consumer;

(3) The consumer's age, culture/cultural history, and disability;

(4) History of substance use and abuse or other co-occurring disorders;

(5) Medical and mental health services history and a list of medications used;

(6) Documentation that consumers receiving court ordered treatment or treatment ordered by the department of corrections (DOC) have been asked if they are under supervision by the department of corrections. The consumer is required to disclose this information.

(7) For children:

(a) Developmental history; and

(b) Parent's goals and desired outcomes.

(8) Sufficient information to justify the diagnosis;

(9) Review of the intake evaluation by a mental health professional.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0420, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.-020, and 43.20B.335. 01-12-047, § 388-865-0420, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0425 Individual service plan. Community support service providers must provide consumers with an individual service plan that meets his or her unique needs. Individualized and tailored care is a planning process that may be used to develop a consumer-driven, strength-based, individual service plan. The individual service plan must:

(1) Be developed collaboratively with the consumer and other people identified by the consumer within thirty days of starting community support services. The service plan should be in language and terminology that is understandable to consumers and their family, and include goals that are measurable;

(2) Address age, cultural, or disability issues of the consumer;

(3) Include measurable goals for progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices, involving other systems when appropriate;

(4) Demonstrate that the provider has worked with the consumer and others at the consumer's request to determine his/her needs in the following life domains:

(a) Housing;

(b) Food;

(c) Income;

(d) Health and dental care;

(e) Transportation;

(f) Work, school or other daily activities;

(g) Social life; and

(h) Referral services and assistance in obtaining supportive services appropriate to treatment, such as substance abuse treatment.

(5) Document review by the person developing the plan and the consumer. If the person developing the plan is not a mental health professional, the plan must also document review by a mental health professional. If the person develop-

ing the plan is not a mental health specialist required per WAC 388-865-405(5) there must also be documented consultation with the appropriate mental health specialist(s);

(6) Document review and update at least every one hundred eighty days or more often at the request of the consumer;

(7) In the case of children:

(a) Be integrated with the individual education plan from the education system whenever possible;

(b) If the child is under three, the plan must be integrated with the individualized family service plan (IFSP) if this exists, consistent with Title 20, Section 1436.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0425, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0430 Clinical record. The community support service provider must maintain a clinical record for each consumer and safeguard the record against loss, defacement, tampering, or use by unauthorized persons. The clinical record must contain:

(1) An intake evaluation;

(2) Evidence that the consumer rights statement was provided to the consumer;

(3) A copy of any advance directives, powers of attorney or letters of guardianship provided by the consumer;

(4) The crisis treatment plan when appropriate;

(5) The individualized service plan and all changes in the plan;

(6) Documentation that services are provided by or under the clinical supervision of a mental health professional;

(7) Documentation that services are provided by, or under the clinical supervision, or the clinical consultation of a mental health specialist. Consultation must occur within thirty days of admission and periodically thereafter as specified by the mental health specialist;

(8) Periodic documentation of the course of treatment and objective progress toward established goals for rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices;

(9) A notation of extraordinary events affecting the consumer;

(10) Documentation of mandatory reporting of abuse, neglect, or exploitation of consumers consistent with chapters 26.44 and 74.34 RCW;

(11) Documentation that the department of corrections was notified by the provider when a consumer on an less restrictive alternative or department of corrections order mental health treatment informs them that they are under supervision by department of corrections. Notification can be either written or oral. If oral notification, it must be confirmed by a written notice, including e-mail and fax. The disclosure to department of corrections does not require the person's consent;

(12) If the consumer has been given relief by the committing court it must be confirmed in writing;

(13) When the mental health provider becomes aware of a violation that relates to public safety of court ordered treatment of a consumer who is both in a less restrictive alternative and is being supervised by the department of corrections, documentation that an evaluation by a designated mental health professional was requested;

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(14) Documentation of informed consent to treatment and medications by the consumer or legally responsible other;

(15) Documentation of confidential information that has been released without the consent of the consumer including, but not limited to provisions in RCW 70.02.050, 71.05.390 and 71.05.630.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0430, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0430, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.-020, and 43.20B.335. 01-12-047, § 388-865-0430, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0435 Consumer access to their clinical record. The service provider must provide access to clinical records for consumers, their designated representative, and/or the person legally responsible for the consumer, consistent with chapters 71.05, 70.02, and 71.34 RCW and RCW 13.50.400 (4)(b) for children. The provider must:

(1) Make the record available within fifteen days;

(2) Review the clinical record to identify and remove any material confidential to another person, agency, provider or reports not originated by the community support service provider;

(3) Allow the consumer appropriate time and privacy to review the clinical record;

(4) Provide a clinical staff member to answer questions at the request of the consumer; and

(5) Charge for copying at a rate not higher than that defined in RCW 70.02.010(12).

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0435, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0436 Clinical record access procedures. The community support service provider must develop policies and procedures to protect information and to ensure that information about consumers is shared or released only in compliance with state and federal law (see chapters 70.02, 71.05, 71.34, 74.04 RCW and RCW 13.50.100 (4)(b)) and this chapter.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0436, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0440 Availability of consumer information. (1) Consumer individualized crisis plans as provided by the consumer must be available twenty-four hours a day, seven days a week to designated mental health professionals, crisis teams, and voluntary and involuntary inpatient evaluation and treatment facilities, as consistent with confidentiality statutes; and

(2) Consumer information must be available to the state and regional support network staff as required for management information, quality management and program review.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0440, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0440, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0445 Establishment of procedures to bill for services. Consumers receiving services or the parent(s) of a person under the age of eighteen, the legal guardian, or the estate of the individual is responsible for payment for services received. The provider must establish policies and procedures to:

(1) Bill all third-party payors and private pay consumers. Persons eligible for the Medicaid program are not to be billed for medically necessary covered services.

(2) Develop a written schedule of fees that considers the consumer's available income, family size, allowable deductions and exceptional circumstances:

(a) Payment must not be required from consumers whose income is below TANF standards as defined in WAC 388-478-0020;

(b) The fee schedule must be posted in the agency and available to provider staff, consumers, the regional support network, and the mental health prepaid health plan.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0445, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0450 Quality management process. Community support service providers must ensure continued progress toward more effective and efficient age and culturally competent services and improved consumer satisfaction and outcomes, including objective measures of progress toward rehabilitation, recovery and reintegration into the mainstream of social, employment and educational choices by maintaining an internal quality management process. The process must:

(1) Review the services offered and provided to improve the treatment of consumers, including the quality of intake evaluations and the effectiveness of prescribed medications;

(2) Review the work of persons providing mental health services at least annually; and

(3) Continuously collect, maintain, and use information to correct deficiencies and improve services. Such data must include but is not limited to reports of serious and emergent incidents as well as grievances filed by consumers or their representatives.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0450, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0452 Emergency crisis intervention services—Additional standards. The community support service provider that is licensed for emergency crisis intervention services must assure that required general minimum standards for community support services are met, plus the additional minimum requirements:

(1) Availability of staff to respond to crises twenty-four hours a day, seven days a week, including:

(a) Bringing services to the person in crisis when clinically indicated;

(b) Requiring that staff remain with the consumer in crisis to stabilize and support him/her until the crisis is resolved or a referral to another service is accomplished;

(c) Resolving the crisis in the least restrictive manner possible;

(d) A process to include family members, significant others, and other relevant treatment providers as necessary to provide support to the person in crisis; and

(e) Written procedures for managing assaultive and/or self-injurious patient behavior.

(2) Crisis telephone screening;

(3) Mobile outreach and stabilization services with trained staff available to provide in-home or in-community stabilization services, including flexible supports to the person where he/she lives.

(4) Provide access to necessary services including:

(a) Medical services, which means at least emergency services, preliminary screening for organic disorders, prescription services, and medication administration;

(b) Interpretive services to enable staff to communicate with consumers who have limited ability to communicate in English, or have sensory disabilities;

(c) Mental health specialists for children, elderly, ethnic minorities or consumers who are deaf or developmentally disabled;

(d) Voluntary and involuntary inpatient evaluation and treatment services, including a written protocol to assure that consumers who require involuntary inpatient services are transported in a safe and timely manner;

(e) Investigation and detention to involuntary services under chapter 71.05 RCW for adults and chapter 71.34 RCW for children who are thirteen years of age or older, including written protocols for contacting the designated mental health professional.

(5) Document all telephone and face-to-face crisis response contacts, including:

(a) Source of referral;

(b) Nature of crisis;

(c) Time elapsed from the initial contact to face-to-face response; and

(d) Outcomes, including basis for decision not to respond in person, follow-up contacts made, and referrals made.

(6) The provider must have a written protocol for referring consumers to a voluntary or involuntary inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis, including arrangements for contacting the designated mental health professional and transporting consumers.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0452, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0452, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0453 Peer support services. (1) Peer support services are a wide range of scheduled activities to assist consumers in exercising control over their own lives and recovery process (e.g., promoting socialization, self advocacy, developing natural supports and maintenance of community living skills). Peer support services may include but are not limited to self-help support groups, telephone support lines, drop-in centers, and sharing of the peer counselor's own life experiences. Services must be limited to four hours per day per consumer.

(2) The community support service provider that is licensed to provide peer support services must assure that all general minimum standards for community support services are met.

(3) Services must be provided by a peer counselor who has been certified consistent with WAC 388-865-0107 and who discloses him/herself to be a consumer of mental health services.

(4) Services must be documented in the clinical record at least monthly, including objective progress toward goals established in the individual service plan.

[Statutory Authority: RCW 71.24.035 (5)(c), 71.24.037, 05-17-156, § 388-865-0453, filed 8/22/05, effective 9/22/05.]

WAC 388-865-0454 Provider of crisis telephone services only. This section applies only to organizations that receive public mental health funds for the purpose of providing crisis telephone services but are not licensed community support providers. In order to be licensed to provide crisis telephone services, the following requirements must be met:

(1) Staff available to respond to crisis calls twenty-four hours a day, seven days a week;

(2) The agency must assure communication and coordination with the consumer's case manager or primary care provider;

(3) The agency must assure that staff are aware of and protect consumer rights as described in WAC 388-865-0410;

(4) The following sections of WAC subsections apply:

(a) WAC 388-865-0405, Competency requirements for staff;

(b) WAC 388-865-0410, Consumer rights;

(c) WAC 388-865-0440, Availability of consumer information;

(d) WAC 388-865-0450, Quality management process;

(e) WAC 388-865-0452 (6)(a) thru (d), Emergency crisis intervention services—Additional standards;

(f) WAC 388-865-0468, The process for licensing service providers;

(g) WAC 388-865-0472, Licensing categories;

(h) WAC 388-865-0474, Fees for community support licensure;

(i) WAC 388-865-0476, Licensure based on deemed status;

(j) WAC 388-865-0478, Renewal of the provider license;

(k) WAC 388-865-0480, Procedures to suspend or revoke a license;

(l) WAC 388-865-0482, Procedures to contest a licensing decision.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0454, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0456 Case management services—Additional standards. The community support service provider for case management services must assure that all general minimum standards for community support services and are met, plus the following additional minimum requirements:

(1) Assist consumers to achieve the goals stated in their individualized service plan;

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(2) Support consumer employment, education or participation in other daily activities appropriate to their age and culture;

(3) Make referrals to other needed services and supports, including treatment for co-occurring disorders and health care;

(4) Assist consumers to resolve crises in least-restrictive settings;

(5) Provide information and education about the consumer's illness so the consumer and family and natural supports are engaged to help consumers manage the consumer's symptoms;

(6) Include, as necessary, flexible application of funds, such as rent subsidies, rent deposits, and in-home care to enable stable community living.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0456, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0458 Psychiatric treatment, including medication supervision—Additional standards. The licensed community support service provider for psychiatric treatment, including medication supervision must meet all general minimum standards for community support in addition to the following minimum requirements:

(1) Document the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Document that consumers and, as appropriate, family members are informed about the medication and possible side effects in language that is understandable to the consumer, and referred to other health care facilities for treatment of nonpsychiatric conditions;

(2) Provider staff must inspect and inventory medication storage areas at least quarterly:

(a) Medications must be kept in locked, well-illuminated storage;

(b) Medications kept in a refrigerator containing other items must be kept in a separate container with proper security;

(c) No outdated medications must be retained, and medications must be disposed of in accordance with regulations of the state board of pharmacy;

(d) Medications for external use must be stored separately from oral and injectable medications;

(e) Poisonous external chemicals and caustic materials must be stored separately.

(3) Medical direction and responsibility is assigned to a physician who is licensed to practice under chapter 18.57 or 18.71 RCW, and is board-certified or -eligible in psychiatry;

(4) Medications are only prescribed and administered by persons consistent with their license and related requirements;

(5) Medications are reviewed at least every three months;

(6) Medication information is maintained in the clinical record and documents at least the following for each prescribed medication:

(a) Name and purpose of medication;

(b) Dosage and method of giving medication;

(c) Dates prescribed, reviewed, and renewed;

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(d) The effects, interactions, and side effects the staff observes or the consumer reports spontaneously or as the result of questions from the staff;

(e) Any laboratory findings;

(f) Reasons for changing or stopping the medication; and

(g) Name and signature of prescribing person.

(7) Assessment and appropriate referrals to or consultation with a physician or other health care provider when physical health problems are suspected or identified;

(8) Address current medical concerns consistent with the individualized service plan;

(9) If the service provider is unable to employ or contract with a psychiatrist, a physician without board eligibility in psychiatry may be utilized, provided that:

(a) Psychiatrist consultation is provided to the physician at least monthly; and

(b) A psychiatrist is accessible in person, by telephone, or by radio communication to the physician for emergency consultation.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0458, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0460 Counseling and psychotherapy services—Additional standards. The licensed community support service provider for counseling and psychotherapy services must assure that all general minimum standards for community support are met.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0460, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0462 Day treatment services—Additional standards. The licensed community support service provider for day treatment services must assure that all general minimum standards for community support are met. Day treatment services are defined as work or other activities of daily living for consumers:

(1) Services for adults include:

(a) Training in basic living and social skills;

(b) Supported work and preparation for work;

(c) Vocational rehabilitation;

(d) Day activities; and, if appropriate;

(e) Counseling and psychotherapy services.

(2) Services for children include:

(a) Age-appropriate living and social skills;

(b) Educational and prevocational services;

(c) Day activities; and

(d) Counseling and psychotherapy services.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0462, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0464 Consumer employment services—Additional standards. The community support service provider licensed for employment services must assure that all general minimum standards for community support are met, plus the following additional minimum requirements:

(1) Assist consumers to achieve the goals stated in his/her individualized service plan and provide access to employment opportunities, including:

(a) A vocational assessment of work history, skills, training, education, and personal career goals;

(b) Information about how employment will affect income and benefits the consumer is receiving because of their disability;

(c) Active involvement with consumers served in creating and revising individualized job and career development plans;

(d) Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests;

(e) Integrated supported employment, including outreach/job coaching and support in a normalized or integrated worksite, if required; and

(f) Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Antidiscrimination law.

(2) Pay consumers according to the Fair Labor Standards Act; and ensure safety standards that comply with local and state regulations are in place if the provider employs consumers as part of the prevocational or vocational program;

(3) Coordinate efforts with other rehabilitation and employment services, such as:

(a) The division of vocational rehabilitation;

(b) The state employment services;

(c) The business community; and

(d) Job placement services within the community.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0464, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0465 Adult residential treatment facility certification—Additional standards. In order to be certified to provide services at an adult residential treatment facility, the licensed mental health agency must assure that all general minimum standards for community support are met, and in addition:

(1) Be licensed as a mental health adult residential treatment facility by the department of health under chapter 246-337 WAC; and

(2) Be certified to provide services to a consumer on a less restrictive alternative court order consistent with WAC 388-865-0466.

[Statutory Authority: RCW 71.05.560. 04-12-043, § 388-865-0465, filed 5/28/04, effective 6/28/04. Statutory Authority: RCW 71.05.560 and chapter 71.05 RCW. 04-01-091, § 388-865-0465, filed 12/16/03, effective 1/16/04.]

WAC 388-865-0466 Community support outpatient certification—Additional standards. In order to provide services to consumers on a less restrictive alternative court order, providers must be licensed to provide the psychiatric and medical service component of community support services and be certified by the mental health division to provide involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:

(1) Document in the consumer clinical record and otherwise ensure:

(a) Detained and committed consumers are advised of their rights under chapter 71.05 or 71.34 RCW and as follows:

(i) To receive adequate care and individualized treatment;

(ii) To make an informed decision regarding the use of antipsychotic medication and to refuse medication beginning twenty-four hours before any court proceeding that the consumer has the right to attend;

(iii) To maintain the right to be presumed competent and not lose any civil rights as a consequence of receiving evaluation and treatment for a mental disorder;

(iv) Of access to attorneys, courts, and other legal redress;

(v) To have the right to be told statements the consumer makes may be used in the involuntary proceedings; and

(vi) To have the right to have all information and records compiled, obtained, or maintained in the course of treatment kept confidential as defined in chapters 71.05 and 71.34 RCW.

(b) A copy of the less restrictive alternative court order and any subsequent modifications are included in the clinical record;

(c) Development and implementation of an individual service plan which addresses the conditions of the less restrictive alternative court order and a plan for transition to voluntary treatment;

(d) That the consumer receives psychiatric treatment including medication management for the assessment and prescription of psychotropic medications appropriate to the needs of the consumer. Such services must be provided:

(i) At least weekly during the fourteen-day period;

(ii) Monthly during the ninety-day and one-hundred eighty day periods of involuntary treatment unless the attending physician determines another schedule is more appropriate, and they record the new schedule and the reasons for it in the consumer's clinical record.

(2) Maintain written procedures for managing assaultive and/or self-destructive patient behavior, and provide training to staff in these interventions;

(3) Have a written protocol for referring consumers to an inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis;

(4) For consumers who require involuntary detention the protocol must also include procedures for:

(a) Contacting the designated mental health professional regarding revocations and extension of less restrictive alternatives, and

(b) Transporting consumers.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0466, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0466, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0468 Emergency crisis intervention services certification—Additional standards. In order to provide emergency services to a consumer who may need to be detained or who has been detained, the service provider must be licensed for emergency crisis intervention services and be certified by the mental health division to provide

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involuntary treatment services consistent with WAC 388-865-0484. In addition, the provider must:

(1) Be available seven-days-a-week, twenty-four-hours-per-day;

(2) Follow a written protocol for holding a consumer and contacting the designated mental health professional;

(3) Provide or have access to necessary medical services;

(4) Have a written agreement with a certified inpatient evaluation and treatment facility for admission on a seven day a week, twenty four hour per day basis; and

(5) Follow a written protocol for transporting individuals to inpatient evaluation and treatment facilities.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0468, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0468, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0470 The process for initial licensing of service providers. An applicant for a community support license must comply with the following process:

(1) Complete and submit an application form, along with the required fee to the mental health division. A copy of the application form must be provided to the area regional support network. The regional support network may make written comments to the mental health division about the provider's application for licensure. The application must indicate the service components the applicant wants to offer, as listed in WAC 388-865-0400;

(2) A regional support network may submit an application to the mental health division to operate as a licensed community support service provider as defined in WAC 388-865-0288;

(3) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(4) The consumer chart review is conducted during a second site review within twelve months of the issuance of the provisional license for the agency or service component if the site review is being conducted in response to a license application for a new agency or a new service component in a currently licensed agency;

(5) The mental health division may include representatives of the regional support network or mental health prepaid health plan in the licensing review process. If a provider is licensed based on deemed status as outlined in WAC 388-865-0476, input from the accrediting agency may be considered;

(6) The on-site review concludes with an exit conference that includes:

(a) Discussion of findings, if any;

(b) Statement of deficiencies requiring a plan of correction;

(c) A plan of correction signed by the applicant agency director and the mental health division review team representative with a completion date no greater than sixty days from the date of the exit conference, unless otherwise negotiated with the review team representative. Consumer health and safety concerns may require immediate corrective action.

(7) If the provider fails to correct the deficiencies noted within the agreed-upon time frames, licensure will be denied. The mental health division notifies the applicant in writing of the reasons for denial and the right to a review of the decision in an administrative hearing;

(8) If licensure is denied, the applicant must wait at least six months following the date of notification of denial before reapplying.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0470, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0472 Licensing categories. The mental health division assigns the community support service applicant or licensee one of the following types of licenses:

(1) Provisional license. This category is given only to a new applicant. The mental health division may grant a provisional license for up to one year if the provider, has:

(a) An acceptable detailed plan for the development and operation of the services;

(b) The availability of administrative and clinical expertise required to develop and provide the planned services;

(c) The fiscal management and existence or projection of resources to reasonably ensure stability and solvency; and

(d) A corrective action plan approved by the mental health division, if applicable, for any deficiencies.

(2) Full License. Full licensure means that the applicant or licensee is in substantial compliance with the law, applicable rules and regulations, and state minimum standards.

(3) Probationary license. The mental health division may issue a probationary license if the service provider is substantially out of compliance with the requirements of state and federal law, applicable rules and regulations and state minimum standards. The mental health division provides the service provider with a written notice of the deficiencies.

(a) If the deficiency has caused or is likely to cause serious injury, harm, impairment or death to a consumer, the deficiencies must be corrected within a time frame specified by the mental health division;

(b) If the provider fails to complete a corrective action plan or correct deficiencies according to the corrective action plan, the license may be suspended or revoked;

(c) To regain full licensure, a service provider in probationary status must provide a written statement to the mental health division when it has made all required corrective actions and now complies with relevant federal and state law, applicable rules and regulations, and state minimum standards;

(d) The mental health division may conduct an on-site review to confirm that the corrections have been made.

(4) The mental health division may perform an onsite visit to determine the validity of a complaint or notice that a community support service provider is out of compliance with law, applicable rules and regulations, and state minimum standards.

(5) If the service provider does not demonstrate compliance with the requirements of this section, the mental health division may initiate procedures to suspend or revoke a license consistent with state and federal laws, rules and regulations consistent with the provisions of RCW 71.24.035 (7) through (11) and of 43.20A.205.

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(6) A regional support network or prepaid health plan may choose to contract with a service provider with a provisional license, full license, or probationary license, but may not contract with a provider with a suspended or revoked license.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0472, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0474 Fees for community support service provider licensure. (1) Fees are due with an initial application or for annual license renewal;

(2) Fees must be paid for a minimum of one year;

(3) If an application is withdrawn prior to issuance or denial, one-half of the fees may be refunded at the request of the applicant;

(4) A change in ownership requires a new license and payment of fees;

(5) Fee payments must be made by check, electronic fund transfer, or money order made payable to the mental health division;

(6) Fees will not be refunded if a license or certificate is denied, revoked, or suspended;

(7) Failure to pay fees when due will result in suspension or denial of the license;

(8) The following fees must be sent with the application for a license or renewal:

Range	Service Hours	Annual Fee
1	0-3,999	\$291.00
2	4,000-14,999	422.00
3	15,000-29,999	562.00
4	30,000-49,999	842.00
5	50,000 or more	1,030.00

(9) Annual service hours are computed on the most recent year. For new entities, annual service hours equals the projected service hours for the year of licensure. The provider must report the number of annual service hours based on the mental health division consumer information system data dictionary.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0474, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0476 Licensure based on deemed status. (1) The mental health division may deem compliance with state minimum standards and issue a community support service license based on the provider being currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division. Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency.

(2) The mental health division will only grant licensure based on deemed status to providers with a full license as defined in WAC 388-865-0472.

(3) Specific requirements of state regulation, contract or policy will be waived through a deeming process consistent with the working agreement between the mental health division and the accrediting agency;

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(4) Specific requirements of state or federal law, or regulation will not be waived through a deeming process.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0476, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0478 Renewal of a community support service provider license. (1) Each year the community support service provider must renew its license. The community support service provider sends the reapplication for licensure to mental health division along with the required fee.

(2) If the service provider contracts with the regional support network or prepaid health plan it must send a copy of the application to the regional support network or mental health prepaid health plan. The regional support network or mental health prepaid health plan may make written comments to the mental health division about renewing the service provider's license. They must send the service provider a copy.

(3) The mental health division considers the request for renewal, along with any recommendations from the regional support network or mental health prepaid health plan and the results of any onsite reviews completed.

(4) If the provider is in compliance with applicable laws and standards, the mental health division sends the service provider a renewed license, with a copy to the regional support network or mental health prepaid health plan if applicable.

(5) Failure to submit the annual application for renewal license and/or to pay fees when due results in expiration of the license and the provider will be placed on probationary status.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0478, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0480 Procedures to suspend, or revoke a license. (1) The mental health division may suspend, revoke, limit or restrict the license of a community support service provider, or refuse to grant or renew a license for failure to conform to the law, applicable rules and regulations, or state minimum standards.

(2) The mental health division may suspend, revoke, limit or restrict the license of a service provider immediately if there is imminent risk to consumer health and safety.

(3) The mental health division sends a written decision to revoke, suspend, or modify the former licensure status under RCW 43.20A.205, with the reasons for the decision and informing the service provider of its right to an administrative hearing. A copy of the letter will be sent to the area regional support network.

(4) A regional support network or mental health prepaid health plan must not contract with a service provider with a suspended or revoked license.

(5) The mental health division may suspend or revoke a license when a service provider in probationary status fails to correct the health and safety deficiencies as agreed in the corrective action plan with the mental health division.

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[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0480, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0482 Procedures to contest a licensing decision. To contest a decision by the mental health division, the service provider, regional support network, or mental health prepaid health plan must, within twenty-eight calendar days:

(1) File a written application for a hearing with a method that shows proof of receipt to: The Board of Appeals, P.O. Box 2465, Olympia, WA 98504; and

(2) Include in the appeal:

(a) The issue to be reviewed and the date the decision was made;

(b) A specific statement of the issue and law involved;

(c) The grounds for contesting a decision of the mental health division; and

(d) A copy of the mental health division decision that is being contested.

(3) The appeal must be signed by the director of the service provider and include the address of the service provider.

(4) The decision will be made following the requirements of the Administrative Procedure Act, chapter 34.05 RCW and chapter 388-02 WAC.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0482, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0484 Process to certify providers of involuntary services. In order to be certified to provide services to consumers on an involuntary basis, the provider must comply with the following process:

(1) Be licensed as a community support provider consistent with this section or licensed as a community hospital by the department of health;

(2) Complete and submit an application for certification to the regional support network;

(3) The regional support network selects providers for certification and makes a request to the mental health division for certification;

(4) The mental health division conducts an on-site review to examine agency policies and procedures, personnel records, clinical records, financial documents, and any other information that may be necessary to confirm compliance with minimum standards of this section;

(5) The mental health division grants certification based on compliance with the minimum standards of this section and chapter 71.05 RCW;

(6) The certificate may be renewed annually at the request of the regional support network and the provider's continued compliance with the minimum standards of this section;

(7) The procedures to suspend or revoke a certificate are the same as outlined WAC 388-865-0468;

(8) The appeal process to contest a decision of the mental health decision is the same as outlined in WAC 388-865-0482.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0484, filed 5/31/01, effective 7/1/01.]

SECTION FIVE—INPATIENT EVALUATION AND TREATMENT FACILITIES

WAC 388-865-0500 Inpatient evaluation and treatment facilities. (1) The mental health division certifies facilities to provide involuntary inpatient evaluation and treatment services for more than twenty-four hours within a general hospital, psychiatric hospital, inpatient evaluation and treatment facility, or child long-term inpatient treatment facility.

(2) Compliance with the regulations in this chapter does not constitute release from the requirements of applicable federal, state, tribal and local codes and ordinances. Where regulations in this chapter exceed other local codes and ordinances, the regulations in this chapter will apply.

(3) This chapter does not apply to state psychiatric hospitals as defined in chapter 72.23 RCW or facilities owned or operated by the department of veterans affairs or other agencies of the United States government.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0500, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0500, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0511 Evaluation and treatment facility certification. To obtain and maintain certification to provide inpatient evaluation and treatment services under chapter 71.05 and 71.34 RCW, a facility must meet the following requirements:

- (1) Be licensed by the department of health as:
 - (a) A hospital as defined in chapter 70.41 RCW;
 - (b) A psychiatric hospital as defined in chapter 246-322 WAC;
 - (c) A mental health inpatient evaluation and treatment facility consistent with chapter 246-337 WAC; or
 - (d) A mental health child long-term inpatient treatment facility consistent with chapter 246-337 WAC.

(2) Be approved by the regional support network, or the mental health division in the case of mental health child long-term inpatient treatment facilities; and

(3) Successfully complete a provisional and annual on-site review by the mental health division to determine facility compliance with the minimum standards of this section and chapters 71.05 and 71.34 RCW.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0511, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0516 Certification fees. Inpatient facilities certified to provide inpatient evaluation and treatment services are assessed an annual certification fee of thirty-two dollars per bed, payable to the mental health division.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0516, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0520 Certification based on deemed status. The mental health division may deem compliance with state minimum standards for facilities that are currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division.

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(1) Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency, to include the minimum standards of this section and chapters 71.05 and 71.34 RCW.

(2) The mental health division retains all responsibilities relating to applications of new providers, complaint investigations, suspensions and revocations.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0520, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0526 Single bed certification. At the discretion of the mental health division, an exception may be granted to allow treatment to an adult on a seventy-two hour detention or fourteen-day commitment in a facility that is not certified under WAC 388-865-0500; or for a maximum of thirty days to allow a community facility to provide treatment to an adult on a ninety- or one hundred eighty-day inpatient involuntary commitment order. For involuntarily detained or committed children, the exception may be granted to allow treatment in a facility not certified under WAC 388-865-0500 until the child's discharge from that setting to the community, or until they transfer to a bed in a children's long-term inpatient program (CLIP).

(1) The regional support network or its designee must submit a written request for a single bed certification to the mental health division prior to the commencement of the order. In the case of a child, the facility must submit the written request directly to the mental health division.

(2) The facility receiving the single bed certification must meet all requirements of this section unless specifically waived by the mental health division.

(3) The request for single bed certification must describe why the consumer meets at least one of the following criteria:

(a) The consumer requires services that are not available at a facility certified under this chapter or a state psychiatric hospital; or

(b) The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the consumer's individual treatment needs.

(4) The mental health division director or the director's designee makes the decision and gives written notification to the requesting regional support network in the form of a single bed certification. The single bed certification must not contradict a specific provision of federal law or state statute.

(5) The mental health division may make site visits at any time to verify that the terms of the single bed certification are being met. Failure to comply with any term of this exception may result in corrective action. If the mental health division determines that the violation places consumers in imminent jeopardy, immediate revocation of this exception can occur.

(6) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding single bed certification decisions by mental health division staff.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0526, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0531 Exception to rule—Long-term certification. (1) For adults: At the discretion of the mental health division, a facility may be granted an exception to

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WAC 388-865-0229 in order to allow the facility to be certified to provide treatment to adults on a ninety- or one hundred eighty-day inpatient involuntary commitment orders.

(2) For children: At the discretion of the mental health division, a facility that is certified as a 'mental health inpatient evaluation and treatment facility' may be granted an exception to provide treatment to a child on a one hundred and eighty-day inpatient involuntary treatment order only until the child is discharged from his/her order to the community, or until a bed is available for that child in a child long-term inpatient treatment facility (CLIP). The child cannot be assigned by the CLIP placement team in accordance with RCW 71.34.100 to any facility other than a CLIP facility.

(3) The exception certification may be requested by the facility, the director of the mental health division or his/her designee, or the regional support network for the facility's geographic area.

(4) The facility receiving the long-term exception certification for ninety- or one hundred eighty-day patients must meet all requirements found in WAC 388-865-0500.

(5) The exception certification must be signed by the director of the mental health division. The exception certification may impose additional requirements, such as types of consumers allowed and not allowed at the facility, reporting requirements, requirements that the facility immediately report suspected or alleged incidents of abuse, or any other requirements that the director of the mental health division determines are necessary for the best interests of residents.

(6) The mental health division may make unannounced site visits at any time to verify that the terms of the exception certification are being met. Failure to comply with any term of the exception certification may result in corrective action. If the mental health division determines that the violation places residents in imminent jeopardy, immediate revocation of the certification can occur.

(7) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding the decision to grant or not to grant exception certification.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0531, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0536 Standards for administration.

The inpatient evaluation and treatment facility must develop a policy to implement the following administrative requirements:

(1) A description of the program, including age of consumers to be served, length of stay and services to be provided.

(2) An organizational structure including clear lines of authority for management and clinical supervision.

(3) Designation of a physician or other mental health professional as the professional person in charge of clinical services at that facility.

(4) A quality management plan to monitor, collect data and develop improvements to meet the requirements of this chapter.

(5) A policy management structure that establishes:

(a) Procedures for maintaining and protecting resident medical/clinical records consistent with chapter 70.02 WAC, "Medical Records Health Care Information Access and Dis-

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closure Act" and Health Insurance Portability and Accountability Act (HIPAA);

(b) Procedures for maintaining adequate fiscal accounting records consistent with generally accepted accounting principles (GAAP);

(c) Procedures for management of human resources to ensure that residents receive individualized treatment or care by adequate numbers of staff who are qualified and competent to carry out their assigned responsibilities;

(d) Procedures for admitting consumers needing inpatient evaluation and treatment services seven days a week, twenty-four hours a day, except that child long-term inpatient treatment facilities are exempted from this requirement;

(e) Procedures to assure appropriate and safe transportation for persons who are not approved for admission to his or her residence or other appropriate place;

(f) Procedures to detain arrested persons who are not approved for admission for up to eight hours in order to enable law enforcement to return to the facility and take the person back into custody;

(g) Procedures to assure access to necessary medical treatment, emergency life-sustaining treatment, and medication;

(h) Procedures to assure the protection of consumer and family rights as described in this chapter and chapters 71.05 and 71.34 RCW;

(i) Procedures to inventory and safeguard the personal property of the consumer being detained, including a process to limit inspection of the inventory list by responsible relatives or other persons designated by the detained consumer;

(j) Procedures to assure that a mental health professional and licensed physician are available for consultation and communication with both the consumer and the direct patient care staff twenty-four hours a day, seven days a week;

(k) Procedures to provide warning to an identified person and law enforcement when an adult has made a threat against an identified victim;

(l) Procedures to ensure that consumers detained for up to fourteen or ninety additional days of treatment are evaluated by the professional staff of the facility in order to be prepared to testify that the consumer's condition is caused by a mental disorder and either results in likelihood of serious harm or the consumer being gravely disabled;

(m) Procedures to assure the rights of consumers to make mental health advance directives, and facility protocols for responding to consumer and agent requests consistent with RCW 71.32.150.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0536, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0541 Admission and intake evaluation.

(1) For consumers who have been involuntarily detained, the facility must obtain a copy of the petition for initial detention stating the evidence under which the consumer was detained.

(2) The facility must document that each resident has received timely evaluations to determine the nature of the disorder and the treatment necessary, including:

(a) A health assessment of the consumer's physical condition to determine if the consumer needs to be transferred to an appropriate hospital for treatment;

(b) Examination and medical evaluation within twenty-four hours by a licensed physician, advanced registered nurse practitioner, or physician assistant-certified;

(c) Psychosocial evaluation by a mental health professional;

(d) Development of an initial treatment plan;

(e) Consideration of less restrictive alternative treatment at the time of admission; and

(f) The admission diagnosis and what information the determination was based upon.

(3) A consumer who has been delivered to the facility by a peace officer for evaluation must be evaluated by a mental health professional within the following time frames:

(a) Three hours of an adult consumer's arrival;

(b) Twelve hours of arrival for a child in an inpatient evaluation and treatment facility; or

(c) At any time for a child who has eloped from a child long-term inpatient treatment facility and is being returned to the facility.

(4) If the licensed physician and mental health professional determine that the needs of an adult consumer would be better served by placement in a chemical dependency treatment facility then the consumer must be referred to an approved treatment program defined under chapter 70.96A RCW.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0541, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0545 Use of seclusion and restraint procedures—Adults. Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) Staff must notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion;

(2) The consumer must be informed of the reasons for use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from these procedures;

(3) The clinical record must document staff observation of the consumer at least every fifteen minutes and observation recorded in the consumer's clinical record;

(4) If the use of restraint or seclusion exceeds twenty-four hours, a licensed physician must assess the consumer and write a new order if the intervention will be continued. This procedure is repeated again for each twenty-four hour period that restraint or seclusion is used;

(5) All assessments and justification for the use of seclusion or restraint must be documented in the consumer's medical record.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0545, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0546 Use of seclusion and restraint procedures—Children. Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) In the event of an emergency use of restraints or seclusion, a licensed physician must be notified within one hour and must authorize the restraints or seclusion;

(2) No consumer may be restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. Such consumer must be directly observed every fifteen minutes and the observation recorded in the consumer's clinical record;

(3) If the restraint or seclusion exceeds twenty-four hours, the consumer must be examined by a licensed physician. The facts determined by his or her examination and any resultant decision to continue restraint or seclusion over twenty-four hours must be recorded in the consumer's clinical record over the signature of the authorizing physician. This procedure must be repeated for each subsequent twenty-four hour period of restraint or seclusion.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0546, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0547 Plan of care/treatment. The medical record must contain documentation of:

(1) Diagnostic and therapeutic services prescribed by the attending clinical staff.

(2) An individualized plan for treatment developed collaboratively with the consumer. This may include participation of a multidisciplinary team or mental health specialists as defined in WAC 388-865-0150, or collaboration with members of the consumer's support system as identified by the consumer.

(3) Copies of advance directives, powers of attorney or letters of guardianship provided by the consumer.

(4) A plan for discharge including a plan for follow-up where appropriate.

(5) Documentation of the course of treatment.

(6) That a mental health professional has contact with each involuntary consumer at least daily for the purpose of:

(a) Observation;

(b) Evaluation;

(c) Release from involuntary commitment to accept treatment on a voluntary basis;

(d) Discharge from the facility to accept voluntary treatment upon referral.

(7) For consumers who are being evaluated as dangerous mentally ill offenders under RCW 72.09.370(7), the professional person in charge of the evaluation and treatment facility must consider filing a petition for a ninety day less restrictive alternative in lieu of a petition for a fourteen-day commitment.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0547, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0551 Qualification requirements for staff. The provider must document that staff and clinical supervisors are qualified for the position they hold and have the education, experience, or skills to perform the job requirements, including:

- (1) A current job description.
- (2) A current Washington state department of health license or certificate or registration as may be required for his/her position.
- (3) Washington state patrol background checks for employees in contact with consumers consistent with RCW 43.43.830.
- (4) Clinical supervisors must meet the qualifications of mental health professionals or specialists as defined in WAC 388-865-0150.
- (5) An annual performance evaluation.
- (6) Development of an individualized annual training plan, to include at least:
 - (a) The skills he or she needs for his/her job description and the population served;
 - (b) Least restrictive alternative options available in the community and how to access them;
 - (c) Methods of resident care;
 - (d) Management of assaultive and self-destructive behaviors, including proper and safe use of seclusion and/or restraint procedures; and
 - (e) The requirements of chapter 71.05 and 71.34 RCW, this chapter, and protocols developed by the mental health division.
- (7) If contract staff are providing direct services, the facility must ensure compliance with the training requirements outlined in (6) above.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0551, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0561 Posting of consumer rights. The consumer rights assured by RCW 71.05.370 and 71.34.160 must be prominently posted within the department or ward of the community or inpatient evaluation and treatment facility and provided in writing to the consumer, as follows: "You have the right to:

- (1) Immediate release, unless involuntary commitment proceedings are initiated.
- (2) Wear your own clothes and to keep and use personal possessions, except when deprivation is essential to protect your safety or that of another person.
- (3) Keep and be allowed to spend a reasonable sum of your own money for canteen expenses and small purchases.
- (4) Adequate care and individualized treatment.
- (5) Have all information and records compiled, obtained, or maintained in the course of receiving services kept confidential.
- (6) Have access to individual storage space for your private use.
- (7) Have visitors at reasonable times.
- (8) Have reasonable access to a telephone, both to make and receive confidential calls.

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(9) Have ready access to letter writing materials, including stamps, and to send and receive uncensored correspondence through the mails.

(10) Not to consent to the administration of anti-psychotic medications beyond the hearing conducted pursuant to RCW 71.05.320(2) or the performance of electroconvulsant therapy or surgery, except emergency life-saving surgery, unless ordered by a court of competent jurisdiction pursuant to the following standards and procedures: RCW 71.05.200(1)(e); 71.05.215; and 71.05.370(7).

(11) To dispose of property and sign contracts unless you have been adjudicated as incompetent in a court proceeding directed to that particular issue.

(12) Not to have psychosurgery performed under any circumstances."

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0561, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0566 Rights of consumers receiving involuntary services. The provider must ensure that consumers who are receiving inpatient services involuntarily are informed of the following rights orally and provided with a copy in the primary language spoken/used/understood by the person. "You have the right to:

- (1) Remain silent and any statement you make may be used against you.
- (2) Access to attorneys, courts and other legal redress, including the name and address of the attorney the mental health professional has designated for you.
- (3) Immediately be informed of your right to speak with an attorney and a review of the legality of your detention including representation at the probable cause hearing.
- (4) Have access to a qualified language interpreter in the primary language understood by you, consistent with chapter 388-03 WAC.
- (5) Have a responsible member of your immediate family if possible, guardian or conservator, if any, and such person as designated by you be given written notice of your inpatient status, and your rights as an involuntary consumer.
- (6) A medical and psychosocial evaluation within twenty-four hours of admission to determine whether continued detention in the facility is necessary.
- (7) A judicial hearing before a superior court if you are not released within seventy-two hours (excluding Saturday, Sunday, and holidays), to decide if continued detention within the facility is necessary.
- (8) Not forfeit any legal right or suffer any legal disability as a consequence of any actions taken or orders made, other than as specifically provided.
- (9) Not to be denied treatment by spiritual means through prayer in accordance with the tenets and practices of a church or religious denomination.
- (10) Refuse psychiatric medication, except medications ordered by the court under WAC 388-865-0570 but not any other medication previously prescribed by an authorized prescriber.
- (11) Refuse treatment, but not emergency lifesaving treatment unless otherwise specified in a written advance directive provided to the facility.
- (12) Be given a copy of WAC 388-865-0585 outlining limitations on the right to possess a firearm."

[Title 388 WAC—p. 1377]

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0566, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0570 Rights related to antipsychotic medication. All consumers have a right to make an informed decision regarding the use of antipsychotic medication consistent with the provisions of RCW 71.05.370(7) and 71.05.215. The provider must develop and maintain a written protocol for the involuntary administration of antipsychotic medications, including the following requirements:

- (1) The clinical record must document:
 - (a) The physician's attempt to obtain informed consent;
 - (b) The consumer was asked if he or she wishes to decline treatment during the twenty-four hour period prior to any court proceeding wherein the consumer has the right to attend and is related to his or her continued treatment. The answer must be in writing and signed when possible. In the case of a child under the age of eighteen, the physician must be able to explain to the court the probable effects of the medication.
 - (c) The reasons why any anti-psychotic medication is administered over the consumer's objection or lack of consent.
- (2) The physician may administer anti-psychotic medications over a consumer's objections or lack of consent only when:
 - (a) An emergency exists, provided there is a review of this decision by a second physician within twenty-four hours. An emergency exists if:
 - (i) The consumer presents an imminent likelihood of serious harm to self or others;
 - (ii) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and
 - (iii) In the opinion of the physician, the consumer's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician.
 - (b) There is an additional concurring opinion by a second physician for treatment up to thirty days;
 - (c) For continued treatment beyond thirty days through the hearing on any one hundred eighty-day petition filed under RCW 71.05.370(7), provided the facility medical director or director's medical designee reviews the decision to medicate a consumer. Thereafter, antipsychotic medication may be administered involuntarily only upon order of the court. The review must occur at least every sixty days.
- (3) The examining physician must sign all one hundred eighty-day petitions for antipsychotic medications files under the authority of RCW 71.05.370(7);
- (4) Consumers committed for one hundred eighty days who refuse or lack the capacity to consent to antipsychotic medications have the right to a court hearing under RCW 71.05.370(7) prior to the involuntary administration of antipsychotic medications;
- (5) In an emergency, antipsychotic medications may be administered prior to the court hearing provided that an examining physician files a petition for an antipsychotic medication order the next judicial day;

(6) All involuntary medication orders must be consistent with the provisions of RCW 71.05.370 (7)(a) and (b), whether ordered by a physician or the court.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0570, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0575 Special considerations for serving children. Inpatient evaluation and treatment facilities serving children must develop policies and procedures to address special considerations for serving children, including:

- (1) Adults must be separated from children who are not yet thirteen years of age;
- (2) Children who have had their thirteenth birthday, but are under the age of eighteen, may be served with adults only if the child's clinical record contains a professional judgment saying that placement in an adult facility will not be harmful to the child or adult.
- (3) Examination and evaluation by a children's mental health specialist within twenty-four hours of admission.
- (4) Provisions for evaluation of children brought to the facility for evaluation by their parents.
- (5) Procedures to notify child protective services any time the facility has reasonable cause to believe that abuse, neglect, financial exploitation or abandonment of a child has occurred.
- (6) For a child thirteen years or older who is brought to an inpatient evaluation and treatment facility or hospital for immediate mental health services, the professional person in charge of the facility must evaluate the child's mental condition, determine a mental disorder, need for inpatient treatment, and willingness to obtain voluntary treatment. The facility may detain or arrange for the detention of the child up to twelve hours for evaluation by a designated mental health professional to commence detention proceedings.
- (7) Admission of children thirteen years or older admitted without parental consent must have concurrence of the professional person in charge of the facility and written review and documentation no less than every one hundred eighty days.
- (8) Notice must be provided to parents when a child is voluntarily admitted to inpatient treatment without parental consent within twenty four hours of admission in accordance with the requirements of RCW 71.34.510.
- (9) Children who have been admitted on the basis of a designated mental health professional petition for detention must be evaluated by the facility providing seventy two hour evaluation and treatment to determine the child's condition and either admit or release the child. If the child is not approved for admission, the facility must make recommendations and referral for further care and treatment as necessary.
- (10) Examination and evaluation of a child approved for inpatient admission to include:
 - (a) The needs to be served by placement in a chemical dependency facility;
 - (b) Restricting the right to associate or communicate with parents; and
 - (c) Advising the child of rights in accordance with chapter 71.34 RCW.
- (11) Petition for fourteen-day commitment in accordance with the requirements of RCW 71.34.730.

(12) Commitment hearing requirements and release from further inpatient treatment which may be subject to reasonable conditions if appropriate in accordance with RCW 71.34.740.

(13) Discharge and conditional release of a child in accordance with RCW 71.34.770, provided that the professional person in charge gives the court written notice of the release within three days of the release. If the child is on a one hundred eighty-day commitment, the children's long-term inpatient program administrator must also be notified.

(14) Rights of children undergoing treatment and posting of such rights must be in accordance with RCW 71.34.355, 71.34.620, and 71.34.370.

(15) Release of a child who is not accepted for admission or who is released by an inpatient evaluation and treatment facility in accordance with RCW 71.34.365.

(16) Information concerning treatment of children and all information obtained through treatment under this chapter may be disclosed only in accordance with RCW 71.34.340.

(17) Availability of court records and files in accordance with RCW 71.34.335.

(18) Mental health services information must only be released in accordance with RCW 71.34.345 and other applicable state and federal statutes.

[Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0575, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0575, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0580 Child long-term inpatient treatment facilities. Child long-term inpatient treatment facilities must develop a written plan for assuring that services provided are appropriate to the developmental needs of children and youth, including:

(1) If there is not a child psychiatrist on the staff, there must be a child psychiatrist available for consultation.

(2) There must be a psychologist with documented evidence of skill and experience in working with children and youth available either on the clinical staff or by consultation, responsible for planning and reviewing psychological services and for developing a written set of guidelines for psychological services.

(3) There must be a registered nurse, with training and experience in working with psychiatrically impaired children and youth, on staff as a full-time or part-time employee who must be responsible for all nursing functions.

(4) There must be a social worker with experience in working with children and youth on staff as a full-time or part-time employee who must be responsible for social work functions and the integration of these functions into the individualized treatment plan.

(5) There must be an educational/vocational assessment of each resident with appropriate educational/vocational programs developed and implemented or assured on the basis of that assessment.

(6) There must be an occupational therapist available who has experience in working with psychiatrically impaired children and youth responsible for occupational therapy functions and the integration of these functions into treatment.

(7) There must be a recreational therapist available who has had experience in working with psychiatrically impaired

children and youth responsible for the recreational therapy functions and the integration of these functions into treatment.

(8) Disciplinary policies and practices must be stated in writing:

(a) Discipline must be fair, reasonable, consistent and related to the behavior of the resident. Discipline, when needed, must be consistent with the individualized treatment plan;

(b) Abusive, cruel, hazardous, frightening or humiliating disciplinary practices must not be used. Seclusion and restraints must not be used as punitive measures. Corporal punishment must not be used;

(c) Disciplinary measures must be documented in the medical record.

(9) Residents must be protected from assault, abuse and neglect. Suspected or alleged incidents of nonaccidental injury, sexual abuse, assault, cruelty or neglect to a child must be reported to a law enforcement agency or to the department of social and health services and comply with chapter 26.44 RCW.

(10) Orientation material must be made available to facility personnel, clinical staff and/or consultants informing practitioners of their reporting responsibilities and requirements. Appropriate local police and department phone numbers must be available to personnel and staff.

(11) When suspected or alleged abuse is reported, the medical record must reflect the fact that an oral or written report has been made to the child protective services of DSHS or to a law enforcement agency. This note must include the date and time that the report was made, the agency to which it was made and the signature of the person making the report. Contents of the report need not be included in the medical record.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0580, filed 3/4/04, effective 4/4/04.]

WAC 388-865-0585 Petition for the right to possess a firearm. An adult is entitled to the restoration of the right to firearm possession when he or she no longer requires treatment or medication for a condition related to the involuntary commitment. This is described in RCW 9A.10.047 (3)(a).

(1) an adult who wants his or her right to possess a firearm restored may petition the court that ordered involuntary treatment or the superior court of the county in which he or she lives for a restoration of the right to possess firearms. At a minimum, the petition must include:

(a) The fact, date, and place of involuntary treatment;

(b) The fact, date, and release from involuntary treatment;

(c) A certified copy of the most recent order of commitment with the findings and conclusions of law.

(2) The person must show the court that he/she no longer requires treatment or medication for the condition related to the commitment.

(3) If the court requests relevant information about the commitment or release to make a decision, the mental health professionals who participated in the evaluation and treatment must give the court that information.

[Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. 04-07-014, § 388-865-0585, filed 3/4/04, effective 4/4/04.]

SECTION SIX—DEPARTMENT OF CORRECTIONS ACCESS TO CONFIDENTIAL MENTAL HEALTH INFORMATION

WAC 388-865-0600 Purpose. In order to enhance and facilitate the department of corrections' ability to carry out its responsibility of planning and ensuring community protection, mental health records and information, as defined in this section, that are otherwise confidential shall be released by any mental health service provider to the department of corrections personnel for whom the information is necessary to carry out the responsibilities of their office as authorized in RCW 71.05.445 and 71.34.225. Department of corrections personnel must use records only for the stated purpose and must assure that records remain confidential and subject to the limitations on disclosure outlined in chapter 71.05 RCW, except as provided in RCW 72.09.585.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0600, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0610 Definitions. Relevant records and reports includes written documents obtained from other agencies or sources, often referred to as third-party documents, as well as documents produced by the agency receiving the request. Relevant records and reports do not include the documents restricted by either federal law or federal regulation related to treatment for alcoholism or drug dependency or the Health Insurance Portability and Accountability Act or state law related to sexually transmitted diseases, as outlined in RCW 71.05.445 and 71.34.225.

(1) **"Relevant records and reports"** means:

(a) Records and reports of inpatient treatment:

(i) Inpatient psychosocial assessment - Any initial, interval, or interim assessment usually completed by a person with a master's degree in social work (or equivalent) or equivalent document as established by the holders of the records and reports;

(ii) Inpatient intake assessment - The first assessment completed for an admission, usually completed by a psychiatrist or other physician or equivalent document as established by the holders of the records and reports;

(iii) Inpatient psychiatric assessment - Any initial, interim, or interval assessment usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(iv) Inpatient discharge/release summary - Summary of a hospital stay usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(v) Inpatient treatment plan - A document designed to guide multidisciplinary inpatient treatment or equivalent document as established by the holders of the records and reports;

(vi) Inpatient discharge and aftercare plan data base - A document designed to establish a plan of treatment and support following discharge from the inpatient setting or equivalent document as established by the holders of the records and reports.

(vii) Forensic discharge review - A report completed by a state hospital for individuals admitted for evaluation or treatment who have transferred from a correctional facility or is or has been under the supervision of the department of corrections.

(b) Records and reports of outpatient treatment:

(i) Outpatient intake evaluation - Any initial or intake evaluation or summary done by any mental health practitioner or case manager the purpose of which is to provide an initial clinical assessment in order to guide outpatient service delivery or equivalent document as established by the holders of the records and reports;

(ii) Outpatient periodic review - Any periodic update, summary, or review of treatment done by any mental health practitioner or case manager. This includes, but is not limited to: Documents indicating diagnostic change or update; annual or periodic psychiatric assessment, evaluation, update, summary, or review; annual or periodic treatment summary; concurrent review; individual service plan as required by WAC 388-865-0425 through 388-865-0430, or equivalent document as established by the holders of the records and reports;

(iii) Outpatient crisis plan - A document designed to guide intervention during a mental health crisis or decompensation or equivalent document as established by the holders of the records and reports;

(iv) Outpatient discharge or release summary - Summary of outpatient treatment completed by a mental health professional or case manager at the time of termination of outpatient services or equivalent document as established by the holders of the records and reports;

(v) Outpatient treatment plan - A document designed to guide multidisciplinary outpatient treatment and support or equivalent document as established by the holders of the records and reports.

(c) Records and reports regarding providers and medications:

(i) Current medications and adverse reactions - A list of all known current medications prescribed by the licensed practitioner to the individual and a list of any known adverse reactions or allergies to medications or to environmental agents;

(ii) Name, address and telephone number of the case manager or primary clinician.

(d) Records and reports of other relevant treatment and evaluation:

(i) Psychological evaluation - A formal report, assessment, or evaluation based on psychological tests conducted by a psychologist;

(ii) Neuropsychological evaluation - A formal neuropsychological report, assessment, or evaluation based on neuropsychological tests conducted by a psychologist;

(iii) Educational assessment - A formal report, assessment, or evaluation of educational needs or equivalent document as established by the holders of the records and reports;

(iv) Functional assessment - A formal report, assessment, or evaluation of degree of functional independence. This may include but is not limited to: Occupational therapy evaluations, rehabilitative services data base activities assessment, residential level of care screening, problem severity scale, instruments used for functional assessment or equivalent.

lent document as established by the holders of the records and reports;

(v) Forensic evaluation - An evaluation or report conducted pursuant to chapter 10.77 RCW;

(vi) Offender/violence alert - A any documents pertaining to statutory obligations regarding dangerous or criminal behavior or to dangerous or criminal propensities. This includes, but is not limited to, formal documents specifically designed to track the need to provide or past provision of: Duty to warn, duty to report child/elder abuse, victim/witness notification, violent offender notification, and sexual/kidnaping offender notification per RCW 4.24.550, 10.77.205, 13.40.215, 13.40.217, 26.44.330, 71.05.120, 71.05.330, 71.05.340, 71.05.425, 71.09.140, and 74.34.035;

(vii) Risk assessment - Any tests or formal evaluations including department of corrections risk assessments administered or conducted as part of a formal violence or criminal risk assessment process that is not specifically addressed in any psychological evaluation or neuropsychological evaluation.

(e) Records and reports of legal status - Legal documents are documents filed with the court or produced by the court indicating current legal status or legal obligations including, but not limited to:

- (i) Legal documents pertaining to chapter 71.05 RCW;
- (ii) Legal documents pertaining to chapter 71.34 RCW;
- (iii) Legal documents containing court findings pertaining to chapter 10.77 RCW;
- (iv) Legal documents regarding guardianship of the person;
- (v) Legal documents regarding durable power of attorney;
- (vi) Legal or official documents regarding a protective payee;
- (vii) Mental health advance directive.

(2) **"Relevant information"** means descriptions of a consumer's participation in, and response to, mental health treatment and services not available in a relevant record or report, including all statutorily mandated reporting or duty to warn notifications as identified in WAC 388-865-610 (1)(d) (vi), Offender/Violence alert, and all requests for evaluations for involuntary civil commitments under chapter 71.05 RCW. The information may be provided in verbal or written form at the discretion of the mental health service provider.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166, 05-14-082, § 388-865-0610, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.-020, and 43.20B.335. 01-12-047, § 388-865-0610, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0620 Scope. Many records and reports are updated on a regular or as needed basis. The scope of the records and reports to be released to the department of corrections are dependent upon the reason for the request.

(1) For the purpose of a presentence investigation release only the most recently completed or received records of those completed or received within the twenty-four-month period prior to the date of the request; or

(2) For all other purposes including risk assessments release all versions of records and reports that were com-

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pleted or received within the ten year period prior to the date of the request that are still available.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166, 05-14-082, § 388-865-0620, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.-020, and 43.20B.335. 01-12-047, § 388-865-0620, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0630 Time frame. The mental health service provider shall provide the requested relevant records, reports and information to the authorized department of corrections person in a timely manner, according to the purpose of the request:

(1) Presentence investigation - within seven calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the seven-day-period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(2) All other purposes - within thirty calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the thirty-day period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(3) Emergent situation requests - When an offender subject has failed to report for department of corrections supervision or in an emergent situation that poses a significant risk to the public, the mental health provider shall upon request, release information related to mental health services delivered to the offender and, if known, information regarding the whereabouts of the offender. Requests if oral must be subsequently confirmed in writing the next working day, which includes e-mail or facsimile so long as the requesting person at the department of corrections is clearly defined. The request must specify the information being requested. Disclosure of the information requested does not require the consent of consumer.

(a) Information that can be released is limited to:

(i) A statement as to whether the offender is or is not being treated by the mental health services provider; and

(ii) Address or information about the location or whereabouts of the offender.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166, 05-14-082, § 388-865-0630, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.-020, and 43.20B.335. 01-12-047, § 388-865-0630, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0640 Written requests. The written request for relevant records, reports and information shall include:

(1) Verification that the person for whom records, reports and information are being requested is under the authority of the department of corrections, per chapter 9.94A RCW, and the expiration date of that authority.

(2) Sufficient information to identify the person for whom records, reports and information are being requested including name and other identifying data.

(3) Specification as to which records and reports are being requested and the purpose for the request.

(4) Specification as to what relevant information is requested and the purpose for the request.

(5) Identification of the department of corrections person to whom the records, reports and information shall be sent, including the person's name, title and address.

(6) Name, title and signature of the requestor and date of the request.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.-047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0640, filed 5/31/01, effective 7/1/01.]

Chapter 388-875 WAC

CRIMINALLY INSANE PERSON COMMITTED TO THE CARE OF THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES—EVALUATION, PLACEMENT, CARE AND DISCHARGE (Formerly chapter 275-59 WAC)

WAC

388-875-0010	Purpose.
388-875-0020	Definitions.
388-875-0030	Mental health division.
388-875-0040	Schedule of maximum payment for defendant expert or professional person.
388-875-0050	Time limitations and requirements.
388-875-0060	Individualized treatment.
388-875-0070	Transfer of a patient between state-operated facilities for persons with mental illness.
388-875-0080	Restoration procedure for a former involuntarily committed person's right to firearm possession.
388-875-0090	Conditional release.
388-875-0100	Retroactivity.
388-875-0110	Access to records by criminal justice agencies.

WAC 388-875-0010 Purpose. These regulations are adopted pursuant to and in accordance with chapter 117, Laws of 1973 1st ex. sess. They are adopted to provide procedures for the evaluation, placement, care and discharge of persons committed to the care of the department of social and health services, under the aforementioned Act, relating to the criminally insane.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0010, filed 12/6/00, effective 1/6/01; Order 846, § 275-59-010, filed 8/9/73.]

WAC 388-875-0020 Definitions. "Department" means the state department of social and health services.

"Division" means the mental health division, department of social and health services.

"Evaluation" means the initial procedure when a court requests the department to provide an opinion if a person charged with a crime is competent to stand trial or, if indicated and appropriate, if the person was suffering under a mental disease or defect excluding responsibility at the time of the commission of the crime.

"Indigent" means any person who is financially unable to obtain counsel or other necessary expert or professional services without causing substantial hardship to himself or his family.

[Title 388 WAC—p. 1382]

"Professional person" means:

(1) A psychiatrist. This is defined as a person having a license as a physician and surgeon in this state, who has in addition, completed three years of graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association and who is certified or is eligible to be certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

(2) A psychologist. This is defined as a person who has been licensed as a psychologist pursuant to chapter 18.83 RCW.

(3) A social worker. This is defined as a person with a master's or further advanced degree from an accredited school of social work or a degree deemed equivalent under rules adopted by the secretary.

"Secretary" means the secretary of the department of social and health services or his designee.

"Superintendent" means the person responsible for the functioning of a treatment facility.

"Treatment facility" means any facility operated or approved by the department of social and health services for the treatment of the criminally insane. Such definition shall not include any state correctional institution or facility.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0020, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-020, filed 3/1/79; Order 846, § 275-59-020, filed 8/9/73.]

WAC 388-875-0030 Mental health division. The secretary designates to the division the responsibility for:

(1) Evaluation and treatment of any person committed to the secretary for evaluation or treatment, under chapter 10.77 RCW;

(2) Assisting the court in obtaining nondepartmental experts or professional persons to participate in the evaluation or a hearing on behalf of the defendant and supervising the procedure whereby such professionals will be compensated, according to fee schedule if the person being evaluated or treated is an indigent;

(3) Assuring that any nondepartmental expert or professional person requesting compensation has maintained adequate evaluation and treatment records which justify compensation;

(4) Assisting the court by designation of experts or professional persons to examine the defendant and report to the court when the defendant is not committed to the secretary;

(5) Determination of what treatment facility shall have custody of persons committed to the secretary under chapter 10.77 RCW.

(6) If the court is advised by any party that the defendant may be developmentally disabled, at least one of the experts or professional persons appointed shall be a developmental disabilities professional.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0030, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-030, filed 3/1/79; Order 846, § 275-59-030, filed 8/9/73.]

WAC 388-875-0040 Schedule of maximum payment for defendant expert or professional person. Department

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payments to an expert or professional person for department services an indigent person receives shall not exceed:

- (1) One hundred dollars an hour for services; or
- (2) Eight hundred dollars total payment for services.

The department shall only approve an exception to this section ruling when the exception is approved, in writing, by the division director. The department shall only approve payment for one mental health examination per indigent person in each six month period.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0040, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01-090. 91-24-045 (Order 3298), § 275-59-041, filed 11/27/91, effective 1/1/92; 79-03-038 (Order 1373), § 275-59-041, filed 3/1/79.]

WAC 388-875-0050 Time limitations and requirements. If a person is committed to the secretary as criminally insane, commitment and treatment cannot exceed the maximum possible sentence for any offense charged. Therefore:

(1) The superintendent, if no superintendent then the division, with the assistance of the office of the attorney general where necessary shall determine at the time of commitment the maximum possible sentence for any offense charged, and thereby compute a maximum release date for every individual so committed.

(2) If the committed person has not been released by court order six months prior to the expiration of the maximum possible release date, the superintendent, if no superintendent, the division, shall notify the committing court and prosecuting attorney of its computation of maximum release date and the requirement that the person must be released on that date unless civil proceedings are instituted or the court determines that the computation of maximum release date is incorrect.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0050, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-050, filed 3/1/79; Order 846, § 275-59-050, filed 8/9/73.]

WAC 388-875-0060 Individualized treatment. (1) Whenever a person is committed to the secretary as criminally insane, the treatment facility to which the person is assigned shall, within fifteen days of admission to the facility, evaluate and diagnose the committed person for the purpose of devising an individualized treatment program.

(2) Every person, committed to the secretary as criminally insane, shall have an individualized treatment plan formulated by the treatment facility. This plan shall be developed by appropriate treatment team members and implemented as soon as possible but no later than fifteen days after the person's admission to the treatment facility as criminally insane. Each individualized treatment plan shall include, but not be limited to:

- (a) A statement of the nature of the specific problems and specific needs of the patient;
- (b) A statement of the physical setting necessary to achieve the purposes of commitment;
- (c) A description of intermediate and long-range treatment goals, with a projected timetable for their attainment;
- (d) A statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

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(e) A specification of staff responsibility and a description of proposed staff involvement with a patient in order to attain these treatment goals;

(f) Criteria for recommendation to the court for release.

(3) This individualized treatment plan shall be reviewed by the treatment facility periodically, at least every six months, and a copy of the plan shall be sent to the committing court.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, amended and recodified as § 388-875-0060, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.090. 79-03-038 (Order 1373), § 275-59-060, filed 3/1/79; Order 846, § 275-59-060, filed 8/9/73.]

WAC 388-875-0070 Transfer of a patient between state-operated facilities for persons with mental illness. In some instances, it is appropriate for the department to transfer a patient currently residing in a state facility to another state facility for ongoing treatment. The department shall accomplish the transfer with the utmost care given to the therapeutic needs of the patient. This section describes the procedures for handling a patient transfer between state facilities in a manner consistent with the best interest of the patient.

(1) The department may use the following criteria when determining the appropriateness of a patient transfer:

- (a) The patient's family resides within the receiving facility's catchment area; or
- (b) The patient's primary home of residence is in the receiving facility's catchment area; or
- (c) A particular service or need of the patient is better met at the receiving facility; or
- (d) Transfer to the receiving facility may facilitate community discharge due to the availability of community service in the receiving facility's catchment area; or
- (e) The county, regional support network, or patient requests a transfer.

(2) Prior to any proposed transfer of a patient, the state facility shall comply with the following:

- (a) The sending facility, at the request of the superintendent, shall in writing forward information necessary to make a decision on whether transfer is appropriate to the receiving facility's liaison and the regional support network liaison;
 - (b) The receiving facility's liaison and the regional support network liaison shall recommend appropriate action to the superintendent of the sending facility in writing within five calendar days of receipt of the request;
 - (c) If the receiving facility accepts the proposed patient transfer, the sending facility shall notify the patient, guardian, regional support network liaison, and attorney, if known, at least five days before the proposed patient transfer;
 - (d) The sending facility is responsible for all patient transfer arrangements, e.g., transportation, staff escort, etc., and shall coordinate the day and time of arrival with the receiving facility's liaison; and
 - (e) The sending facility shall arrange for the transfer of patient's medical record to the receiving facility.
- (3) The sending state facility shall document the following in the patient's record:
- (a) Physician documentation of the medical suitability of the patient for transfer; and
 - (b) Social worker documentation regarding:

- (i) Justification as to why the transfer is considered in the patient's best interests; and
 - (ii) The patient's wishes regarding transfer.
- (4) The sending facility shall contact the prosecuting attorney's office of the committing county prior to the transfer.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0070, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 74.05.-560 [71.05.560]. 91-22-044 (Order 3275), § 275-59-071, filed 10/31/91, effective 12/1/91. Statutory Authority: RCW 71.05.560. 88-23-021 (Order 2724), § 275-59-071, filed 11/7/88.]

WAC 388-875-0080 Restoration procedure for a former involuntarily committed person's right to firearm possession. (1) The department and mental health professionals implementing chapter 10.77 RCW shall recognize and affirm that a person is entitled to the immediate restoration of the right to firearm possession, as described under RCW 9.41.040 (6)(c), when the person no longer requires treatment or medication for a condition related to the commitment.

(2) Mental health professionals implementing the provisions of chapter 71.05 RCW shall provide to the court of competent jurisdiction such relevant information concerning the commitment and release from commitment as the court may request in the course of reaching a decision on the restoration of the person's right to firearm possession. (See RCW 9.41.097.)

(3) A person who has been barred from firearm possession under RCW 9.41.040(6) and who wishes to exercise this right, may petition the court which ordered involuntary treatment or, the superior court of the county in which the person resides for restoration of the right to possess firearms. At a minimum, such petition shall include:

- (a) The fact, date, and place of involuntary treatment;
- (b) The fact, date, and release from involuntary treatment;
- (c) A certified copy of the order of final discharge entered by the committing court.

(4) A petitioner shall show that the petitioner no longer requires treatment or medication for a condition related to the commitment.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0080, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 9.41.-040(6). 94-06-025 (Order 3709), § 275-59-072, filed 2/23/94, effective 3/26/94.]

WAC 388-875-0090 Conditional release. (1) Any person committed to the secretary as criminally insane may make application to the secretary for conditional release.

(2) The secretary designates the superintendent of the treatment facility, if no superintendent, then the director of the division, as the person to receive and act on such application for conditional release.

(3) The person making application for conditional release shall not, under any circumstances, be released until there is a court hearing on the application and recommendations and a court order authorizing conditional release has been issued.

(4) If conditional release is denied by the court the person making the applications may reapply after a period of six months from the date of denial.

[Title 388 WAC—p. 1384]

(5) If the court grants conditional release and places the person making application under the supervision of a department employee, that supervising department employee shall make monthly reports, unless indicated otherwise by the court, concerning the conditionally released person's progress and compliance with the terms and conditions of conditional release. Such reports shall be forwarded to the committing court, the division, the prosecuting attorney, and the treatment facility in which the person was most recently housed.

(6) The following persons are designated to exercise power and authority of the secretary contained in RCW 10.77.190:

- (a) The director or designee of the division;
- (b) The probation and parole office, if any, supervising the conditionally released person; and
- (c) The treatment facility supervising the conditionally released person or from which the person was conditionally released.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0090, filed 12/6/00, effective 1/6/01. Statutory Authority: RCW 72.01.-090. 79-03-038 (Order 1373), § 275-59-080, filed 3/1/79; Order 846, § 275-59-080, filed 8/9/73.]

WAC 388-875-0100 Retroactivity. (1) This chapter shall apply to persons committed to the secretary or the department, under prior rules and regulations, as incompetent to stand trial or as being criminally insane and therefore requires that these individuals be provided:

- (a) An individualized treatment plan;
- (b) An evaluation to be forwarded to the committing court;
- (c) Applicability of time limitations and requirements provided herein;
- (d) A maximum release date; and
- (e) An opportunity to apply for conditional release.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, recodified as § 388-875-0100, filed 12/6/00, effective 1/6/01; Order 846, § 275-59-090, filed 8/9/73.]

WAC 388-875-0110 Access to records by criminal justice agencies. Upon written request, criminal justice agencies shall have access to the following documents developed pursuant to the procedures set forth in chapter 10.77 RCW. the most recent forensic:

- (1) Psychiatric assessment;
- (2) Release summary; and
- (3) Pre-trial report of the examination, either inpatient or outpatient.

Other relevant information may be provided by agreement between the requesting criminal justice agency and the treatment facility, subject to federal and state confidentiality provisions.

[Statutory Authority: Chapter 10.77 RCW. 01-01-008, § 388-875-0110, filed 12/6/00, effective 1/6/01.]

(2007 Ed.)

Chapter 388-880 WAC**SPECIAL COMMITMENT—SEXUALLY VIOLENT PREDATORS**

(Formerly chapter 275-155 WAC)

WAC

388-880-005	Special commitment of sexually violent predators— Legal basis.
388-880-007	Purpose.
388-880-010	Definitions.
388-880-020	Authorization for indefinite commitment to the sexual predator program.
388-880-030	Sexual predator program initial evaluation.
388-880-031	Sexual predator program annual evaluation.
388-880-033	Evaluator—Qualifications.
388-880-034	Evaluator—Pretrial evaluation responsibilities.
388-880-035	Refusal to participate in pretrial evaluation.
388-880-036	Pretrial evaluation—Reporting.
388-880-040	Individual treatment.
388-880-042	Resident records—Purposes.
388-880-043	Resident clinical records—Location and custody.
388-880-044	Resident records—Access.
388-880-045	Resident records—Retention.
388-880-050	Rights of a person court-detained or court-committed to the special commitment center.
388-880-055	Recommendation for release to a less restrictive alterna- tive (LRA).
388-880-060	Sexual predator program reimbursement.
388-880-070	Escorted leave—Purpose.
388-880-080	Reasons allowed.
388-880-090	Conditions.
388-880-100	Application requests and approval for escorted leave.
388-880-110	Escort procedures.
388-880-120	Expenses.
388-880-130	Expenses—Paid by resident.
388-880-140	Expenses—Paid by department.

**DISPOSITION OF SECTIONS FORMERLY
CODIFIED IN THIS CHAPTER**

388-880-032	Recommendation for release to a less restrictive alterna- tive (LRA). [Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-032, filed 12/27/01, effective 1/27/02.] Repealed by 03-23-022, filed 11/10/03, effective 12/11/03. Statutory Authority: RCW 71.09.040(4).
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WAC 388-880-005 Special commitment of sexually violent predators—Legal basis. (1) Chapter 71.09 RCW authorizes the department to develop a sexual predator program (SPP) for a person the court determines to be a sexually violent predator.

(2) The department's SPP shall provide:

(a) Custody, supervision, and evaluation of a person court-detained to the SPP to determine if the person meets the definition of a sexually violent predator under chapter 71.09 RCW; and

(b) Treatment, care, evaluation and control of a person court-committed as a sexually violent predator.

(3) Evaluations and evaluation procedures may be established in coordination with the department, the department of corrections and the end of sentence review committee.

(4) Secure facilities operated by the department for the sexual predator program include the special commitment center (SCC) total confinement facility, the secure community transition facility, and any community-based facilities established under chapter 71.09 RCW and operated by the secretary or under contract with the secretary.

(5) The secretary or designee may execute such agreements as appropriate and necessary to implement this chapter.

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[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-005, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-005, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-005, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-005, filed 8/21/90, effective 9/21/90.]

WAC 388-880-007 Purpose. These rules carry out the legislative intent of chapter 71.09 RCW, authorizing the department to provide evaluation, care, control, and treatment of persons court-detained or court-committed to the sexual predator program.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-007, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-007, filed 12/27/01, effective 1/27/02.]

WAC 388-880-010 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

"Appropriate facility" means the total confinement facility the department uses to hold and evaluate a person court-detained under chapter 71.09 RCW.

"Care" means a service the department provides during a person's detention or commitment within a secure facility toward adequate health, shelter, and physical sustenance.

"Control" means a restraint, restriction, or confinement the department applies protecting a person from endangering self, others, or property during a period of custody under chapter 71.09 RCW.

"Department" means the department of social and health services.

"Escorted leave" means a leave of absence from a facility housing persons court-detained or court-committed under chapter 71.09 RCW under the continuous supervision of an escort.

"Evaluation" means an examination, report, or recommendation by a professionally qualified person to determine if a person has a personality disorder and/or mental abnormality which renders the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.

"Immediate family" includes a resident's parents, step-parents, parent surrogates, legal guardians, grandparents, spouse, brothers, sisters, half or stepbrothers or sisters, children, stepchildren, and other dependents.

"Indigent" means a resident who has not been credited with twenty-five dollars or more total from any source for deposit to the resident's trust fund account during the thirty days preceding the request for an escorted leave and has less than a twenty-five dollar balance in his/her trust fund account on the day the escorted leave is requested, and together with his/her requesting immediate family member affirm in writing that they cannot afford to pay the costs of the escorted leave without undue hardship. A declaration of indigency shall be signed by the resident and the resident's requesting immediate family member on forms provided by the department.

"Individual treatment plan (ITP)" means an outline the SCC staff persons develop detailing how control, care, and treatment services are provided to a court-committed person or to a court-detained person.

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"Less restrictive alternative" means court-ordered treatment in a setting less restrictive than total confinement which satisfies the conditions stated in RCW 71.09.092.

"Less restrictive alternative facility" means a secure community transition facility as defined under RCW 71.09.-020(1).

"Mental abnormality" means a congenital or acquired condition, including a personality disorder, affecting the person's emotional or volitional capacity, predisposing the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others.

"Oversight" means official direction, guidance, review, inspection, investigation, and information gathering activities conducted for the purposes of program quality assurance by persons or entities within, or external to, the SCC.

"Personality disorder" carries the same definition as found in the DSM-IV-TR and includes psychopathy as assessed using the Hare PCL-R or similar instrument.

"Predatory" means acts a person directs toward:

- (1) Strangers;
- (2) Individuals with whom a relationship has been established or promoted for the primary purpose of victimization; or
- (3) Persons of casual acquaintance with whom no substantial personal relationship exists.

"Professionally qualified person" means:

(1) **"Psychiatrist"** means a person licensed as a physician in this state, or licensed or certified in another state, in accordance with chapters 18.71 and 18.57 RCW. In addition, the person shall:

(a) Have completed three years of graduate training in a psychiatry program approved by the American Medical Association or the American Osteopathic Association; and

(b) Be certified, or eligible to be certified, by the American Board of Psychiatry and Neurology.

(2) **"Psychologist"** means a person licensed as a doctor of psychology in this state, or licensed or certified in another state, in accordance with chapter 18.83 RCW;

(3) **"Clinical practitioner"** means a sex offender treatment provider certified by the department of health under chapter 18.155 RCW.

"Resident" means a person court-detained or court-committed pursuant to chapter 71.09 RCW.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"Secure community transition facility" means a residential facility for persons civilly committed and conditionally released to a less restrictive alternative under chapter 71.09 RCW. A secure community transition facility has supervision and security, and either provides or ensures the provision of sex offender treatment services. Secure community transition facilities include, but are not limited to, the facilities established in RCW 71.09.201 and any community-based facilities established under chapter 71.09 RCW and operated by the secretary or under contract with the secretary.

"Secure facility" means a residential facility for persons court-detained or court-committed under the provisions of chapter 71.09 RCW that includes security measures sufficient to protect the community. Such facilities include total confinement facilities, secure community transition facilities,

and any residence used as a court-ordered placement in RCW 71.09.096.

"Sexual predator program" means a department-administered and operated program including the special commitment center (SCC) established for:

- (1) A court-detained person's custody and evaluation; or
- (2) Control, care, and treatment of a court-committed person defined as a sexually violent predator under chapter 71.09 RCW.

"Sexually violent offense" means an act defined under chapter 9A.28 RCW, RCW 9.94A.030 and 71.09.020.

"Sexually violent predator" means any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility.

"Superintendent" means the person delegated by the secretary of the department to be responsible for the general operation, program, and facilities of the SCC.

"Total confinement facility" means a facility that provides supervision and sex offender treatment services in a total confinement setting. Total confinement facilities include the special commitment center and any similar facility designated as a secure facility by the secretary.

[Statutory Authority: RCW 71.09.040(4), 03-23-022, § 388-880-010, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286, 02-02-054, § 388-880-010, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230, 97-24-054, § 275-155-010, filed 12/1/97, effective 1/1/98. Statutory Authority: 1990 c 3, 90-17-120 (Order 3054), § 275-155-010, filed 8/21/90, effective 9/21/90.]

WAC 388-880-020 Authorization for indefinite commitment to the sexual predator program. A person must be admitted to the custody of the department when, under RCW 71.09.060, a court or jury determines, beyond a reasonable doubt, that the person is a sexually violent predator and commits the person for placement in a secure facility operated by the department for control, care, and treatment.

[Statutory Authority: RCW 71.09.040(4), 03-23-022, § 388-880-020, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286, 02-02-054, § 388-880-020, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-020, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.030 and 71.09.050, 93-17-027 (Order 3609), § 275-155-020, filed 8/11/93, effective 9/11/93. Statutory Authority: 1990 c 3, 90-17-120 (Order 3054), § 275-155-020, filed 8/21/90, effective 9/21/90.]

WAC 388-880-030 Sexual predator program initial evaluation. (1) When a court orders a person transferred to an appropriate facility for an evaluation as to whether the person is a sexually violent predator, pursuant to RCW 71.09.-040(4), the department shall, prior to the scheduled commitment hearing or trial, provide an evaluation to the court, and must make a recommendation as to whether the person has been convicted of or charged with a crime of sexual violence and suffers from a mental abnormality or personality disorder which makes the person more likely than not to engage in predatory acts of sexual violence if not confined in a secure facility.

(2) The evaluation must be conducted in accordance with the criteria set forth in WAC 388-880-033, and must be in the

form required by and filed in accordance with WAC 388-880-034 and 388-880-036.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-030, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286, 02-02-054, § 388-880-030, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-030, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3, 90-17-120 (Order 3054), § 275-155-030, filed 8/21/90, effective 9/21/90.]

WAC 388-880-031 Sexual predator program annual evaluation. (1) Annually or as required by court order, the department shall conduct an evaluation and examine the mental condition of each person court-committed under chapter 71.09 RCW.

(2) The annual evaluation must include consideration of whether:

(a) The person currently meets the definition of a sexually violent predator; and

(b) Conditional release to a less restrictive alternative is in the best interest of the person and conditions can be imposed that would adequately protect the community.

(3) The report of the department shall be in the form of a declaration or certification in compliance with the requirements of RCW 9A.72.085 and shall be prepared by a professionally qualified person as defined herein.

(4) The department shall file this periodic report with the court that detained or committed the person under chapter 71.09 RCW.

(5) A copy of this report shall be served on the prosecuting agency involved in the initial hearing or commitment and upon the detained or committed person and his or her counsel.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-031, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286, 02-02-054, § 388-880-031, filed 12/27/01, effective 1/27/02.]

WAC 388-880-033 Evaluator—Qualifications. Professionally qualified persons under contract to provide evaluative services must:

(1) Have demonstrated expertise in conducting evaluations of sex offenders, including diagnosis and assessment of re-offense risk,

(2) Have demonstrated expertise in providing expert testimony related to sex offenders of other forensic topics, and

(3) Provide documentation of such qualification to the department.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-033, filed 11/10/03, effective 12/11/03.]

WAC 388-880-034 Evaluator—Pretrial evaluation responsibilities. The evaluation done in accordance with WAC 388-880-030(1) in preparation for a trial or hearing must be based on the following:

(1) Examination of the resident, including a forensic interview and a medical examination, if necessary;

(2) Review of the following records, tests or reports relating to the person:

(a) All available criminal records, to include arrests and convictions, and records of institutional custody, including city, county, state and federal jails or institutions, with any records and notes of statements made by the person regarding

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criminal offenses, whether or not the person was charged with or convicted of the offense;

(b) All necessary and relevant court documents;

(c) Sex offender treatment records and, when permitted by law, substance abuse treatment program records, including group notes, autobiographical notes, progress notes, psycho-social reports and other material relating to the person's participation in treatment;

(d) Psychological and psychiatric testing, diagnosis and treatment, and other clinical examinations, including records of custody in a mental health treatment hospital or other facility;

(e) Medical and physiological testing, including plethysmography and polygraphy;

(f) Any end of sentence review report, with information for all prior commitments upon which the report or reports were made;

(g) All other relevant and necessary records, evaluations, reports and other documents from state or local agencies;

(h) Pertinent contacts with collateral informants;

(i) Other relevant and appropriate tests that are industry standard practices;

(j) All evaluations, treatment plans, examinations, forensic measures, charts, files, reports and other information made for or prepared by the SCC which relate to the resident's care, control, observation, and treatment.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-034, filed 11/10/03, effective 12/11/03.]

WAC 388-880-035 Refusal to participate in pretrial evaluation. If the person refuses to participate in examinations, forensic interviews, psychological testing or any other interviews necessary to conduct the initial evaluation under WAC 388-880-030(1), the evaluator must notify the SCC. The SCC will notify the prosecuting agency for potential court enforcement.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-035, filed 11/10/03, effective 12/11/03.]

WAC 388-880-036 Pretrial evaluation—Reporting.

(1) The evaluation must be in the form of a declaration or certification in compliance with the requirements of RCW 9A.72.085 and must be prepared by a professionally qualified person.

(2) The report of the evaluation must include:

(a) A description of the nature of the examination;

(b) A diagnosis of the mental condition of the person;

(c) A determination of whether the person suffers from a mental abnormality or personality disorder;

(d) An opinion as to whether the person meets the definition of a sexually violent predator.

(3) The department shall file the evaluation with the court that detained or committed the person under chapter 71.09 RCW.

(4) A copy of the evaluation must be served on the prosecuting agency involved in the initial hearing or commitment, and upon the court-detained or court-committed person and his or her counsel.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-036, filed 11/10/03, effective 12/11/03.]

WAC 388-880-040 Individual treatment. (1) When the court detains a person or commits a person to the SCC, SCC staff persons shall develop an individual treatment plan (ITP) for the person.

(2) The ITP shall be based upon, but not limited to, the following information as may be available:

- (a) The person's offense history;
- (b) A psycho-social history;
- (c) The person's most recent evaluation; and
- (d) A statement of high risk factors for potential reoffense, as may be ascertained over time.

(3) The ITP shall include, but not be limited to:

(a) A description of the person's specific treatment needs in:

- (i) Sex offender specific treatment;
- (ii) Substance abuse treatment;
- (iii) Supports to promote psychiatric stability;
- (iv) Supports for medical conditions and disability;
- (v) Social, family, and life skills.

(b) An outline of intermediate and long-range treatment goals, with cognitive and behavioral measures for achieving the goals;

(c) The treatment strategies for achieving the treatment goals;

(d) A description of SCC staff persons' responsibilities; and

(e) A general plan and criteria, keyed to the resident's achievement of long-range treatment goals, for recommending to the court whether the person should be released to a less restrictive alternative.

(4) SCC staff persons shall review the person's ITP every six months.

(5) A court-detained person's plan may include access to program services and opportunities available to persons who are court-committed, with the exception that the court-detained person may be restricted in employment and other activities, depending on program resources and incentives reserved for persons who are court-committed and/or actively involved in treatment.

(6) Nothing in this chapter shall exclude a court-detained person from engaging in the sex offender treatment program and, should the person elect to engage in treatment prior to the person's commitment trial:

(a) The person shall be accorded privileges and access to program services in a like manner as are accorded to a court-committed person in treatment; and

(b) Shall not, solely by reason of the person's voluntary participation in treatment, be judged nor assumed by staff, administrators or professional persons of the SCC or of the department to meet the definition of a sexually violent predator under chapter 71.09 RCW.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-040, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-040, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-040, filed 10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-040, filed 8/21/90, effective 9/21/90.]

WAC 388-880-042 Resident records—Purposes. (1) The SCC shall maintain records for each person court-detained for evaluation or court-committed for treatment as a sexually violent predator. Such records shall include:

(a) All evaluations, records, reports, and other documents obtained from other agencies relating to the person prior to the person's detention and/or commitment to the SCC;

(b) All evaluations, clinical examinations, forensic measures, charts, files, reports, and other information made for or prepared by SCC personnel, contracted professionals, or others which relate to the person's care, control, and treatment during the person's detention or commitment to, the SCC.

(2) Records made by contracted professional persons providing treatment or residential services may be maintained in their professional files, subject to contractual arrangement for SCC or department access to those records.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-042, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-042, filed 12/27/01, effective 1/27/02.]

WAC 388-880-043 Resident clinical records—Location and custody. (1) Records pertaining to residents of the SCC shall be kept in a location accessible only to assigned treatment providers and authorized staff persons.

(2) During the period of a person's residence at the SCC secure facility or LRA facility:

(a) The person's treatment records shall be maintained in the facility wherein the resident is housed.

(b) The person's medical and psychiatric records shall be maintained in the facility wherein the resident is housed and directly available to medical and emergency treatment providers and authorized staff persons.

(3) During the period of a person's residence in a less restrictive alternative facility operated by the department, the person's treatment records shall be maintained in a safe location accessible only by authorized staff.

(4) During a period of a resident's less restrictive alternative placement in a private home or in a facility operated by a contracting agency:

(a) Original behavioral and treatment records and evaluations shall be maintained by the contracted professional person providing treatment and copies thereof shall be made available to the SCC or the department by contract requirement; and

(b) Copies of documents held by the SCC may be made available as necessary to the contracting agency, the contracted treatment provider, and the assigned community corrections officer.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-043, filed 12/27/01, effective 1/27/02.]

WAC 388-880-044 Resident records—Access. (1) Upon request and proper showing, the department shall provide to the following persons access to a court-detained or court-committed person for an evaluation and access to all records and reports related to the person's detention, commitment, control, care, and treatment:

- (a) The person's attorney;
- (b) The person's professionally qualified person, if any;
- (c) The prosecuting attorney, or the attorney general, if requested by the prosecuting attorney;
- (d) The professionally qualified person; and

(e) Any entity, person or agency having lawful access to such records.

(2) Upon documented request by a resident, the SCC shall provide the resident supervised access to all records and reports, or to redacted copies thereof, related to the person's commitment, control, care, and treatment. The SCC may reasonably limit conditions, frequency and duration of the person's access to the person's records and reports.

(3) A policy on access to resident records shall be maintained and published to residents of the SCC.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-044, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-044, filed 12/27/01, effective 1/27/02.]

WAC 388-880-045 Resident records—Retention. (1)

The SCC shall create schedules and requirements, consistent with department policy, for the retention, storage, and disposal of records, documents, evaluations, reports, and other material related to SCC residents, to include:

(a) While a person is currently court-detained or court-committed to the SCC;

(b) Following a court ruling that a person does not meet the definition of a sexually violent predator within chapter 71.09 RCW and upon the person's release from the custody of the department;

(c) Following a resident's unconditional discharge from commitment;

(d) Following a resident's death.

(2) All original records specified herein and held by the SCC shall be retained in the SCC total confinement facility for a period of five years, and in the records center of the Secretary of State for a period consistent with department administrative policy, after a resident's:

(a) Release following a court ruling that the person does not meet the definition of a sexually violent predator within chapter 71.09 RCW;

(b) Unconditional discharge from commitment; or

(c) Death.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-045, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-045, filed 12/27/01, effective 1/27/02.]

WAC 388-880-050 Rights of a person court-detained or court-committed to the special commitment center. (1) During a person's period of detention or commitment, the department shall:

(a) Apprise the person of the person's right to an attorney and to retain a professionally qualified person to perform an evaluation on the person's behalf;

(b) Provide access to the person and the person's records in accordance with RCW 71.09.080 and WAC 388-880-044.

(2) A person the court detains for evaluation or commits to the SCC shall:

(a) Receive adequate care and individualized treatment;

(b) Be permitted to wear the person's own clothing except as may be required during an escorted leave from the secure facility, and to keep and use the person's own possessions, except when deprivation of possessions is necessary

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for the person's protection and safety, the protection and safety of others, or the protection of property within the SCC;

(c) Be permitted to accumulate and spend a reasonable amount of money in the person's SCC account;

(d) Have access to reasonable personal storage space within SCC limitations;

(e) Be permitted to have approved visitors within reasonable limitations;

(f) Have reasonable access to a telephone to make and receive confidential calls within SCC limitations; and

(g) Have reasonable access to letter writing material and to:

(i) Receive and send correspondence through the mail within SCC limitations and according to established safeguards against the receipt of contraband material to include, in the resident's presence, opening and inspecting packages and fanning written material; and

(ii) Send written communication regarding the fact of the person's detention or commitment.

(3) A person the court commits to the SCC shall have the following procedural rights to:

(a) Have reasonable access to an attorney and be informed of the name and address of the person's designated attorney;

(b) Petition the court for release from the SCC; and

(c) Receive annual written notice of the person's right to petition the committing court for release. The department's written notice and waiver shall:

(i) Include the option to voluntarily waive the right to petition the committing court for release; and

(ii) Annually be forwarded to the committing court by the department.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-050, filed 11/10/03, effective 12/11/03. Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-050, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-050, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.030 and 71.09.050. 93-17-027 (Order 3609), § 275-155-050, filed 8/11/93, effective 9/11/93. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-050, filed 8/21/90, effective 9/21/90.]

WAC 388-880-055 Recommendation for release to a less restrictive alternative (LRA). If the court or jury determines that the person is a sexually violent predator, upon an evaluation which supports a person's unconditional discharge or release to a less restrictive alternative, the secretary or secretary's designee shall authorize the person to petition the court in accordance with RCW 71.09.090.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-055, filed 11/10/03, effective 12/11/03.]

WAC 388-880-060 Sexual predator program reimbursement. (1) The department shall obtain reimbursement under RCW 43.20B.330, 43.20B.335, 43.20B.340, 43.20B.-345, 43.20B.350, 43.20B.355, 43.20B.360, and 43.20B.370 for the cost of care of a person court-committed to a SPP to the extent of the person's ability to pay.

(2) The department shall calculate ability to pay and assess liability under chapter 275-16 WAC.

[Statutory Authority: RCW 71.09.040(4). 03-23-022, § 388-880-060, filed 11/10/03, effective 12/11/03. 99-21-001, recodified as § 388-880-060, filed

10/6/99, effective 10/6/99. Statutory Authority: 1990 c 3. 90-17-120 (Order 3054), § 275-155-060, filed 8/21/90, effective 9/21/90.]

WAC 388-880-070 Escorted leave—Purpose. The purpose of WAC 275-155-070 through 275-155-140 is:

- (1) To set forth the conditions under which residents will be granted leaves of absence;
- (2) To provide for safeguards to prevent escape, the obtaining of contraband, and the commission of new crimes, while on leaves of absence; and
- (3) To outline the process for the reimbursement of the state by the resident and the resident's family for the costs of the leave of absence.

[99-21-001, recodified as § 388-880-070, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-070, filed 12/1/97, effective 1/1/98.]

WAC 388-880-080 Reasons allowed. An escorted leave of absence may be granted by the superintendent, or designee, subject to the approval of the secretary, to residents to:

- (1) Go to the bedside of a member of the resident's immediate family as defined in WAC 275-155-010, who is seriously ill;
- (2) Attend the funeral of a member of the resident's immediate family as defined in WAC 275-155-010; and
- (3) Receive necessary medical or dental care which is not available in the institution.

[99-21-001, recodified as § 388-880-080, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-080, filed 12/1/97, effective 1/1/98.]

WAC 388-880-090 Conditions. (1) An escorted leave shall be authorized only for trips within the boundaries of the state of Washington.

(2) The duration of an escorted leave to the bedside of a seriously ill member of the resident's immediate family or attendance at a funeral shall not exceed forty-eight hours unless otherwise approved by the superintendent, or designee.

(3) Other than when housed in a city or county jail or state institution the resident shall be in the visual or auditory contact of an approved escort at all times.

(4) The resident shall be housed in a city or county jail or state institution at all times when not in transit or actually engaged in the activity for which the escorted leave was granted.

(5) Unless indigent, the resident and immediate family member shall, in writing, make arrangements to reimburse the state for the cost of the leave prior to the date of the leave.

(6) The superintendent, or designee, shall notify county and city law enforcement agencies with jurisdiction in the area of the resident's destination before allowing any escorted leave of absence.

[99-21-001, recodified as § 388-880-090, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-090, filed 12/1/97, effective 1/1/98.]

WAC 388-880-100 Application requests and approval for escorted leave. The superintendent, or designee, shall establish a policy and procedures governing the

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method of handling the requests by individual residents. The superintendent, or designee, shall evaluate each leave request and, in writing, approve or deny the request within forty-eight hours of receiving the request based on:

- (1) The nature and length of the escorted leave;
- (2) The community risk associated with granting the request based on the resident's history of security or escape risk;
- (3) The resident's overall history of stability, cooperative or disruptive behavior, and violence or other acting out behavior;
- (4) The resident's degree of trustworthiness as demonstrated by his/her performance in unit assignments, security level, and general cooperativeness with facility staff;
- (5) The resident's family's level of involvement and commitment to the escorted leave planning process;
- (6) The rehabilitative or treatment benefits which could be gained by the resident; and
- (7) Any other information as may be deemed relevant.

The resident's, and family's, ability to reimburse the state for the cost of the escorted leave shall not be a determining factor in approving or denying a request.

[99-21-001, recodified as § 388-880-100, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-100, filed 12/1/97, effective 1/1/98.]

WAC 388-880-110 Escort procedures. (1) Only persons approved by the superintendent, or designee, will be authorized to serve as escorts. All escorts from the total confinement facility must be employees of either the department of social and health services or the department of corrections and must have attained permanent employee status. At least one of the escorts must be experienced in the escort procedures.

(2) The superintendent, or designee, shall determine the use and type of restraints necessary for each escorted leave on an individual basis.

(3) Escorted leaves supervised by department of corrections staff shall require the approval of the SCC superintendent, or designee, and be done in accordance with applicable department of corrections policy and procedures. The department of corrections shall be reimbursed, according to rates and procedures established between the department of social and health services and the department of corrections. Correctional officers may wear civilian clothing when escorting a resident for a bedside visit or a funeral.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-880-110, filed 12/27/01, effective 1/27/02. 99-21-001, recodified as § 388-880-110, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-110, filed 12/1/97, effective 1/1/98.]

WAC 388-880-120 Expenses. (1) Staff assigned escort duties shall be authorized per diem reimbursement for meals, lodging, and transportation at the rate established by the state travel policy.

(2) Staff assigned escort duties shall receive appropriate compensation at regular salary or overtime for all hours spent in actual escort of the resident, but not including hours spent sleeping or not engaged in direct supervision of the resident. The salary shall be paid at the appropriate straight time and overtime rates as provided in the merit system rules.

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(3) Cost of housing the resident in a city or county jail shall be charged to the resident in accordance with WAC 275-155-130.

[99-21-001, recodified as § 388-880-120, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-120, filed 12/1/97, effective 1/1/98.]

WAC 388-880-130 Expenses—Paid by resident. (1)

The expenses of the escorted leave as enumerated in WAC 275-155-120 shall be reimbursed by the resident or his/her immediate family member unless the superintendent, or designee, has authorized payment at state expense in accordance with WAC 275-155-140.

(2) Payments by the resident, or the resident's immediate family member, shall be made to the facility's business office and applied to the appropriate fund as defined by law, applicable provisions of the Washington Administrative Code, or department policy.

[99-21-001, recodified as § 388-880-130, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-130, filed 12/1/97, effective 1/1/98.]

WAC 388-880-140 Expenses—Paid by department.

The expenses of the escorted leave shall be absorbed by the state if:

(1) The resident and his/her immediate family are indigent as defined in WAC 275-155-010; or

(2) The expenses were incurred to secure medical care.

[99-21-001, recodified as § 388-880-140, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.230. 97-24-054, § 275-155-140, filed 12/1/97, effective 1/1/98.]

Chapter 388-881 WAC

SEXUAL PREDATOR PROGRAM—EXTERNAL OVERSIGHT

(Formerly chapter 275-155 WAC)

WAC

388-881-010	External oversight of the special commitment center.
388-881-015	External oversight—Governing body.
388-881-020	External oversight—Professional standards.
388-881-025	External oversight—Annual inspection of care (IOC).
388-881-030	External oversight—Ombudsman service.
388-881-035	External oversight—Investigation of incidents.

WAC 388-881-010 External oversight of the special commitment center. Independent external oversight of the SCC shall include:

- (1) A governing body;
- (2) Professional standards to be used as a benchmark for evaluation;
- (3) An inspection of care according to accepted professional standards;
- (4) An ombudsman service; and
- (5) External investigation of incidents.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-010, filed 12/27/01, effective 1/27/02.]

WAC 388-881-015 External oversight—Governing body. The governing body for the special commitment center shall:

(2007 Ed.)

(1) Be appointed by the secretary of the department of social and health services (DSHS);

(2) Derive its membership in accordance with department policy established to this purpose;

(3) Operate under by-laws approved by the secretary, DSHS.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-015, filed 12/27/01, effective 1/27/02.]

WAC 388-881-020 External oversight—Professional standards. (1) The department shall develop and governing body approve for use professional practice standards applicable to treatment programs for civilly committed adult sex offenders.

(2) Such standards shall include provisions requiring:

(a) Staff competency, training, and supervision;

(b) Adequacy of treatment components and measures of progress;

(c) A treatment-supportive environment;

(d) Provision of medical services appropriate to a residential treatment setting; and

(e) Program oversight.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-020, filed 12/27/01, effective 1/27/02.]

WAC 388-881-025 External oversight—Annual inspection of care (IOC). (1) An independent, annual, on-site inspection of care, performed according to professional standards approved under this chapter, shall be conducted of the SCC at least annually.

(2) The purpose of the IOC shall be to provide objective measures of service delivery, for internal program use and quality management, to the governing body.

(3) Members of the inspection of care team shall be contracted by the department annually for a specified period during which they shall:

(a) Conduct an on-site and documentary inspection;

(b) Prepare interim and final, and, as requested by the SCC superintendent or governing body, supplementary reports;

(c) Receive and consider SCC program responses to all reports.

(4) The IOC team shall be of no fewer than four and no more than six persons.

(a) At least one member of the IOC team must not be a DSHS employee; and

(b) At least one member must be a sex offender treatment provider.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-025, filed 12/27/01, effective 1/27/02.]

WAC 388-881-030 External oversight—Ombudsman service. (1) The SCC shall retain an ombudsman service for the purpose of conducting independent, neutral reviews of program conformance with internal SCC policies in the care, control and treatment of residents at the SCC.

(2) The ombudsman function shall be outside the supervision of the superintendent of the SCC and of the assistant secretary for health and rehabilitation services.

(3) In performance of the ombudsman function, the individual(s) so employed shall be afforded access to all records and documents normally available to public inspection according to rules and policies of the department and of the state of Washington.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-030, filed 12/27/01, effective 1/27/02.]

WAC 388-881-035 External oversight—Investigation of incidents. (1) The Washington state patrol shall investigate incidents which involve SCC residents in accordance with department policy.

(2) The scope and authority for such investigations shall be determined through an interagency agreement between the department and the Washington state patrol.

(3) Criteria to determine which incidents justify external investigation shall be approved by the secretary, DSHS.

[Statutory Authority: Chapter 71.09 RCW, 2000 c 44, 2001 c 286. 02-02-054, § 388-881-035, filed 12/27/01, effective 1/27/02.]

Chapter 388-885 WAC

CIVIL COMMITMENT COST REIMBURSEMENT

(Formerly chapter 275-156 WAC)

WAC

388-885-005	Purpose.
388-885-010	Definitions.
388-885-015	Limitation of funds.
388-885-020	Maximum allowable reimbursement for civil commitment cost.
388-885-025	Billing procedure.
388-885-030	Exceptions.
388-885-035	Effective date.
388-885-040	Audits.

WAC 388-885-005 Purpose. These rules establish the standards and procedures for reimbursing counties for the cost incurred during civil commitment trial, annual evaluation, and review processes and release procedures related to chapter 71.09 RCW. The department's reimbursement to counties is limited to appropriated funds.

[99-21-002, recodified as § 388-885-005, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-005, filed 10/8/91, effective 11/8/91.]

WAC 388-885-010 Definitions. (1) "Attorney cost" means the fully documented fee directly related to the violent sexual predator civil commitment process for:

- (a) A single assigned prosecuting attorney;
- (b) When the person is indigent, a single court-appointed attorney; and
- (c) Additional counsel, when additional counsel is approved by the trial judge for good cause. Said fee includes the cost of paralegal services.

(2) "Department" means the department of social and health services.

(3) "Evaluation by expert cost" means a county-incurred service fee directly resulting from the completion of a comprehensive examination and/or a records review, by a single examiner selected by the county, of a person:

- (a) Investigated for "sexually violent predator" probable cause;

(b) Alleged to be a "sexually violent predator" and who has had a petition filed; or

(c) Committed as a "sexually violent predator" and under review for release.

In the case where the person is indigent, "evaluation by expert cost" includes the fee for a comprehensive examination and/or records review by a single examiner selected by the person examined. When additional examiners are approved by the trial judge for good cause, "evaluation by expert cost" includes the cost of additional examiners.

(4) "Incidental cost" means county-incurred efforts or costs that are not otherwise covered and are exclusively attributable to the trial of a person alleged to be a "sexually violent predator."

(5) "Investigative cost" means a cost incurred by a police agency or other investigative agency in the course of investigating issues specific to:

(a) Filing or responding to a petition alleging a person is a "sexually violent predator;" or

(b) Testifying at a hearing to determine if a person is a "sexually violent predator."

(6) "Medical cost" means a county-incurred extraordinary medical expense beyond the routine services of a jail.

(7) "Secretary" means the secretary of the department of social and health services.

(8) "Transportation cost" means the cost a county incurs when transporting a person alleged to be, or having been found to be, a "sexually violent predator," to and from a sexual predator program facility.

(9) "Trial cost" means the costs a county incurs as the result of filing a petition for the civil commitment of a person alleged to be a "sexually violent predator" under chapter 71.09 RCW. This cost is limited to fees for:

- (a) Judges, including court clerk and bailiff services;
- (b) Court reporter services;
- (c) Transcript typing and preparation;
- (d) Expert and nonexpert witnesses;
- (e) Jury; and
- (f) Jail facilities.

[99-21-002, recodified as § 388-885-010, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-010, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-010, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-010, filed 10/8/91, effective 11/8/91.]

WAC 388-885-015 Limitation of funds. The department shall:

(1) Reimburse funds to a county when funds are available;

(2) Limit a county's reimbursement to costs of civil commitment trials or hearings as described under this chapter;

(3) Restrict a county's reimbursement to documented investigation, expert evaluation, attorney, transportation, trial, incidental, and medical costs;

(4) Not pay a county a cost under the rules of this section when said cost is otherwise reimbursable under law;

(5) Pay a county's claim for a trial or hearing occurring during each biennium in the order in which the claim is received at the office of accounting services, special commit-

ment center, until the department's biennial appropriation is expended.

[99-21-002, recodified as § 388-885-015, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-015, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-015, filed 10/8/91, effective 11/8/91.]

WAC 388-885-020 Maximum allowable reimbursement for civil commitment cost. The department shall reimburse a county for actual costs incurred up to the maximum allowable rate as specified:

(1) Attorney cost - Up to forty-nine dollars and forty-one cents per hour;

(2) Evaluation by expert cost - Actual costs, within reasonable limits, plus travel and per diem according to state travel policy;

(3) Trial costs:

(a) Judge - Up to forty-six dollars and five cents per hour;

(b) Court reporters - Up to twenty dollars and seventy-one cents per hour;

(c) Transcript typing and preparation services - Up to four dollars and thirteen cents per page;

(d) Expert witnesses - Actual costs within reasonable limits plus travel and per diem according to state travel policy;

(e) Nonexpert witnesses - Actual compensation, travel and per diem paid to witnesses, provided compensation is in accordance with chapter 2.40 RCW and state travel policy;

(f) Jurors - Actual compensation, travel, and per diem paid to jurors provided compensation is in accordance with chapter 2.36 RCW and state travel policy;

(g) Jail facilities - Thirty dollars per day.

(4) Investigative cost - Up to twenty dollars and sixty-six cents per hour. Medical costs - Up to fifty dollars per day, not to exceed five consecutive days; and

(5) Transportation cost - Actual compensation paid to transport staff, plus mileage and per diem at the rate specified in the state travel policy.

[99-21-002, recodified as § 388-885-020, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-020, filed 5/19/94, effective 6/19/94. Statutory Authority: Chapter 71.09 RCW. 92-18-037 (Order 3447), § 275-156-020, filed 8/27/92, effective 9/27/92. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-020, filed 10/8/91, effective 11/8/91.]

WAC 388-885-025 Billing procedure. (1) When a county requests the department reimburse a county's cost, the county shall:

(a) Make a claim using the state of Washington invoice voucher, Form A 19 1-A;

(b) Attach to the claim necessary documentation, support, and justification materials;

(c) Report expenses billed by the hour in one-quarter hour increments unless smaller increments are provided to the county by the vendor; and

(d) Include the name of the person for whom the costs were incurred and the cause number when it exists.

(2) The department may subject a county's claim documentation to periodic audit at the department's discretion.

(2007 Ed.)

(3) Only an authorized administrator, or the county administrator's designee, may submit to the department a request for a county's cost reimbursement.

(4) A county shall submit a reimbursement claim to the department within thirty days of final costs incurred to assure proper handling of the claim.

(5) When a county submits a reimbursement claim, the county shall submit a reimbursement claim to the special commitment center, offices of accounting services.

(6) If the department's reimbursement appropriation becomes exhausted before the end of a biennium, a county may continue to make a claim for reimbursement. The department may use the reimbursement claim to justify a request for adequate department funding during future biennia.

[99-21-002, recodified as § 388-885-025, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-025, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-025, filed 10/8/91, effective 11/8/91.]

WAC 388-885-030 Exceptions. (1) The secretary may grant exceptions to the rules of this chapter.

(2) A county seeking an exception shall request the exception, in writing from the secretary or secretary's designee.

(3) The department shall deny a claim which does not follow the rules of this chapter unless the secretary or secretary's designee granted an exception before the claim was filed.

[99-21-002, recodified as § 388-885-030, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 71.09.050 and 43.20A.050. 94-12-006 (Order 3736), § 275-156-030, filed 5/19/94, effective 6/19/94. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-030, filed 10/8/91, effective 11/8/91.]

WAC 388-885-035 Effective date. When a county submits a reimbursement claim according to this chapter, the claim shall be only for costs incurred as defined in this chapter, on or after July 1, 1990.

[99-21-002, recodified as § 388-885-035, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-035, filed 10/8/91, effective 11/8/91.]

WAC 388-885-040 Audits. The department may audit county reimbursement claims at the department's discretion.

[99-21-002, recodified as § 388-885-040, filed 10/6/99, effective 10/6/99. Statutory Authority: RCW 43.20A.050. 91-21-027 (Order 3263), § 275-156-040, filed 10/8/91, effective 11/8/91.]

Chapter 388-890 WAC

REHABILITATION SERVICES FOR INDIVIDUALS WITH DISABILITIES

(Formerly chapter 490-500 WAC (part))

WAC

INDEPENDENT LIVING PROGRAM—TITLE VII

388-890-0780	What is the independent living (IL) program?
388-890-0785	What types of services does the IL program offer?
388-890-0790	Who is eligible for Title VII IL program services?
388-890-0795	What is a significant disability?
388-890-0800	Who provides IL program services?
388-890-0805	What are my responsibilities in the IL program?

388-890-0810	How do I apply for IL program services?		
388-890-0815	What happens after I submit my application for IL program services?	388-890-0020	How does DVR support the informed choice process? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0020, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0410.
388-890-0820	Who decides if I am eligible for IL program services?		
388-890-0825	Where does the IL program get the information needed to decide if I am eligible?		
388-890-0830	How do I find out if I am eligible for IL program services?		
388-890-0835	What if I disagree with a decision about my eligibility for IL or a decision about IL program services?	388-890-0025	What decisions can I make using informed choice? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0025, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0410.
388-890-0840	Under what conditions can I get IL program services?		
388-890-0845	How are my IL program services planned?		
388-890-0850	What is included on a written or verbal IL plan?		
388-890-0855	Who signs and keeps a written IL plan?		
388-890-0860	How often is my IL plan reviewed?		
388-890-0870	What are IL advocacy services?		
388-890-0875	What are IL rehabilitation technology services?		
388-890-0880	What are IL communication services?		
388-890-0885	What are IL counseling services?		
388-890-0890	What are IL housing services?		
388-890-0895	Are IL program payments for home modifications limited?	388-890-0030	What if I don't know how to use the informed choice decision making process? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0030, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0420.
388-890-1000	What is IL skills training?		
388-890-1005	What are IL information and referral services?		
388-890-1010	What is IL peer counseling?		
388-890-1015	What is IL mobility training?		
388-890-1020	What is IL personal assistance training?		
388-890-1025	Does the IL program pay for attendant services as part of personal assistance training?	388-890-0035	Who is eligible to receive VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0035, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0420.
388-890-1030	What are IL physical rehabilitation services?		
388-890-1035	What are IL preventative services?		
388-890-1040	What are IL recreational services?		
388-890-1045	What are IL program services to family members?		
388-890-1050	What are IL therapeutic services?		
388-890-1055	What are IL transportation services?		
388-890-1060	What other services does the IL program offer?		
388-890-1065	How long can I receive independent living services?		
388-890-1070	Why does the IL program stop providing or paying for IL program services?	388-890-0040	How does DVR determine whether VR services will enable me to work? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0040, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0420.
388-890-1075	Am I involved in the decision to stop receiving IL program services?		
388-890-1080	How does the IL program notify me that my services are stopping?		
388-890-1085	If the IL program decides I am not eligible for IL program services, is the decision reviewed?		
388-890-1090	Does the IL program keep a record of my IL program services?		
388-890-1095	Does the IL program keep personal information confidential?	388-890-0045	Am I eligible for VR services if I receive Social Security disability benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0045, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0420.
DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER		388-890-0050	What criteria are not considered in the eligibility decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0050, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0420.
388-890-0005	What is the purpose of this chapter? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0005, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0005.		
388-890-0010	What definitions apply to this chapter? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0010, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0010.		
388-890-0015	What is informed choice? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0015, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0010.		

	26.44 RCW. Later promulgation, see WAC 388-891-1025.	388-890-0085	Am I required to provide proof of my identity and work status? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0085, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0910.
388-890-0055	What information does DVR use to make an eligibility decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0055, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1005.		
388-890-0060	After I submit my application to DVR, how long does it take DVR to make an eligibility decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0060, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1010.	388-890-0090	If I don't live in Washington, can I receive VR or IL program services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0090, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0920.
388-890-0065	What happens if DVR determines that I am not eligible? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0065, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1045.	388-890-0095	Can I receive VR services if I am legally blind? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0095, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0930.
388-890-0070	If I am not eligible for DVR services, can DVR help me find other services and programs to meet my needs? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0070, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1050.	388-890-0100	Can I receive VR or IL program services if I am Native American? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0100, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0940.
388-890-0071	If I am eligible for or ineligible for VR services, how will I be notified? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0071, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1045.	388-890-0105	How do I apply for VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0105, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0980.
388-890-0075	Who can apply for vocational rehabilitation services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0075, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0900.	388-890-0110	Under what general conditions does DVR provide vocational rehabilitation services to individuals? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0110, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300.
388-890-0080	Can I receive VR services if I am not a United States citizen? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0080, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0910.	388-890-0115	Can I ask for an exception to a rule or a condition relating to VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0115, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
		388-890-0120	How do I ask for an exception to a rule or condition in this chapter? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act

- of 1973 as amended in August 1998. 99-18-053, § 388-890-0120, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0205 and 388-891-0210.
- 388-890-0125 What happens if the service I want exceeds what I need or is more expensive than a similar service? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0125, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0370.
- 388-890-0130 Can a guardian or another representative act on my behalf? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0130, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0200.
- 388-890-0135 What is the purpose of vocational rehabilitation (VR) services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0135, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0140 How do I know which VR services are right for me? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0140, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0400, 388-891-0410, 388-891-0420, 388-891-0430 and 388-891-0440.
- 388-890-0145 What vocational rehabilitation services are available to individuals from DVR? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0145, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0600.
- 388-890-0150 What are assessment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0150, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0605.
- 388-890-0155 To determine whether I am eligible for VR services, who decides what assessment services I need and where to get the assessment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0155, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0430 and 388-891-1005.
- 388-890-0160 If I need assessment services to help me choose an employment goal and what VR services I need, who decides what assessment services I need and where to get the assessment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0160, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0430.
- 388-890-0165 What if I already have assessment information to help me and DVR make the decisions we need to make? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0165, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1005 and 388-891-1100.
- 388-890-0170 How do I provide needed assessment information to DVR? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0170, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0175 What is an assistive technology device? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0175, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0660.
- 388-890-0180 Under what conditions does DVR provide and issue assistive technology devices? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0180, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300, 388-891-1200, 388-891-1210, 388-891-1220, 388-891-1230, and 388-891-1240.
- 388-890-0185 Under what conditions does DVR provide vehicle modifications? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0185, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0665.

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	chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300.		388-891-1210, 388-891-1220, 388-891-1230, and 388-891-1240.
388-890-0345	What are self-employment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0345, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0685.	388-890-0380	What are training services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0380, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0710.
388-890-0350	Under what conditions does DVR provide self-employment services and issue items for self-employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0350, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.-832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300, 388-891-1200, 388-891-1210, 388-891-1220, 388-891-1230, 388-891-1240, and 388-891-0685.	388-890-0385	What is on-the-job training? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0385, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0715.
388-890-0355	What are services to family members? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0355, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0690.	388-890-0390	Under what conditions does DVR provide on-the-job training? [Statutory Authority: RCW 74.29.020, 74.08.-090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0390, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300 and 388-891-0715.
388-890-0360	Under what conditions does DVR provide services to my family members? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0360, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300 and 388-891-0695.	388-890-0395	Under what conditions does DVR provide training services and issue items for training? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0395, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300, 388-891-1200, 388-891-1210, 388-891-1220, 388-891-1230, 388-891-1240, and 388-891-0745.
388-890-0365	What are supported employment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0365, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0840.	388-890-0400	Do I have to apply for a student loan to pay for training services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0400, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0745.
388-890-0370	What are tools, equipment, initial stocks and supplies? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0370, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.-832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0705.	388-890-0405	Can I receive training services from a private school, an out-of-state training agency or an out-of-state college? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0405, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.-832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0750.
388-890-0375	Under what conditions does DVR provide and issue tools, equipment, initial stocks and supplies? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0375, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300, 388-891-1200,	388-890-0410	What are transition services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0410, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.-

- 340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0755.
- 388-890-0415 Under what conditions does DVR provide transition services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0415, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300 and 388-891-0755.
- 388-890-0420 How does DVR coordinate with public high schools to provide transition services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0420, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0425 How does DVR help me plan transition services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0425, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0400, 388-891-0410, 388-891-0420, 388-891-0430, 388-891-0440, and 388-891-0755.
- 388-890-0430 Who decides what transition services I get from DVR? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0430, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0400, 388-891-0410, 388-891-0420, 388-891-0430, 388-891-0440, and 388-891-0755.
- 388-890-0435 What activities does DVR support after I leave high school? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0435, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0440 What are transportation services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0440, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0765.
- 388-890-0445 Under what conditions does DVR provide transportation services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0445, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0765.
- 388-890-0450 Under what conditions does DVR provide and issue a vehicle? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0450, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300, 388-891-0370, 388-891-0770, 388-891-0775, 388-891-0400, 388-891-0410, 388-891-0420, and 388-891-0440.
- 388-890-0455 Under what conditions does DVR issue a device, tool, piece of equipment or other item I need to participate in VR services or to get a job? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0455, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300 and 388-891-1200.
- 388-890-0460 What conditions apply to the use of a device, tool, piece of equipment or other item that is issued to me? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0460, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1200.
- 388-890-0465 What types of devices, tools, pieces of equipment or other items can DVR issue to me? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0465, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1200 and 388-891-1210.
- 388-890-0470 Does DVR issue new or used devices, tools, pieces of equipment, or other items? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0470, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1200.
- 388-890-0475 What happens if I fail to return a device, tool, piece of equipment or other item if requested by DVR? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0475, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1230.
- 388-890-0480 What happens to a device, tool, piece of equipment or other item if I need it when my DVR case service record is closed? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0480, filed 8/27/99, effective 11/1/99.] Repealed by

- 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1240.
- 388-890-0485 What is an individualized plan for employment (IPE)? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0485, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1115.
- 388-890-0490 How do I develop an IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0490, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1130.
- 388-890-0495 What information does DVR give me to develop my IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0495, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1125.
- 388-890-0500 Who makes decisions about what to include on my IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0500, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1115.
- 388-890-0505 Can I include any VR services I want on my IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0505, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0370 and 388-891-1140.
- 388-890-0510 What if the employment goal I choose is religious in nature? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0510, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0515 What must be included on my IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0515, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1140.
- 388-890-0520 Who signs the IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0520, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1145.
- 388-890-0525 Is the IPE reviewed and updated? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0525, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1150.
- 388-890-0530 Why does DVR close a case service record? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0530, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1300.
- 388-890-0535 Under what conditions does DVR determine that I am working and no longer need VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0535, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1310.
- 388-890-0540 Am I involved in the decision to close my case? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0540, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1320.
- 388-890-0545 What is competitive employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0545, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0010.
- 388-890-0550 What is extended employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-0550, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0010.
- 388-890-0555 If the job I get is in extended employment, what follow-up does DVR provide? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-

- 388-890-0635 Who provides the extended services I need? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0635, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0860.
- 388-890-0640 What is natural support? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0640, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0865.
- 388-890-0645 Are supported employment services time-limited? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0645, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0870.
- 388-890-0650 What is required for me to change from supported employment services to extended services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0650, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0875.
- 388-890-0655 What happens if my VR counselor and I do not find a source for extended services and/or we cannot establish natural supports during the initial eighteen months of my individualized plan for employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0655, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0880.
- 388-890-0660 Under what conditions does DVR close my case service record for supported employment? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0660, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0885.
- 388-890-0665 Under what conditions does DVR provide supported employment services as post-employment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0665, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0890.
- 388-890-0670 What is a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0670, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0675 What happens during a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0675, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0680 Who decides if a trial work experience is needed to determine if I am eligible for DVR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0680, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1015.
- 388-890-0685 What services does DVR provide during a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0685, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0690 What if I am too significantly disabled to participate in a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0690, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1035.
- 388-890-0695 What choices can I make about the trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0695, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030 and 388-891-0430.
- 388-890-0700 Am I evaluated during the trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0700, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0705 When does DVR make an eligibility decision when I am in a trial work experience? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabil-

- itation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0705, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1030.
- 388-890-0710 Are there any vocational rehabilitation services that can be provided to a group of individuals with disabilities? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0710, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0715 Under what conditions does DVR provide services to a group of individuals with disabilities to establish, develop or improve a community rehabilitation program? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0715, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0720 Under what conditions does DVR provide services to a group of individuals with disabilities that cannot be purchased under an individual IPE? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0720, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0725 Under what conditions does DVR provide consulting and/or technical assistance to plan for the transition of students with disabilities? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0725, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-0730 What if DVR does not have funding to serve all eligible individuals? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0730, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0500.
- 388-890-0745 If DVR has to decide in what category to place me, who decides what assessment services I need and where to get the assessment services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0745, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-1005 and 388-891-0430.
- 388-890-0750 What categories are used by DVR to determine the priority by which eligible individuals are served and in what order are the categories prioritized? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0750, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0510.
- 388-890-0755 What information does DVR use to determine whether I am in category one? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0755, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0520.
- 388-890-0760 What information does DVR use to determine whether I am in category two? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0760, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0530.
- 388-890-0765 What information does DVR use to determine whether I am in category three? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0765, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0540.
- 388-890-1100 How are costs for VR and IL program services paid? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1100, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300.
- 388-890-1110 What are comparable services and benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1110, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0300.
- 388-890-1115 What VR or IL program services are provided without a determination of comparable services or benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1115, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0310.

- 388-890-1120 What if determining the availability of comparable services and benefits would result in a delay or interrupt my progress? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1120, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0320.
- 388-890-1125 What is extreme medical risk? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1125, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0320.
- 388-890-1130 Does DVR pay for a service if comparable services and benefits are available, but I don't want to use them? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1130, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0325.
- 388-890-1135 Are awards and scholarships based on merit considered comparable services and benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1135, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-1140 How do I get comparable services and benefits? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1140, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-1145 How does DVR determine whether I pay for all or part of my VR or IL services using my own financial resources? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1145, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0340.
- 388-890-1150 Do I have to report my financial status if I receive public assistance or income support from another public program? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1150, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0345.
- 388-890-1155 What financial information does DVR use to decide if I need to help pay for VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1155, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0350.
- 388-890-1160 Are any of my resources not counted in the decision about whether I have to help pay for services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1160, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0360.
- 388-890-1165 How does DVR decide whether I have resources to help pay for VR services? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1165, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0355.
- 388-890-1170 How is the amount I pay for VR or IL program services determined? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1170, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0355.
- 388-890-1175 What VR or IL program services am I not required to help pay for? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1175, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0365.
- 388-890-1180 What if a VR counselor makes a decision about my VR services that I don't agree with? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1180, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0215.
- 388-890-1185 What is the client assistance program (CAP)? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1185, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0220.

- 388-890-1190 What is mediation? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1190, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0225.
- 388-890-1195 When can I ask for mediation? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1195, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0230.
- 388-890-1200 Who arranges and pays for mediation? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1200, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0235.
- 388-890-1205 Is information discussed during mediation confidential? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1205, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0240.
- 388-890-1210 How do I request mediation? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1210, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09-340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-1215 After the mediation session, do I receive a written statement of the results? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1215, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0245.
- 388-890-1220 What is a formal hearing? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1220, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0250.
- 388-890-1225 When is a formal hearing available? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1225, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0255.
- 388-890-1230 How do I request a formal hearing? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1230, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09-340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0255.
- 388-890-1235 After I submit a request for a formal hearing, when is it held? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1235, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0260.
- 388-890-1240 Do I receive a written formal hearing decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1240, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0270.
- 388-890-1245 Is the decision after a formal hearing final? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1245, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0275.
- 388-890-1250 Can DVR suspend, reduce or terminate my services while waiting for a formal hearing decision? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1250, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0295.
- 388-890-1255 How do I know what personal information I must give DVR and how it is used? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1255, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.
- 388-890-1260 Does DVR keep a record of my VR services on file? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1260, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW.

- 26.44 RCW. Later promulgation, see WAC 388-891-0100.
- 388-890-1265 Under what conditions does DVR share personal information in my record with another service provider or organization? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1265, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0130.
- 388-890-1270 When DVR gets personal information about me from another agency or service provider, is it kept confidential? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1270, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0130.
- 388-890-1275 Does DVR change incorrect information in my record? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1275, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0120.
- 388-890-1280 How do I receive copies of information from my DVR record? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1280, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0140.
- 388-890-1285 Can DVR release personal information without my written consent? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1285, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0130.
- 388-890-1290 Under what conditions does DVR release personal information for audit, evaluation or research? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1290, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0150.
- 388-890-1295 How does DVR protect personal information about drug, alcohol, HIV/AIDS and sexually transmitted diseases? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1295, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0135.
- 388-890-1300 How do I contact DVR if I don't speak English? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1300, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0950.
- 388-890-1305 What other methods of communication does DVR use? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1305, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0960.
- 388-890-1310 When does DVR communicate with me using methods other than English? [Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1310, filed 8/27/99, effective 11/1/99.] Repealed by 03-02-014, filed 12/20/02, effective 2/3/03. Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. Later promulgation, see WAC 388-891-0960.

INDEPENDENT LIVING PROGRAM—TITLE VII

WAC 388-890-0780 What is the independent living (IL) program? (1) The independent living (IL) program is authorized by the department of social and health services, division of vocational rehabilitation under Title VII of the Rehabilitation Act, as amended.

(2) Independent living (IL) is a program of services that assists adults and emancipated minors with significant disabilities to live more independently in their families and communities. IL program services are not offered in all DVR offices. Individuals interested in IL program services must be able to receive services in a region where IL program services are offered.

(3) In addition to the rules in sections WAC 388-890-0780 through 388-890-1095 covering independent living program services, the following vocational rehabilitation rules apply:

(a) Payment for VR and IL program services, WAC 388-890-1100 through 388-890-1175;

(b) Confidentiality of personal information, WAC 388-890-1265 through 388-890-1295; and

(c) How to contact DVR if you don't speak English, WAC 388-890-1300 through 388-890-1310.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0780, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0785 What types of services does the IL program offer? If you are eligible, the IL program can help you get the following types of services, as needed, to reach your IL goals:

- (1) Advocacy services;
- (2) Rehabilitation technology services;
- (3) Communications services;
- (4) IL counseling services;
- (5) Housing services;
- (6) IL skills training;
- (7) Information and referral services;
- (8) Mobility training;
- (9) Peer counseling services;
- (10) Personal assistance services;
- (11) Physical rehabilitation services;
- (12) Preventative services;
- (13) Recreational services;
- (14) Services to family members;
- (15) Therapeutic treatment services;
- (16) Transportation services; and
- (17) Other IL program services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0785, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0790 Who is eligible for Title VII IL program services? (1) You are eligible for IL program services under Title VII if you are an adult or emancipated minor and you:

- (a) Have a significant disability, as defined under WAC 388-890-0795;
 - (b) Are not currently eligible for VR services; and
 - (c) Can receive IL program services in a region that offers the services.
- (2) Eligibility is not based on your age, color, creed, gender, sexual orientation, national origin, race, religion, or type of disability.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0790, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0795 What is a significant disability? In the Title VII IL program, you have a significant disability if:

- (1) You have a physical, mental, cognitive or sensory impairment that greatly limits your level of independence in your family or community; and
- (2) IL program services are likely to improve or maintain your level of independence in any of these areas.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0795, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0800 Who provides IL program services? (1) An IL counselor provides IL program services; or

(2) The IL counselor may refer you to a service provider who meets standards established by the IL program.

(3) When a service provider is used, the service provider must provide IL program services that you, the IL counselor, and the service provider have agreed to in advance of starting the service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0800, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0805 What are my responsibilities in the IL program? To receive independent living services, you must:

- (1) Complete tasks that you have agreed to complete to reach your IL goals;
- (2) Be willing to learn new skills and try new things; and
- (3) Accept responsibility for your decisions and actions related to your IL goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0805, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0810 How do I apply for IL program services? To apply for IL program services you:

- (1) Fill out and sign an IL program services application form; or
- (2) Submit the following information:
 - (a) Your name, address and the county where you live;
 - (b) Your birthdate and gender;
 - (c) Your Social Security Number (optional);
 - (d) A short description of the type of disability; and
 - (e) The date of your application.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0810, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0815 What happens after I submit my application for IL program services? After you apply for IL program services, you meet with an IL counselor to:

- (1) Fill out other forms and releases needed by the IL program to collect the information needed to decide if you are eligible for services;
- (2) Complete an assessment to:
 - (a) Verify whether you have a significant disability that greatly limits your level of independence in your family or community;
 - (b) Identify your IL needs; and
 - (c) Decide if IL program services can help you to improve or maintain your level of independence in your family or community.
- (3) The assessment may include, but is not limited to, the following areas:
 - (a) Your home and living environment, including housing, ability to get around, and safety;
 - (b) Financial issues, such as budgeting, paying bills, and managing money;
 - (c) Your basic skills in cooking, cleaning, shopping and general home and family care;
 - (d) How you relate to your family or others socially, and how you spend your free time;
 - (e) How you manage your own personal care;
 - (f) School or work interests.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0815, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0820 Who decides if I am eligible for IL program services? (1) An IL counselor determines whether you meet the eligibility requirements as outlined under WAC 388-890-0790; or

(2) If an individual or organization has a contract with the IL program to offer IL program services, the individual or organization may determine whether you meet the eligibility requirements under WAC 388-890-0790.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0820, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0825 Where does the IL program get the information needed to decide if I am eligible? The IL program uses information that you, your family, your doctor, or other organizations submit to decide if you are eligible.

(1) If the information does not verify whether you are eligible for IL program services, you may need to get additional assessments, exams, or tests to get the information.

(2) The IL program pays for services needed to verify whether you are eligible.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0825, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0830 How do I find out if I am eligible for IL program services? (1) If the IL program verifies you are eligible, the IL program notifies you of the decision.

(2) If the IL program determines you are not eligible, the IL program must:

(a) Talk with you about the decision;

(b) Send you, or your representative, a notice of the decision in writing, including information about the services offered by the client assistance program and how to ask for services; and

(c) When possible, refer you to other agencies or programs that offer services to meet your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0830, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0835 What if I disagree with a decision about my eligibility for IL or a decision about IL program services? If an IL counselor makes a decision about your IL program services that you don't agree with, you have the following options:

(1) Try to resolve the disagreement by talking to the IL counselor, his or her supervisor, or regional administrator;

(2) Contact the client assistance program as outlined under WAC 388-890-1185; and/or

(3) Request mediation as outlined under WAC 388-890-1190 through 388-890-1215.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0835, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0840 Under what conditions can I get IL program services? (1) The IL program offers services as needed to:

(a) Establish your eligibility;

(b) Assess your IL needs;

(c) Develop an IL plan; and

(d) Reach your IL goals.

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(2) The IL program provides services only if you are not eligible to receive a comparable service from another organization or program.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0840, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0845 How are my IL program services planned? (1) If you are eligible for IL program services, you work with an IL counselor to develop a written IL plan or a verbal IL plan.

(a) You can get the same IL program services under a written IL plan and a verbal IL plan.

(b) If you choose a verbal IL plan, you must sign a waiver declining a written IL plan.

(2) Before the IL program purchases services under a written IL plan or verbal IL plan, you must complete a financial statement as outlined under WAC 388-890-1145, unless you receive public assistance or support from another program as outlined under WAC 388-890-1150.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0845, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0850 What is included on a written or verbal IL plan? The written or verbal IL plan includes:

(1) Your goals for addressing the barriers that limit your level of independence in your family or community;

(2) The IL program services you are using to achieve each goal; and

(3) How long you expect to use each service.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0850, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0855 Who signs and keeps a written IL plan? (1) You and an IL counselor sign the written IL plan.

(2) The IL counselor gives you a copy of the written IL plan in a format that you can understand and use.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0855, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0860 How often is my IL plan reviewed? (1) You and an IL counselor review your IL plan at least once a year, and more often if needed to decide whether:

(a) IL program services should continue, change or stop;

(b) You can and want to be referred to DVR to apply for vocational rehabilitation services as outlined under WAC 388-890-105; and

(c) You should be referred to another program or service.

(2) You may develop a new plan, if changes are needed.

(3) When you develop a new plan, the new plan is developed as outlined in WAC 388-890-0845 through 388-890-0855.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0860, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0870 What are IL advocacy services?

IL advocacy services support and assist you to express your interests or concerns to others to:

- (1) Reach your IL goals; or
- (2) Get other benefits and services you need.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0870, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0875 What are IL rehabilitation technology services? IL rehabilitation technology services assist you to use devices, equipment, or technology services that enable you to reach your IL goals. IL rehabilitation technology services assist you to:

- (1) Assess your technology needs;
- (2) Try out different types of devices, equipment, and services;
- (3) Obtain devices; and/or
- (4) Receive training on the use of devices or equipment.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0875, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0880 What are IL communication services? IL communication services assist you to learn skills or use services that enable you to understand and share information. Examples of communication services include, but are not limited to:

- (1) How to get and use interpreter services, including tactile interpreter services;
- (2) Training in the use of equipment that helps you communicate;
- (3) Braille training;
- (4) How to get and use reader services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0880, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0885 What are IL counseling services? (1) IL counseling services include support and advice from an IL counselor to help you reach your IL goals by finding out about issues that get in the way of your independence.

(2) IL counseling services also includes therapeutic counseling services purchased from a qualified therapist on a short-term basis to help you:

- (a) Adjust to your disabling condition; and
- (b) Deal with issues about being more independent.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0885, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0890 What are IL housing services? IL housing services assist you to find or keep a suitable living arrangement and take steps needed to move, if needed. Housing services include, but are not limited to, assisting you to:

- (1) Find out about low-income housing resources and different types of housing;
- (2) Find housing that accommodates your disability;
- (3) Assess what is needed in your current housing to accommodate your disability;
- (4) Find out about ways to make your home accessible.

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[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0890, filed 8/27/99, effective 11/1/99.]

WAC 388-890-0895 Are IL program payments for home modifications limited? (1) The IL program pays for home modifications if:

- (a) The modifications are related to a disability and will improve or maintain independence or safety.
 - (b) You and/or a family member with whom you live:
 - (i) Own the place where you live; and
 - (ii) Complete a financial statement based on the family income to determine whether you must pay, in whole or in part, for home modifications.
 - (c) The housing construction complies with appropriate building codes and permit requirements.
- (2) The IL program does not pay for the cost of labor to construct home modifications.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-0895, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1000 What is IL skills training? IL skills training teaches you skills to manage and balance your life in areas including, but not limited to:

- (1) Budgeting;
- (2) Meal planning and/or preparation;
- (3) Consumer skills;
- (4) Personal care;
- (5) Social interaction.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1000, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1005 What are IL information and referral services? IL information and referral services help you to find out about and get help from other community programs and services. IL information and referral services include, but are not limited to:

- (1) Information about a variety of disability issues;
- (2) Information about health insurance and where it is available;
- (3) Help with contacting other programs and services in the community.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1005, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1010 What is IL peer counseling? IL peer counseling is support, advice, teaching, and information sharing with people with disabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1010, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1015 What is IL mobility training? IL mobility training improves your ability to get around in your home or your community, including but not limited to:

- (1) How to use a wheelchair;
- (2) How to make transfers;
- (3) Training on the use of public transportation.

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[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1015, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1020 What is IL personal assistance training? IL personal assistance training helps you develop the skills to get or keep the services of an attendant or assistant to meet your personal assistance needs. Personal assistance training includes, but is not limited to:

- (1) How to find an attendant or assistant;
- (2) How to manage services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1020, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1025 Does the IL program pay for attendant services as part of personal assistance training? The IL program does not pay for attendant services as part of personal assistance training.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1025, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1030 What are IL physical rehabilitation services? IL physical rehabilitation services include medical assessments or short-term services to assist you to identify or reach your IL goals. Physical rehabilitation services include, but are not limited to:

- (1) Occupational therapy;
- (2) Speech therapy;
- (3) Physical therapy.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1030, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1035 What are IL preventative services? IL preventative services enable you to prevent or limit conditions that result from your disability. IL preventative services enable you to reduce the risk that conditions or limitations worsen. IL preventative services may include, but are not limited to, the purchase of items used to prevent decubitus ulcers.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1035, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1040 What are IL recreational services? IL recreational services assist you to find ways to enjoy activities or hobbies of personal interest to you. IL recreational services may include but are not limited to:

- (1) Assisting you to find information and contact local programs or organizations that offer activities you are interested in;
- (2) Getting short-term instruction in an area of interest to you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1040, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1045 What are IL program services to family members? (1) IL program services to family members assist you and your family members with issues related

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to your disability or independence. Services to family members may include, but are not limited to:

- (a) Giving your family training to understand disability issues;
 - (b) Assisting you to get child care needed to allow you to use IL program services.
- (2) Family member means:
- (a) Your legal guardian;
 - (b) Someone related to you; or
 - (c) Someone you live with who has a strong interest in your well being and who needs IL program services for you to achieve your IL goals.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1045, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1050 What are IL therapeutic services? IL therapeutic services include evaluations to assist you to get specific information from a medical professional, such as a psychologist or neuropsychologist, to help you:

- (1) Identify your IL goals; and/or
- (2) Decide best methods for you to receive services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1050, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1055 What are IL transportation services? (1) IL transportation services help you participate in other IL program services and include, but are not limited to:

- (a) Public transportation fares or passes,
- (b) Estimated cost of gasoline,
- (c) Parking fees.

(2) IL transportation services do not include the purchase of vehicles.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1055, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1060 What other services does the IL program offer? The IL program may offer other services needed to help you to understand IL program services and options or achieve your IL goals. Other IL program services may include, but are not limited to support to attend a class, and support to find volunteer work.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1060, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1065 How long can I receive independent living services? There is no limit on how long IL program services may be provided.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998. 99-18-053, § 388-890-1065, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1070 Why does the IL program stop providing or paying for IL program services? (1) The IL program stops providing or paying for IL program services if you:

- (a) Agree with an IL counselor that you have completed the goals and objectives in your IL plan.

(b) Are no longer available to receive services at a DVR office where IL program services are offered.

(c) Choose to quit using IL program services.

(d) Are eligible and plan to use vocational rehabilitation services.

(2) The IL program stops providing or paying for IL program services if an IL counselor:

(a) Determines you no longer need IL program services.

(b) Determines you are not progressing in your IL plan.

(c) Determines that you are no longer eligible for IL program services.

(d) Refers you to another service or program that offers services that are more likely to meet your needs.

(e) Cannot locate you.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1070, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1075 Am I involved in the decision to stop receiving IL program services? Before the IL program decides to stop providing or paying for your IL program services, an IL counselor must give you an opportunity to discuss the reasons for the decision.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1075, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1080 How does the IL program notify me that my services are stopping? (1) If an IL counselor decides that you are no longer eligible for IL program services, the IL counselor must follow the procedures in WAC 388-890-0065 to notify you about the decision.

(2) If you and an IL counselor have decided to stop IL program services for another reason, the IL program must send you a written notice. The written notice must explain:

(a) The reason the IL program has decided to stop providing or paying for IL program services; and

(b) The services offered by the client assistance program as outlined under WAC 388-890-1185 and how to ask for those services.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1080, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1085 If the IL program decides I am not eligible for IL program services, is the decision reviewed? (1) If the IL program decides that you are not eligible for IL program services, an IL counselor must contact you to review the decision within twelve months.

(2) If you have a change in your life that affects your eligibility for IL program services, you may ask the IL program to review the decision.

(3) The IL program is not required to review your eligibility if you:

(a) Refuse or decline a review;

(b) Are no longer available to receive services at a DVR office that provides IL program services; or

(c) Cannot be located.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1085, filed 8/27/99, effective 11/1/99.]

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WAC 388-890-1090 Does the IL program keep a record of my IL program services? The IL program keeps a record of your services, either electronically or in writing for three years after you stop receiving IL program services. The record includes, but is not limited to:

(1) Records that verify your eligibility or ineligibility;

(2) IL goals and objectives that are:

(a) Established with your input, whether on a written IL plan or not; and

(b) Achieved by you.

(3) Services you requested and received;

(4) A written IL plan or a written form signed by you declining a plan.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1090, filed 8/27/99, effective 11/1/99.]

WAC 388-890-1095 Does the IL program keep personal information confidential? (1) The IL program protects your personal information as outlined in WAC 388-890-1255 through 388-890-1295.

(2) When a service provider is used, the service provider must have and follow policies and procedures that are consistent with WAC 388-890-1255 through 388-890-1295.

[Statutory Authority: RCW 74.29.020, 74.08.090 and chapter 74.29 RCW, Rehabilitation Act of 1973 as amended in August 1998, 99-18-053, § 388-890-1095, filed 8/27/99, effective 11/1/99.]

Chapter 388-891 WAC

VOCATIONAL REHABILITATION SERVICES FOR INDIVIDUALS WITH DISABILITIES

(Formerly chapter 388-890 WAC (part))

WAC

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388-891-0120 Can I ask DVR to change incorrect information in my case service record?

388-891-0130 Can DVR share personal information in my record with others?

388-891-0135 How does DVR protect personal information about drug, alcohol, HIV/AIDS and sexually transmitted diseases?

388-891-0140 Can I obtain copies of information in my case service record?

388-891-0150 How does DVR protect personal information that is released for audit, evaluation or research?

CUSTOMER RIGHTS

388-891-0200 Can a guardian or another representative act on my behalf with DVR?

388-891-0205 How do I ask for an exception to a rule in this chapter?

388-891-0210 What happens after I submit a request for an exception?

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388-891-0220 What is the client assistance program (CAP)?

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388-891-0300	Under what conditions does DVR provide and/or pay for vocational rehabilitation services to individuals?	388-891-0720	What is post-secondary training?
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388-891-0330	Does DVR consider academic awards and scholarships as income?	388-891-0740	What other training does DVR provide?
388-891-0340	How does DVR determine whether I must pay part of my VR services using my own financial resources?	388-891-0745	What conditions apply to receiving training services at an institution of higher education?
388-891-0345	Do I have to pay a portion of my VR services if I receive assistance or income support from another public program?	388-891-0750	Can I receive training services from a private school, an out-of-state training agency or an out-of-state college?
388-891-0350	What financial information does DVR use to decide if I need to help pay for VR services?	388-891-0755	What are transition services?
388-891-0355	How is the amount I pay for VR services determined?	388-891-0760	What are translation services?
388-891-0360	What personal resources are not counted in the decision about whether I have to help pay for services?	388-891-0765	What are transportation services?
388-891-0365	What VR program services am I not required to help pay for?	388-891-0770	Under what conditions does DVR provide a vehicle?
388-891-0370	Can I select the services and service provider of my choice?	388-891-0775	What happens if DVR has a question about my driving safety?
INFORMED CHOICE		388-891-0780	What other services does DVR provide?
388-891-0400	What is informed choice?	388-891-0790	What are post-employment services?
388-891-0410	How does DVR support the informed choice process?	SUPPORTED EMPLOYMENT	
388-891-0420	What if I don't know how to use the informed choice decision making process?	388-891-0800	What is supported employment?
388-891-0430	What decisions can I make using informed choice?	388-891-0810	Who is eligible for supported employment?
388-891-0440	What information and assistance will DVR provide to help me make informed choices about VR services and service providers?	388-891-0815	Who decides if I am eligible for supported employment?
ORDER OF SELECTION		388-891-0820	What is competitive work in supported employment?
388-891-0500	What happens if DVR cannot serve every eligible person?	388-891-0825	What is an integrated setting in supported employment?
388-891-0510	How are individuals selected for services when DVR is operating under an order of selection?	388-891-0830	Is my work setting integrated if my interactions at the work site are with nondisabled supported employment service providers?
388-891-0520	What is the criteria for priority category 1—Individuals with most severe disabilities?	388-891-0835	What is transitional employment?
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VR SERVICES		388-891-0850	What are extended services?
388-891-0600	What vocational rehabilitation services are available to individuals from DVR?	388-891-0855	Does DVR provide extended services?
388-891-0605	What are assessment services?	388-891-0860	Who provides the extended services I need?
388-891-0610	What are independent living services and/or evaluation?	388-891-0865	What is natural support?
388-891-0615	What are information and referral services?	388-891-0870	Are supported employment services time-limited?
388-891-0620	What are interpreter services?	388-891-0875	What is required for me to change from supported employment services to extended services?
388-891-0625	What are job placement services?	388-891-0880	What happens if my DVR counselor and I do not find a source for extended services and/or we cannot establish natural supports during the initial eighteen months of my individualized plan for employment?
388-891-0630	What are job retention services?	388-891-0885	Under what conditions does DVR close my case service record for supported employment?
388-891-0635	What are maintenance services?	388-891-0890	Under what conditions does DVR provide supported employment services as post-employment services?
388-891-0640	What are occupational licenses?	APPLYING FOR VR SERVICES	
388-891-0645	What are personal assistance services?	388-891-0900	Who can apply for vocational rehabilitation services?
388-891-0650	What are physical and mental restoration services?	388-891-0910	Am I required to provide proof of my identity and work status?
388-891-0655	What are the medical treatments DVR does not pay for?	388-891-0920	If I don't live in Washington, can I receive VR services?
388-891-0660	What is rehabilitation technology?	388-891-0930	Can I receive VR services if I am legally blind?
388-891-0665	Under what conditions does DVR provide vehicle modifications as a rehabilitation technology service?	388-891-0940	Can I receive VR services if I am Native American?
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		388-891-1000	Who is eligible to receive VR services?
		388-891-1005	How does DVR determine if I am eligible?
		388-891-1010	After I submit my application to DVR, how long does it take DVR to make an eligibility decision?
		388-891-1015	What if a DVR counselor cannot presume that I am capable of working as a result of receiving VR services because of the severity of my disability?

388-891-1020	Am I eligible for VR services if I receive Social Security disability benefits?
388-891-1025	What criteria are not considered in the eligibility decision?
388-891-1030	What is involved in a trial work experience?
388-891-1035	What if I cannot participate in a trial work experience?
388-891-1040	What is an extended evaluation?
388-891-1045	What happens if DVR determines that I am not eligible or no longer eligible for VR services?
388-891-1050	If I am not eligible for VR services, can DVR help me find other services and programs to meet my needs?

IPE DEVELOPMENT

388-891-1100	What is an assessment for determining vocational rehabilitation needs?
388-891-1105	Do I have to disclose criminal history information to DVR?
388-891-1110	What other assessments might be required?
388-891-1115	What is an individualized plan for employment (IPE)?
388-891-1120	Who develops an IPE?
388-891-1125	What information does DVR provide to help me develop my IPE?
388-891-1130	What are the options for developing an IPE?
388-891-1135	Does DVR support any job I choose?
388-891-1140	What must be included on the IPE form?
388-891-1145	When does the IPE become effective?
388-891-1150	Is the IPE reviewed and updated?

LOANING EQUIPMENT

388-891-1200	Under what conditions does DVR loan equipment, devices or other items to me?
388-891-1210	What if I need an item customized for my own personal needs?
388-891-1220	What conditions apply to the use of a device, tool, piece of equipment or other item that is loaned to me?
388-891-1230	What happens if I fail to return a device, tool, piece of equipment or other item if requested by DVR?
388-891-1240	What happens to a device, tool, piece of equipment or other item if I need it when my DVR case service record is closed?

CASE CLOSURE

388-891-1300	Why does DVR close a case service record?
388-891-1310	How does DVR determine that I have achieved an employment outcome?
388-891-1320	Am I involved in the decision to close my case?
388-891-1330	Under what conditions does DVR follow up with me after my case is closed?

PURPOSE

WAC 388-891-0005 What is the purpose of this chapter? This chapter explains the types of vocational rehabilitation services (referred to as **"VR services"** in this chapter) available to individuals who are eligible through the department of social and health services (DSHS), division of vocational rehabilitation (DVR).

VR services are offered to assist individuals with disabilities to prepare for, get, and keep jobs that are consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. This chapter is consistent with the Rehabilitation Act of 1973, as amended by the Rehabilitation Act Amendments of 1998 and codified in 34 Code of Federal Regulations, Parts 361 and 363 and with state laws and DSHS requirements.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0005, filed 12/20/02, effective 2/3/03.]

DEFINITIONS

WAC 388-891-0010 What definitions apply to this chapter? "Competitive employment" means:

- (1) Part-time or full-time work;
- (2) Work that is performed in an integrated setting;
- (3) Work for which an individual is paid at or above the minimum wage; and
- (4) Work for which an individual earns the same wages and benefits as other employees doing similar work who are not disabled.

"Employment outcome" means competitive employment, supported employment, self-employment, telecommuting, business ownership, or any other type of employment in an integrated setting that is consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

"Extended employment" means work in a nonintegrated or sheltered setting for a public or private nonprofit agency or organization that provides compensation in accordance with the Fair Labor Standards Act.

"Extreme medical risk" means medical conditions that are likely to result in substantial physical or mental impairments or death if services, including mental health services, are not provided quickly.

"Family member" means a person who is your relative or legal guardian; or someone who lives in the same household as you and has a substantial interest in your well being.

"Individual with a disability" means an individual:

- (1) Who has a physical or mental impairment;
- (2) Whose impairment results in a substantial impediment (medical, psychological, vocational, educational, communication, and others) hindering her or his ability to achieve an employment outcome; and
- (3) Who can achieve an employment outcome as a result of receiving VR services.

"Integrated setting" means:

- (1) The setting in which you receive a VR service is integrated if it is a setting commonly found in the community (such as a store, office or school) where you come into contact with nondisabled people while you are receiving the service. The nondisabled people you come into contact with are not the same people providing VR services to you.
- (2) The setting in which you work is integrated if it is a setting commonly found in the community where you come into contact with nondisabled people as you do your work. The amount of contact you have with nondisabled people is the same as what a nondisabled person in the same type of job would experience.

"Most recent tax year" means the most recent calendar year for which you filed or were required to file an income tax return with the United States Internal Revenue Service (IRS).

"Physical, mental or sensory impairment" means:

- (1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculo-skeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or

(2) Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Representative" means any person chosen by an applicant or eligible individual, including a parent, family member or advocate, unless a representative has been appointed by a court to represent the individual, in which case the court-appointed representative is the individual's representative.

"Substantial impediment to employment" means the limitations you experience as a result of a physical, mental or sensory impairment that hinder your ability to prepare for, find, or keep a job that matches your abilities and capabilities.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0010, filed 12/20/02, effective 2/3/03.]

PROTECTION AND USE OF CONFIDENTIAL INFORMATION

WAC 388-891-0100 What personal information about me does DVR keep on file? DVR keeps a case service record while you are receiving services and for three years after your case is closed. The case service record includes, but is not limited to:

(1) The DVR application form or written request for VR services.

(2) Documentation explaining the need for the trial work experience or extended evaluation, if conducted, and the written plan for conducting the trial work experience or extended evaluation, and documentation of progress reviews.

(3) Documentation and records that support the determination of eligibility or ineligibility.

(4) Documentation supporting the severity of disability and priority category determination.

(5) Financial statement and/or related records.

(6) Plan for employment, amendments to the plan, if amended, and information supporting the decisions documented on the plan.

(7) Documentation describing how you used informed choice to make decisions throughout the process, including assessment services, selection of an employment outcome, VR services, service provider, type of setting and how to get VR services.

(8) If VR services are provided in a setting that is not integrated, documentation of the reason(s) for using a nonintegrated setting;

(9) If you achieve a competitive employment outcome, documentation to show:

(a) Your wages and benefits;

(b) That the job you have is:

(i) Described in your plan for employment;

(ii) Consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice; and

(iii) In an integrated setting.

(c) That the services provided to you in your plan for employment helped you become employed;

(d) That you have been employed for at least ninety days and that you no longer need vocational rehabilitation services;

(e) That you and your VR counselor agree that your employment is satisfactory and that you are performing well; and

(f) That you have been informed, through appropriate modes of communication about the availability of post-employment services.

(10) If you are referred to another state or federal program for services to prepare for, find or keep a job, documentation of the referral, the reason(s) for the referral, and the name of the program(s) to which you are referred.

(11) Documentation of case closure, including:

(a) Reasons for closing the case service record;

(b) How you were involved in the decision to close the case; and

(c) A copy of the closure letter that explains the reason(s) for case closure and your rights if you disagree with the decision.

(12) Documentation of the results of mediation or fair hearings, if held;

(13) Documentation of annual reviews after your case service record is closed as outlined in WAC 388-891-1330 if:

(a) You choose extended employment in a nonintegrated setting;

(b) You achieve a supported employment outcome in an integrated setting for which you are paid in accordance with section 14(c) of the Fair Labor Standards Act; or

(c) DVR determines you are ineligible because you are too severely disabled to benefit from VR services.

(14) Other documentation that relates to your participation in VR services, including your progress, throughout the VR process.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0100, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0110 What happens if DVR receives information that indicates I have a previous history of behavior involving violent or predatory acts? (1) If a VR counselor receives information or records that reasonably lead the VR counselor to believe you have a previous history of violent or predatory behavior, you must participate in an assessment conducted by a licensed psychiatrist, psychologist, counselor, certified sex offender treatment provider, or other qualified professional prior to developing a plan for employment. The assessment is for the purpose of determining the level of risk you present to yourself or others in an employment situation.

(2) The VR counselor must consider the results and recommendations of the assessment in developing the plan for employment, including any restrictions relating to employment outcome or employment setting.

(3) If the results of the assessment indicate a potential risk to a service provider or employer, the individual must consent to release information about the behavior to a potential service provider or potential employer prior to referral for services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0110, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0120 Can I ask DVR to change incorrect information in my case service record? You may ask DVR to correct information in your case service record that you believe is incorrect. DVR corrects the information, unless DVR disagrees that the information is incorrect. If there is a disagreement about the accuracy of the information, you may provide a written document explaining the information you believe incorrect. DVR puts the document in your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0120, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0130 Can DVR share personal information in my record with others? (1) DVR shares personal information with others only if:

- (a) Another organization or program involved in your VR services needs the information to serve you effectively;
 - (b) You request information in the case service record be shared with another organization for its program purposes;
 - (c) You select an employment outcome in a field that customarily requires a criminal history background check as a condition of employment; and
 - (d) You sign a written consent giving DVR permission to release, exchange, or obtain the information.
- (2) DVR may release personal information without your written consent only under the following conditions:
- (a) If required by federal or state law;
 - (b) To a law enforcement agency to investigate criminal acts, unless prohibited by federal or state law;
 - (c) If given an order signed by a judge, magistrate, or authorized court official;
 - (d) If DVR reasonably believes you are a danger to yourself or others;
 - (e) To the DSHS division of child support; or
 - (f) To an organization, agency or person(s) conducting an audit, evaluation or research.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0130, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0135 How does DVR protect personal information about drug, alcohol, HIV/AIDS and sexually transmitted diseases? (1) DVR uses special protections when you share personal information about drug or alcohol abuse or about HIV/AIDS and sexually transmitted diseases.

(2) DVR asks for your specific permission to copy information of this nature before sharing it with a service provider or organization that is helping you reach your employment goals.

(3) Information about drug and alcohol abuse must be handled in accordance with RCW 70.96A.150 and applicable federal and state laws and regulations.

(4) Information about HIV/AIDS or other sexually transmitted diseases must be handled in accordance with RCW 70.24.105 and applicable federal and state laws and regulations.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0135, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0140 Can I obtain copies of information in my case service record? (1) You may review or obtain copies of information contained in your case service record by submitting a written request to DVR. DVR provides access to or provides copies of records upon request, except in the following circumstances:

- (a) If DVR believes the medical, psychological, or other records in your case service record may be harmful to give to you, DVR only releases the records to a third party that you choose, such as your representative, parent, legal guardian or a qualified medical professional.
- (b) If DVR receives personal information about you from another agency or service provider, DVR may only share the records as authorized by the agency or service provider that provided the information.
- (c) If a representative has been appointed by a court to represent you, the information must be released to the representative.

(2) DVR provides access or gives you copies of records within ten business days of receiving your written request. If DVR cannot fulfill your request within ten business days, DVR will send you a written notice of the reason(s) the request cannot be met and the date you are granted access or the date the requested information will be provided.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0140, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0150 How does DVR protect personal information that is released for audit, evaluation or research? DVR may release personal information for audit, evaluation or research if the results would improve the quality of life or VR services for people with disabilities. Before any personal information is shared, the organization, agency, or individual must agree to the following conditions:

- (1) The information must only be used by people directly involved in the audit, evaluation or research;
- (2) The information must only be used for the reasons approved by DVR in advance;
- (3) The information must be kept secure and confidential;
- (4) The information must not be shared with any other parties, including you or your representative; and
- (5) The final product or report must not contain any personal information that would identify you without your written consent.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130,

and chapter 26.44 RCW. 03-02-014, § 388-891-0150, filed 12/20/02, effective 2/3/03.]

CUSTOMER RIGHTS

WAC 388-891-0200 Can a guardian or another representative act on my behalf with DVR? (1) You may select someone to act as your representative, as appropriate, during the VR program.

(2) If you have a legal guardian or a court-appointed representative, he or she must act as your representative.

(a) A legal guardian or court-appointed representative must provide DVR with documentation of guardianship.

(b) Your legal guardian or court-appointed representative must sign the application and other documents that require your signature.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0200, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0205 How do I ask for an exception to a rule in this chapter? (1) A request for exception to a rule in this chapter is submitted to the DVR director or designee in writing, and must include:

- (a) A description of the exception being requested;
- (b) The reason you are asking for the exception; and
- (c) The duration of the exception, if applicable.

(2) An exception requesting a medical service that is otherwise not provided by DVR may only be requested on a trial basis or for a short duration to be specified in the request.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0205, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0210 What happens after I submit a request for an exception? (1) After receiving your request for an exception, the DVR director or designee decides whether to approve the request based on:

(a) The impact of the exception on accountability, efficiency, choice, satisfaction, and quality of services;

(b) The degree to which your request varies from the WAC; and

(c) Whether the rule or condition is a federal regulation that cannot be waived.

(2) The DVR director or designee responds to the request for an exception within ten working days of receiving the request.

(a) If the request is approved, the DVR director or designee provides a written approval that includes:

- (i) The specific WAC for which an exception is approved;
- (ii) Any conditions of approval; and
- (iii) Duration of the exception.

(b) If the request is denied, the DVR director or designee will provide a written explanation of the reasons for the denial.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0210, filed 12/20/02, effective 2/3/03.]

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ters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0210, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0215 What if a DVR counselor makes a decision about my VR services that I don't agree with?

(1) If a DVR counselor makes a decision that affects the VR services provided to you that you don't agree with, you may try to resolve the disagreement by any one of the following or a combination of the following:

(a) Seek assistance from the client assistance program, talk to the VR counselor, talk to the VR supervisor, or talk to the DVR director or his or her designee;

(b) Request mediation; and/or

(c) Request a fair hearing.

(2) You may request a fair hearing and/or mediation while you continue to work with the DVR counselor, VR supervisor or DVR director or designee to resolve the disagreement. If you reach agreement prior to the date of the scheduled mediation or fair hearing, the request may be withdrawn.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0215, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0220 What is the client assistance program (CAP)? The client assistance program (CAP) is a program independent of DVR that offers information and advocacy about your rights as a DVR customer and offers assistance to help you receive services. You may ask for help or information from CAP at any time during the rehabilitation process by asking a DVR staff person for information about how to contact CAP or by calling CAP toll free at 1-800-544-2121 voice/TTY. A CAP representative may represent you with DVR if a disagreement occurs that you cannot resolve on your own. CAP attempts to resolve disagreements informally through discussions with the DVR employee(s) involved as a first step. If informal efforts are not successful, CAP may represent you in mediation and/or a fair hearing. CAP services are available at no cost to you.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0220, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0225 What is mediation? (1) Mediation is a process in which a trained mediator conducts a meeting with you and a representative from DVR, usually your DVR counselor to help you settle a disagreement.

(a) The mediator does not work for DVR.

(b) The mediator does not make decisions about your case.

(c) Mediation is voluntary for all parties.

(2) During mediation:

(a) Each party presents information or evidence;

(b) The mediator reviews and explains the laws that apply; and

(c) The mediator helps you and the VR representative reach an agreement, if possible.

(3) You may ask someone to represent you during the mediation, including a CAP representative, however, you must be present.

(4) Agreements you and DVR reach through mediation are not legally binding.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0225, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0230 When can I ask for mediation?

You may ask for mediation any time you disagree with a decision DVR makes that affects the VR services that DVR provides to you. Mediation is not used to deny or delay your right to a fair hearing. You may request both mediation and a fair hearing at the same time. If an agreement is reached during mediation, the fair hearing is cancelled.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0230, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0235 Who arranges and pays for mediation? DVR schedules mediation in a timely manner at a location that is convenient to all parties. DVR pays for costs related to mediation, except costs related to a representative or attorney you ask to attend. DVR may pay for VR services you require to participate in mediation, such as transportation or child care.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0235, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0240 Is information discussed during mediation confidential? Discussions during mediation are confidential and may not be used in a later fair hearing or civil proceeding, if one is held. Before beginning a mediation session, all parties must sign a statement of confidentiality.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0240, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0245 If the mediation session results in an agreement, do I receive a written statement of the results? If you and the DVR representative reach an agreement during mediation:

- (1) The agreement is documented in writing;
- (2) You and the DVR representative sign the written agreement; and
- (3) DVR provides you with a copy of the agreement.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0245, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0250 What is a fair hearing? A fair hearing is a review process outlined under the Administrative Procedure Act, chapter 34.05 RCW and chapter 388-02 WAC that is conducted by an administrative law judge who works for the office of administrative hearings. During a fair hearing, both you and DVR may present information, witnesses, and/or documents to support your position. You may ask someone to represent you, such as an attorney, a friend, a relative, a representative from the client assistance program, or someone else you choose. The administrative law judge makes a decision after hearing all of the information presented; reviewing any documents submitted, and reviewing relevant laws and regulations.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0250, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0255 How do I request a fair hearing?

(1) To ask for a fair hearing, send a written request to the office of administrative hearings. You must include the following information in your written request:

- (a) Your name, address, and telephone number;
- (b) The name of the DSHS program that the fair hearing involves (such as DVR);
- (c) A written statement describing the decision and the reasons you disagree; and
- (d) Any other information or documents that relate to the matter.

(2) You must submit your request for a fair hearing within twenty days of the date the VR counselor makes the decision with which you disagree.

(3) You may ask any DVR employee for instructions or assistance to submit a request for a fair hearing.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0255, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0260 After I submit a request for a fair hearing, when is it held? The office of administrative hearings holds a fair hearing within sixty days of receipt of your written request for a hearing, unless you or DVR ask for a later hearing date and the office of administrative hearings determines there is a reasonable cause for the delay.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0260, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0265 What is a pre-hearing meeting?

After you submit a request for a fair hearing, DVR offers you a pre-hearing meeting. The pre-hearing meeting can be conducted in person, by telephone, or by another method agreeable to all parties. The purpose of the pre-hearing meeting is to:

- (1) Clarify the decision with which you disagree;
- (2) Exchange copies of laws, rules or other information to be presented in the fair hearing;

- (3) Explain how the fair hearing is conducted; and
- (4) Settle the disagreement, if possible.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0265, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0270 Do I receive a written fair hearing decision? The office of administrative hearings sends you a written report of the findings and decision within thirty days of the fair hearing.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0270, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0275 Is the fair hearing decision final?

(1) The office of administrative hearings decision is final and DVR must implement the decision.

(2) If you do not agree with the office of administrative hearings decision, you may pursue civil action through superior court to review that decision.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0275, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0295 Can DVR suspend, reduce or terminate my services if I request a fair hearing? DVR may not suspend, reduce, or terminate agreed upon services if you have requested a fair hearing, unless DVR provides evidence that you provided false information, committed fraud or other criminal acts involving VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0295, filed 12/20/02, effective 2/3/03.]

PAYING FOR VR SERVICES

WAC 388-891-0300 Under what conditions does DVR provide and/or pay for vocational rehabilitation services to individuals? DVR provides and pays for VR services if:

- (1) You have completed the application requirements;
- (2) You have provided documents that verify your identity and legal work status;
- (3) DVR authorizes the services before the services begin;
- (4) The services are needed to:
 - (a) Determine your eligibility for services;
 - (b) Identify your vocational rehabilitation needs; and/or
 - (c) Help you get and/or keep a job.
- (5) The services to be provided, except services listed in WAC 388-891-0310, are not provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits;

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(6) You have completed the financial statement, if required, and have agreed upon what portion, if any, you are required to for your VR services; and

(7) The service provider meets all federal, state, and agency requirements for approval as a DVR service provider.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0300, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0310 What VR services are provided without determining whether services or benefits are available from another program or organization? DVR is not required to determine whether the following services or benefits can be provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits:

- (1) Assessment services to determine eligibility and/or VR needs;
- (2) Counseling and guidance, including information and referral;
- (3) Independent living services and evaluations provided by DVR staff;
- (4) Job placement and job retention services;
- (5) Rehabilitation technology services;
- (6) Post-employment services when providing the services listed in subsection (1) through (5) above.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0310, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0320 What if looking for services and benefits available from another program would delay or interrupt my progress toward achieving an employment outcome? (1) A DVR counselor may begin providing VR services without conducting a review to determine whether services or benefits can be provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits if the review would delay or interrupt:

- (a) VR services to an individual determined to be at extreme medical risk, based on medical evidence provided by a qualified professional;
 - (b) An immediate job placement; or
 - (c) Your progress toward achieving the employment outcome identified on your individual plan for employment.
- (2) If you receive VR services before services or benefits are available from another program, you begin using the services and benefits from the other program when they become available.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0320, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0325 Does DVR pay for a VR service if services and benefits are available from another program or organization, but I don't want to use them?

[Title 388 WAC—p. 1419]

Except for the services outlined in WAC 388-891-0310, DVR does not pay for services or benefits that can be provided to you or paid for, in whole or in part, by other federal, state, or local public agencies, by health insurance, or by employee benefits. If you choose not to apply for and use the services or benefits, you are responsible for the cost of the services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0325, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0330 Does DVR consider academic awards and scholarships as income? Academic awards and scholarships you earn based on merit are not counted as income for purposes of determining your participation in the cost of services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0330, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0340 How does DVR determine whether I must pay part of my VR services using my own financial resources? (1) To determine whether you are required to pay a portion of VR services using your own financial resources:

(a) You must complete a DVR financial statement to document your financial status, except for the services outlined in WAC 388-891-0365;

(b) You must provide copies of financial records requested by DVR to establish your financial status.

(2) Depending on your income tax filing status for the most recent tax year, you must provide financial information based on your own individual resources or based on your family resources.

(a) If your income tax status was reported as married filing jointly, married filing separately, or you were listed as a dependent of another person, complete the financial statement based on family resources.

(b) If your income tax status was reported as single, complete the financial statement based on your own financial resources.

(3) If you fail to report your financial status accurately or fail to provide the required information, DVR may deny or suspend services at any time in the rehabilitation process, except the services listed under WAC 388-891-0365.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0340, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0345 Do I have to pay a portion of my VR services if I receive assistance or income support from another public program? If you provide verification that you receive benefits from one of the following programs, you are not required to pay any portion of your VR services.

(1) Department of social and health services (DSHS) income assistance;

(2) Medicaid; or

(3) Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0345, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0350 What financial information does DVR use to decide if I need to help pay for VR services?

(1) You complete a DVR financial statement to disclose the following information used to determine whether you must pay any part of the cost of VR services:

(a) Income from all sources, assets, including but not limited to bank accounts, vehicles, personal property, stocks, bonds, and trusts; and

(b) Living expenses, including household expenses, credit or loan payments, disability-related expenses and other financial obligations.

(2) If the results of the financial statement show that you do not have resources available to help pay for your VR services, DVR provides the services at no cost to you.

(3) If you decline to complete the financial statement or decline to contribute to the cost of VR services, DVR provides only those services listed under WAC 388-891-0365.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0350, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0355 How is the amount I pay for VR services determined? After completing the financial statement, you and a DVR counselor agree how to use the resources identified on the financial statement to help pay for VR services. The costs you agree to pay are documented on the individualized plan for employment (IPE). If your financial status changes, you are required to report the changes to your DVR counselor.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0355, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0360 What personal resources are not counted in the decision about whether I have to help pay for services? DVR does not count the following resources when deciding whether you need to help pay for DVR:

(1) The value of your primary home and furnishings;

(2) The value of items that you keep because of personal attachment, rather than because of monetary value;

(3) The value of one vehicle per household member needed for work, school, or to participate in VR services;

(4) Retirement, insurance, or trust accounts that do not pay a current benefit to you or your family;

(5) If a retirement, insurance or trust account pays a current benefit, only the monthly benefit is counted as income and the balance of the account is excluded;

(6) Awards or scholarships you earn based on merit;

(7) Up to five thousand dollars of your total assets are excluded as exempt;

(8) Equipment or machinery used to produce income;

(9) Livestock used to produce income; and

(10) Disability-related items and/or services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0360, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0365 What VR program services am I not required to help pay for? You are not required to pay any portion of the following VR services, regardless of your financial status:

(1) Assessment services to determine eligibility or VR needs, including independent living evaluations;

(2) Counseling and guidance services provided by DVR staff;

(3) Information and referral services;

(4) Interpreter and reader services;

(5) Personal assistance services;

(6) Job placement;

(7) Job retention services;

(8) Independent living services provided directly by DVR staff; and

(9) Post-employment services that include any of the services in subsections (1) through (8) above.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0365, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0370 Can I select the services and service provider of my choice? (1) You may select VR services that you need to achieve an employment outcome that is consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

(2) You may select the service provider of your choice if the service provider meets the following conditions:

(a) DVR pays for services that meet your needs at the least cost possible.

(i) If two or more service providers or programs offer comparable services but differ in cost, and you choose the higher cost service or program, you are responsible for those costs in excess of the lower cost service. You can use resources other than DVR funds to pay the remaining cost.

(ii) DVR may pay for a service or program at a higher cost than another service or program if the costs are reasonably comparable.

(b) The service provider meets all federal, state, and DVR requirements for DVR approval.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0370, filed 12/20/02, effective 2/3/03.]

(2007 Ed.)

INFORMED CHOICE

WAC 388-891-0400 What is informed choice?

Informed choice is the process by which an individual receiving services from DVR makes decisions about VR goals and the VR services and service providers necessary to reach those goals. The decision-making process takes into account the individual's values, lifestyle, and characteristics, the availability of resources and alternatives, and general economic conditions. Informed choice involves communicating clearly with an individual receiving VR services to assure the individual understands and uses pertinent information in the decision making process. The intent of informed choice is to ensure VR services are provided in a manner that promotes respect for individual dignity, personal responsibility, self-determination, and the pursuit of meaningful careers.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0400, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0410 How does DVR support the informed choice process? DVR supports the informed choice process by providing counseling and guidance, information and support to help you make choices that match your strengths, resources, priorities, concerns, abilities, capabilities, and interests, including:

(1) Explaining what choices you can make throughout the rehabilitation process;

(2) Assisting you to identify and get the information you need to explore the options available; and

(3) Helping you understand and evaluate the options.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0410, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0420 What if I don't know how to use the informed choice decision making process? DVR explains how to use informed choice to make decisions about VR goals and services. If it is difficult for you to make informed choices, DVR can help you understand the options available and choose the one that meets your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0420, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0430 What decisions can I make using informed choice? You have the right to make informed choices about VR goals and services throughout the rehabilitation process, including but not limited to:

(1) What assessment services and/or service provider(s) you will use to get the information necessary for DVR to determine eligibility and/or identify your VR needs;

(2) What to include on your individualized plan for employment (IPE), including:

(a) Type of employment outcome and setting;

(b) VR services needed to achieve the employment outcome;

(c) Service provider(s) that will provide the service and setting in which to receive the services; and

(d) Method(s) of arranging and paying for services, from the methods available to DVR under state law and agency policy.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0430, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0440 What information and assistance will DVR provide to help me make informed choices about VR services and service providers? To help you select the VR services you need to achieve an employment outcome and the service provider(s) to use, DVR will help you get the following information, to the extent the information is available and/or appropriate:

- (1) Cost, accessibility, and duration of services;
- (2) Consumer satisfaction with those services;
- (3) Qualifications of potential service providers;
- (4) Type(s) of services offered by each service provider;
- (5) Type of setting in which the services are provided, including whether the setting is integrated or nonintegrated; and
- (6) Outcomes achieved by others served by the service provider.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0440, filed 12/20/02, effective 2/3/03.]

ORDER OF SELECTION

WAC 388-891-0500 What happens if DVR cannot serve every eligible person? If DVR cannot serve all eligible individuals, because there are not enough funds or other resources, DVR must:

- (1) Establish a statewide waiting list for services;
- (2) Implement a process called order of selection that establishes the order in which DVR selects eligible individuals from the waiting list to begin receiving VR services; and
- (3) Provide you with information and guidance (which may include counseling and referral for job placement) about other federal or state programs that offer services to help you meet your employment needs, if available.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0500, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0510 How are individuals selected for services when DVR is operating under an order of selection? When DVR is operating under an order of selection, individuals are selected for services as follows:

- (1) At the time you are determined eligible for VR services, a DVR counselor establishes a priority for services category based on the severity of your disability.

(2) As resources become available for DVR to serve additional individuals, DVR selects names from the waiting list in the priority category being served at that time.

(3) The priority categories include:

(a) Priority category 1—Individuals with most severe disabilities;

(b) Priority category 2—Individuals with severe disabilities; and

(c) Priority category 3—Individuals with disabilities.

(4) Within a priority category, the date you applied for VR services determines the order in which you are selected from the waiting list.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0510, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0520 What is the criteria for priority category 1—Individuals with most severe disabilities? DVR determines you are in priority category 1—Individuals with most severe disabilities, if you meet the following criteria:

- (1) You require supported employment; and/or
- (2) You meet the criteria for an individual with a severe disability as defined in WAC 388-891-0530, you require two or more VR services over an extended period of time (twelve months or more) and you experience serious functional losses in four or more of the following areas in terms of an employment outcome:

- (a) Mobility;
- (b) Communication;
- (c) Self-care;
- (d) Self-direction;
- (e) Interpersonal skills;
- (f) Work tolerance; or
- (g) Work skills.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0520, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0530 What is the criteria for priority category 2—Individuals with severe disabilities? DVR determines you are in priority category 2—Individuals with severe disabilities if:

- (1) You are receiving disability benefits under Title II or Title XVI of the Social Security Act, but do not meet the criteria for priority category 1; and/or

(2) You meet the eligibility requirements outlined in WAC 388-891-0540, you require two or more VR services over an extended period of time (twelve months or more) and, you experience serious functional losses in one to three of the following areas in terms of an employment outcome:

- (a) Mobility;
- (b) Communication;
- (c) Self-care;
- (d) Self-direction;
- (e) Interpersonal skills;
- (f) Work tolerance; or
- (g) Work skills.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0530, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0540 What is the criteria for priority category 3—Individuals with disabilities? DVR determines you are in priority category 3—Individuals with disabilities if you meet the eligibility requirements outlined in WAC 388-891-1000, but you do not meet the criteria for priority category 1 or priority category 2.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0540, filed 12/20/02, effective 2/3/03.]

VR SERVICES

WAC 388-891-0600 What vocational rehabilitation services are available to individuals from DVR? The following VR services are available to individuals from DVR:

- (1) Assessment services;
- (2) Independent living evaluation and services;
- (3) Information and referral services;
- (4) Interpreter services;
- (5) Job placement services;
- (6) Job retention services;
- (7) Maintenance services;
- (8) Occupational licenses;
- (9) Personal assistance services;
- (10) Physical and mental restoration services;
- (11) Rehabilitation technology services;
- (12) Self-employment services;
- (13) Services to family members;
- (14) Substantial counseling and guidance services;
- (15) Tools, equipment, initial stocks and supplies;
- (16) Training services;
- (17) Transition services;
- (18) Translation services;
- (19) Transportation services;
- (20) Other services; and
- (21) Post-employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0600, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0605 What are assessment services? Assessment services, including services provided in a trial work experience or extended evaluation, are provided to obtain information necessary to determine:

- (1) Whether you are eligible for VR services;
- (2) Severity of disability and priority category; and/or
- (3) The employment outcome and VR services to be included in an individualized plan for employment.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0605, filed 12/20/02, effective 2/3/03.]

(2007 Ed.)

WAC 388-891-0610 What are independent living services and/or evaluation? Independent living services and/or evaluation includes services provided to:

(1) Identify issues that present problems for you in achieving an employment outcome and services you need to address the issues.

(2) Help you manage the services you need to live independently, get information about benefits available to you and about your rights and responsibilities.

(3) Help you set personal goals, make decisions about life issues and employment, and help your family with issues related to your disability and independence.

(4) Help you manage and balance your life in areas such as budgeting, meal preparation and nutrition, shopping, hygiene, time management, recreation, community resources, and attendant management.

(5) Find out about housing resources and the qualifications, make decisions about the living arrangements and about changing to a more independent living arrangement.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0610, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0615 What are information and referral services? Information and referral services include information and guidance provided to help you explore employment services or benefits available to you from other programs, including other programs within the workforce development system.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0615, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0620 What are interpreter services? Interpreter services include sign language or oral interpretation services for individuals who are deaf or hard of hearing, and tactile interpretation services for individuals who are deaf-blind.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0620, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0625 What are job placement services? Job placement means referral to a specific job that results in a job placement.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0625, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0630 What are job retention services? Job retention means services provided after you have been placed in a job to help you achieve satisfactory performance and keep the job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chap-

ters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0630, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0635 What are maintenance services?

Maintenance includes monetary support for expenses such as food, shelter, or clothing that are in excess of your usual living expenses that you need to participate in another VR service. The following examples include, but are not limited to, the ways maintenance may be used:

- (1) A uniform or other suitable clothing required to look for or get a job;
- (2) Short-term lodging and meals required to participate in assessment or training services not within commuting distance of your home; and
- (3) A security deposit or utility hook-ups on housing you need to relocate for a job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0635, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0640 What are occupational licenses?

Occupational licenses are licenses, permits, certificates or bonds showing you meet certain standards or have accomplished certain achievements and/or have paid dues, fees or otherwise qualify to engage in a business, a specific occupation or trade, or other work.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0640, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0645 What are personal assistance services? (1) Personal assistance services include a range of services provided by at least one person to help you perform daily living activities on or off the job that you would perform without assistance if you did not have a disability. Examples include, but are not limited to:

(a) Reader services for individuals who cannot read print because of blindness or other disability. In addition to reading aloud, reader services include transcription of printed information into Braille or sound recordings. Reader services are generally for people who are blind, but may also include individuals unable to read because of serious neurological disorders, specific learning disabilities, or other physical or mental impairments.

(b) Personal attendant services are personal services that an attendant performs for an individual with a disability, including, but not limited to, bathing, feeding, dressing, providing mobility and transportation.

(2) Personal assistance services are only provided in connection with one or more other VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0645, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0650 What are physical and mental restoration services? (1) Physical and mental restoration

services are used to diagnose and treat physical and mental impairments.

(2) DVR provides physical and mental restoration services if your disabling condition is stable or slowly progressive and the service is expected to substantially modify, correct, or improve a physical or mental impairment that is a substantial impediment to employment for you within a reasonable length of time and financial support is not readily available from another source, such as health insurance.

(3) Physical and mental restoration services include:

- (a) Corrective surgery or therapy;
- (b) Diagnosis and treatment of mental or emotional disorders by qualified personnel who meet state licensing requirements;
- (c) Dental treatment if the treatment is directly related to an employment outcome, or in emergency situations involving pain, acute infections, or injury;

(d) Nursing services;

(e) Hospitalization (in-patient or outpatient) in connection with surgery or treatment and clinic services;

(f) Drugs and supplies;

(g) Prosthetic and orthotic devices;

(h) Eyeglasses and visual services, including visual training, and the examination and services necessary for the prescription and provision of eyeglasses, contact lenses, microscopic lenses, telescopic lenses, and other special visual aids;

(i) Podiatry;

(j) Physical therapy;

(k) Occupational therapy;

(l) Speech or hearing therapy;

(m) Mental health services;

(n) Treatment of acute or chronic medical conditions and emergencies that result from providing physical and mental restoration services, or that are related to the condition being treated;

(o) Special services for the treatment of end-stage renal disease; and

(p) Other medical or medically-related rehabilitation services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0650, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0655 What are the medical treatments DVR does not pay for? DVR does not pay for the following medical treatments:

(1) Maintenance of your general health or fitness, including, but not limited to, vitamins, in-patient hospital based weight loss programs or for-profit weight loss programs, exercise programs, health spas, swim programs and athletic fitness clubs;

(2) Cosmetic procedures, such as facelifts, liposuction, cellulite removal;

(3) Maternity care;

(4) Hysterectomies, elective abortions, sterilization, and contraceptive services as independent procedures;

(5) Drugs not approved by the Federal Drug Administration for general use or by state law;

- (6) Life support systems, services, and hospice care;
- (7) Transgender services including surgery and medication management;
- (8) Homeopathic and herbalist services, Christian Science practitioners or theological healers; and
- (9) Treatment that is experimental, obsolete, investigational, or otherwise not established as effective medical treatment.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0655, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0660 What is rehabilitation technology? Rehabilitation technology includes the use of technology, engineering methods and sciences to design, develop, test, evaluate, apply and distribute technology to address problems faced by individuals with disabilities in functional areas such as mobility, communication, hearing, vision and cognition. Rehabilitation technology includes:

(1) Assistive technology devices, equipment, or products used to increase, maintain, or improve the functional capabilities of an individual with a disability including, but not limited to:

- (a) Telecommunications devices;
- (b) Sensory aids and devices, including hearing aids, telephone amplifiers and other hearing devices, captioned videos, taped text, Brailled and large print materials, electronic formats, graphics, simple language materials, and other special visual aids;
- (c) Vehicle modifications; and
- (d) Computer and computer-related hardware and software that is provided to address a disability-related limitation.

(2) Services that assist you in the selection, acquisition, or use of an assistive technology device, including services to:

- (a) Evaluate your needs in performing activities in your daily environment;
- (b) Select, design, fit, customize, adapt, apply, maintain, repair, or replace an assistive technology device;
- (c) Coordinate and use other therapies or services with assistive technology devices, such as education and rehabilitation plans and programs;
- (d) Train or give technical assistance to professionals, employers, family members or others who provide services to you, hire you, or are involved in your major life activities.

- (3) Real time captioning services;
- (4) A written policy, plan, guarantee or warranty (initial or extended) that covers the cost to repair or replace an assistive technology device, a piece of equipment, or another assistive technology product if it is lost or damaged.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0660, filed 12/20/02, effective 2/3/03.]

(2007 Ed.)

WAC 388-891-0665 Under what conditions does DVR provide vehicle modifications as a rehabilitation technology service? DVR provides vehicle modifications under the following conditions:

(1) DVR does not have a question about your driving safety as outlined in WAC 388-891-0775.

(2) The DVR counselor has determined based on disability-related documentation that your disability is stable or slowly progressive and not likely to impair your driving ability in the future, if you plan to drive the vehicle.

(3) You have provided documentation verifying that you and/or a family member is the registered and/or legal owner of the vehicle.

(4) You have provided a copy of a current driver's license and vehicle license with required endorsements for you and/or family member(s) who will operate the vehicle.

(5) If a used vehicle is to be modified, you have provided documentation of an inspection from a certified or journey level auto mechanic that verifies the vehicle is in good condition and capable of being modified.

(6) DVR has obtained documentation from a specialist in evaluation and modification of vehicles for individuals with disabilities that prescribes and inspects the modification, except prescriptions are not required for:

- (a) Placement of a wheelchair lift, ramp, or scooter lift and tie downs for passenger access only;
- (b) Replacement of hand controls;
- (c) Wheelchair carriers; and
- (d) Other minor driving aids.

(7) You have provided documentation of vehicle insurance adequate to cover the cost of replacement for loss or damage, including the cost of the modification.

(8) You have demonstrated or provided documentation that verifies you and/or family member(s) designated as a driver can safely operate the vehicle as modified.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0665, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0670 What types of insurance can DVR pay for? (1) DVR may pay for insurance for assistive technology devices, equipment and products.

(2) DVR does not pay for other types of insurance including, but not limited to, health, vehicle, home, and life insurance.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0670, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0675 What types of assistive technology insurance can DVR pay for? DVR may pay for insurance for assistive technology devices, equipment, and products which covers the cost to repair or replace them if they are lost or damaged if:

(1) The individual with a disability is the holder of the device, equipment or product and is the named insured under the policy; and

(2) The insurer pays for replacement or repair directly to the manufacturer or service provider.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0675, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0680 What types of assistive technology warranties can DVR pay for? (1) DVR may pay for an initial warranty for an assistive technology device, piece of equipment, or product for a specified period of time following the date of purchase if the warranty is available at the time of purchase by the manufacturer. An initial warranty may guarantee repair and/or replacement of parts or the entire device, equipment, or product when the parts and/or workmanship are faulty.

(2) DVR may pay for an initial warranty or for a warranty that extends beyond the period of coverage of an initial warranty for an assistive technology device, piece of equipment, or product if:

(a) The individual with a disability is the holder of the device, equipment, or product;

(b) The manufacturer provides a written guarantee for the materials and workmanship of the device, equipment, or product; and

(c) The manufacturer replaces or repairs faulty parts and workmanship or replaces the device, equipment, or product in whole or the manufacturer directly pays a service provider to repair or replace parts and workmanship or the device, equipment, or product in whole.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0680, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0685 What are self-employment services? Self-employment services include consultation and technical assistance to help you establish a small business to become self-employed and equipment, tools, initial stocks and supplies. Before a DVR counselor agrees to an IPE that includes a self-employment outcome, you must complete assessment services, including the development of a business plan that demonstrates that the self-employment you are considering is feasible, sustainable, and results in an employment outcome. DVR does not support hobbies or activities that do not result in an income-producing self-employment outcome.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0685, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0690 What vocational rehabilitation services can DVR provide to my family member(s)? Vocational rehabilitation services may be provided to a family member if the services are necessary for you to achieve an employment outcome. A family member includes a relative or guardian of an applicant or eligible individual or an individual who lives in the same household as the applicant or

eligible individual and has a substantial interest in her or his well being.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0690, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0695 What types of child care does DVR provide to my family members? (1) DVR pays for the following types of licensed child care and child care exempt from licensing in conformance with DSHS licensing or certification requirements and background check requirements:

(a) Child day care centers;

(b) Family child day care homes; and

(c) School-age child care centers.

(2) DVR pays for in-home or relative child care including:

(a) Child care provided to your child(ren) in your home by a relative or other person; and

(b) Child care provided to your child(ren) by a relative outside of your home.

(3) To be authorized as an in-home/relative child care provider for DVR payment, your in-home or relative child care provider must comply with background check requirements outlined in chapter 388-290 WAC.

(4) DVR pays for child care in states bordering Washington if the child care provider meet their state's licensing regulations.

(5) DVR pays the child care provider's usual rates for child care services directly to the child care provider.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0695, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0700 What is substantial counseling and guidance? Substantial counseling and guidance includes intensive counseling and guidance provided by a DVR counselor throughout the rehabilitation process to help you address medical, family or social issues, vocational counseling, or other counseling and guidance that is over and above the usual counseling and guidance relationship. Substantial counseling and guidance services include counseling and guidance to support a self-directed job search.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0700, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0705 What are tools, equipment, initial stocks and supplies? Tools, equipment, initial stocks and supplies are materials and hardware required to carry out the duties of a job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0705, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0710 What are training services?

Training services are designed to help you gain knowledge, skills and abilities needed to achieve an employment outcome. Training services, include, but are not limited to:

- (1) On-the-job training;
- (2) Post-secondary training;
- (3) Technical or vocational training;
- (4) Basic education/literacy training;
- (5) Community rehabilitation program (CRP) training;
- (6) Other miscellaneous training.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0710, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0715 What is on-the-job training?

On-the-job training is training an employer provides to you after you are placed in a job to help you learn the skills you need. The employer must sign an agreement to include at a minimum:

- (1) Training to be provided, including skills to be learned and training methods;
- (2) Duration or number of hours of training to be provided;
- (3) How the employer will evaluate and report your progress to DVR;
- (4) An agreed-upon fee based on the employer's costs to provide the training; and
- (5) Payment criteria.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0715, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0720 What is post-secondary training? Post-secondary training means academic training above the high school level leading to a degree, an academic certificate, or other recognized educational credential. Post-secondary training is provided by a college or university, community college, junior college or technical college.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0720, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0725 What is technical or vocational training? Technical or vocational training includes occupational, vocational or specific job skill training, not leading to an academic degree, provided by a community college, business school, vocational, technical or trade school to prepare for work in a specific occupation.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0725, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0730 What is basic education/literacy training? Basic education/literacy training teaches basic academic skills, including how to read.

(2007 Ed.)

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0730, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0735 What is community rehabilitation program (CRP) training? Community rehabilitation program (CRP) training is training to prepare an individual for work, such as developing appropriate work habits and behaviors, getting to work on time, dressing appropriately, and/or skills to increase productivity.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0735, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0740 What other training does DVR provide? DVR provides other miscellaneous training services that are not identified in another section, such as high school completion, speech reading or sign language training, cognitive training and tutoring.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0740, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0745 What conditions apply to receiving training services at an institution of higher education?

(1) Training at an institution of higher education (universities, colleges, community or junior colleges, vocational schools, technical institutes, or hospital schools of nursing) is provided only after you and a DVR counselor have made maximum efforts to get and use available grant funding from other sources to pay for costs related to attendance. Grant funding does not include student loans.

(2) You must provide DVR a copy of your grant funding award or denial form, statement of unmet need and/or student budget, and other related documentation.

(3) If an academic institution charges a fee to cover the cost of a student health clinic and the fee is required as a condition of registration, DVR may pay this fee.

(4) If an academic institution charges a liability fee to cover the costs of a student to register in high-risk courses/practicum and the fee is required as a condition of registration, DVR may pay this fee.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0745, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0750 Can I receive training services from a private school, an out-of-state training agency or an out-of-state college? If you choose training services at a private or out-of-state program when an in-state or public program is available and adequate to meet your needs, you are responsible for costs that are in excess of the public or in-state program costs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chap-

ters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0750, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0755 What are transition services? (1)

Transition services are work-related activities you begin while you are in high school that are coordinated with VR services to help you prepare for and go to work in the community after you leave high school.

(2) Transition services may include any of the VR services listed under WAC 388-891-0600.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0755, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0760 What are translation services?

Translation services include oral and written translation of English into the primary language of an applicant or eligible individual.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0760, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0765 What are transportation services? Transportation services include travel and related expenses necessary for you to participate in VR services, such as a bus pass, reimbursement for gasoline, purchase or repair of a vehicle.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0765, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0770 Under what conditions does DVR provide a vehicle? (1) DVR provides a vehicle as a transportation service only in exceptional circumstances to support another VR service on the IPE and must be approved by the director or his or her designee.

(2) A vehicle issued to you remains the property of DVR until you achieve an employment outcome that requires the vehicle and you maintain the employment for at least ninety days.

(3) The director or his or her designee approves the purchase of a vehicle only if:

(a) A DVR counselor determines, based on disability-related documentation that your disability is stable or slowly progressive, and is not likely to impair your ability to drive in the future;

(b) You and a DVR counselor agree it is a necessary service under your individualized plan for employment (IPE) because:

(i) No other transportation options are available and it is not feasible for you to relocate to live closer to employment or other transportation options; or

(ii) A vehicle is required as a condition of employment.

(c) You do not have a vehicle or your vehicle cannot be modified or repaired to the extent that you can drive it.

[Title 388 WAC—p. 1428]

(4) Prior to issuing a vehicle to you, you must submit the following documents to DVR and you must agree to provide ongoing verification upon request of a DVR counselor:

(a) A copy of your current, valid driver's license;

(b) A copy of your driving record disclosing any moving violations and indicating no criminal convictions related to driving a vehicle;

(c) A copy of your motor vehicle insurance coverage with the following minimum coverage and conditions:

(i) Liability in the amount of fifty thousand dollars/one hundred thousand dollars/fifty thousand dollars;

(ii) Uninsured motorist in the amount of fifty thousand dollars/one hundred thousand dollars/fifty thousand dollars;

(iii) Personal injury in the amount of one hundred thousand dollars;

(iv) Replacement cost of the vehicle, including special equipment and modifications, if applicable;

(v) DVR is listed as the lien holder; and

(vi) All drivers who use the vehicle are listed on the policy.

(d) You have signed a written agreement with your DVR counselor that outlines how you will pay for vehicle maintenance and repair, as this is a requirement for subsequent ownership of the vehicle;

(e) You have signed an agreement to return the vehicle to DVR upon request as long as DVR owns the vehicle.

(5) Before DVR transfers ownership of a vehicle to you, you must submit documentation to verify:

(a) You are the registered owner of the vehicle;

(b) The vehicle is insured to cover the cost of replacement for loss or damage at the time ownership is transferred.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0770, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0775 What happens if DVR has a question about my driving safety? (1) DVR does not provide services to facilitate your driving or that of a driver using your vehicle if:

(a) Either you or the driver are uninsured; or

(b) DVR is aware of any fact which raises a question regarding driving safety.

(2) Services to facilitate your driving include, but are not limited to, vehicle modifications provided as a rehabilitation technology service, car repairs, gasoline money, driver license, and license tabs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0775, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0780 What other services does DVR provide? DVR can provide other services not identified in this chapter when the service is needed for you to achieve an employment outcome.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130,

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and chapter 26.44 RCW. 03-02-014, § 388-891-0780, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0790 What are post-employment services? Post employment services include one or more vocational rehabilitation services provided if:

- (1) Your case was closed within the past three years because you achieved an employment outcome;
- (2) Your rehabilitation needs are limited in scope and duration;
- (3) You need post-employment services to maintain, regain or advance in employment that is consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0790, filed 12/20/02, effective 2/3/03.]

SUPPORTED EMPLOYMENT

WAC 388-891-0800 What is supported employment?

- (1) Supported employment is:
 - (a) Competitive work; or
 - (b) Work in an integrated setting while you work toward competitive work consistent with your strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice; or
 - (c) Transitional employment for an individual with a most severe disability due to chronic mental illness.
- (2) Supported employment is for an individual with a most severe disability who:
 - (a) Has not traditionally worked in competitive employment; or
 - (b) Has worked in competitive employment, but the disability has caused the individual to stop working, or work off and on; and
 - (c) Needs intensive supported employment services and extended services to work because of the nature and severity of the disability.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0800, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0810 Who is eligible for supported employment? You are eligible for supported employment services if:

- (1) You are eligible for vocational rehabilitation services under WAC 388-891-1000;
- (2) You have been determined to be an individual with a most severe disability; and
- (3) Supported employment is appropriate for you based on a comprehensive assessment of your needs, including an evaluation of your rehabilitation, career and job needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0810, filed 12/20/02, effective 2/3/03.]

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WAC 388-891-0815 Who decides if I am eligible for supported employment? DVR decides if you are eligible for supported employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0815, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0820 What is competitive work in supported employment? Competitive work, as used in supported employment, is:

- (1) Work in the competitive labor market that you perform on a full-time or part-time basis in an integrated setting; and
- (2) Work for which you are paid at or above the minimum wage, but not less than the usual wage your employer pays to nondisabled employees who do the same or similar work as you.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0820, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0825 What is an integrated setting in supported employment? An integrated setting in supported employment is a work setting commonly found in the community in which you interact with nondisabled people to the same extent that a nondisabled person in the same type of job interacts with other persons.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0825, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0830 Is my work setting integrated if my interactions at the work site are with nondisabled supported employment service providers? Interactions at your work site between you and a nondisabled supported employment service provider do not meet the requirement for an integrated setting.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0830, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0835 What is transitional employment? Transitional employment is a supported employment work model using a series of consecutive jobs in competitive employment for individuals with the most severe disabilities due to mental illness. In transitional employment, ongoing support services must include continuing sequential job placement until job permanency is achieved.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0835, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0840 What are supported employment services? Supported employment services are:

- (1) Ongoing support services as described in WAC 388-891-0845; and
- (2) Vocational rehabilitation services listed in WAC 388-891-0600.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0840, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0845 What are ongoing support services? Ongoing support is a type of supported employment service to help you get and keep a job. Ongoing support services include:

- (1) An assessment of your employment situation at least twice a month, or under special circumstances and especially at your request, an assessment regarding your employment situation that takes place away from your worksite at least twice a month to:

- (a) Determine what is needed to maintain job stability; and

- (b) Coordinate services or provide specific intensive services that are needed at or away from your worksite to help you maintain job stability.

- (2) Intensive job skill training for you at your job site by skilled job trainers;

- (3) Job development, job placement and job retention services;

- (4) Social skills training;

- (5) Regular observation or supervision;

- (6) Follow-up services such as regular contact with your employer, you, your representatives, and other appropriate individuals to help strengthen and stabilize the job placement;

- (7) Facilitation of natural supports at the worksite;

- (8) Other services similar to services described in subsection (1) through (7) above; and

- (9) Any other vocational rehabilitation service.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0845, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0850 What are extended services? Extended services help you keep your job after DVR stops providing or paying for supported employment services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0850, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0855 Does DVR provide extended services? DVR does not provide extended services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0855, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0860 Who provides the extended services I need? Extended services are provided by nonprofit private organizations such as community rehabilitation programs, state and local public agencies, employers, or any other appropriate resources.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0860, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0865 What is natural support? Natural support is a method used to help you keep your job after DVR stops providing supported employment services. Natural support uses the people who you ordinarily come into contact with at work and/or at home to help you with work routines and social interactions at the worksite.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0865, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0870 Are supported employment services time-limited? DVR provides supported employment services as part of your individualized plan for employment for a period not to exceed eighteen months, unless under special circumstances you and your DVR counselor jointly agree to extend the time in order to achieve the employment goals in your individualized plan for employment.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0870, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0875 What is required for me to change from supported employment services to extended services? Prior to helping you change from supported employment services to extended services, a DVR counselor must ensure the following:

- (1) You have made substantial progress toward meeting the number of work hours per week you want to work as documented on your individualized plan for employment;

- (2) You are stabilized in the job; and

- (3) Extended services are readily available and can be provided to you without an interruption in services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0875, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0880 What happens if my DVR counselor and I do not find a source for extended services and/or we cannot establish natural supports during the initial eighteen months of my individualized plan for employment? If you and your DVR counselor do not find a source for extended services and/or cannot establish natural supports during the initial eighteen months of your individualized plan for employment, DVR must determine that you are no longer eligible for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0880, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0885 Under what conditions does DVR close my case service record for supported employment? If you have achieved a supported employment outcome, DVR must wait at least ninety days after helping you change from supported employment services to extended services before closing your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0885, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0890 Under what conditions does DVR provide supported employment services as post-employment services? DVR provides supported employment services to you as post-employment services following the change from supported employment services to extended services if:

- (1) Your extended service provider cannot provide the services; and
- (2) You need such services as job station redesign, repair and maintenance of assistive technology devices and replacement of prosthetic and orthotic devices to keep your job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0890, filed 12/20/02, effective 2/3/03.]

APPLYING FOR VR SERVICES

WAC 388-891-0900 Who can apply for vocational rehabilitation services? Any individual who intends to achieve an employment outcome may apply for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0900, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0910 Am I required to provide proof of my identity and work status? Before DVR pays for VR services, including assessment services, you must provide copies of documents requested by DVR that verify your identity and, if you are not a United States citizen, your legal work status.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0910, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0920 If I don't live in Washington, can I receive VR services? The state in which you live has the primary responsibility to provide VR services to you. If you are not a resident of Washington state, you may receive VR services if you maintain a home, are registered to vote, or are otherwise present in the state.

(2007 Ed.)

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0920, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0930 Can I receive VR services if I am legally blind? The Washington state department of services for the blind, under an agreement with DVR, is the primary agency responsible for providing vocational rehabilitation services to individuals who are blind or have a visual impairment resulting in an impediment to employment. DSB and DVR may coordinate to provide joint services if you would benefit from such coordination.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0930, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0940 Can I receive VR services if I am Native American? DVR serves eligible Native Americans, including Native Americans who belong to an Indian tribe. If you live on an Indian reservation that operates a vocational rehabilitation program, you may apply for VR services from the tribe or from DVR, or from both agencies.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0940, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0950 How do I contact DVR if I don't speak English? If you don't speak English, you may request another type of communication to enable you to meet with DVR. DVR arranges and pays for services you need to communicate with DVR to apply for or receive VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0950, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0960 What other methods of communication does DVR use? DVR uses equipment, devices or other services you need to understand and respond to information. Methods DVR can use to communicate with you include, but are not limited to, the use of:

- (1) Interpreters;
- (2) Readers;
- (3) Captioned videos;
- (4) Telecommunications devices and services;
- (5) Taped text;
- (6) Braille and large print materials; and
- (7) Electronic formats.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0960, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0970 Does DVR translate written communication for people who don't speak English? (1) DVR translates the following written communication into the primary language of an applicant or eligible individual:

- (a) Application for VR services;
- (b) Notification of eligibility or ineligibility;
- (c) Plan for employment;
- (d) Notification of case closure;
- (e) Notification of annual review, if appropriate; and
- (f) Any notice requiring a response or a signature from the individual to continue receiving services.

(2) DVR translates the Washington Administrative Code (WAC) regarding VR services or service providers into the primary language of an applicant or eligible individual upon his or her request.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0970, filed 12/20/02, effective 2/3/03.]

WAC 388-891-0980 How do I apply for VR services? You have completed the application requirements when you:

- (1) Have provided information needed to begin an assessment of eligibility and VR needs.
- (2) Are available to participate in assessment services necessary to determine if you are eligible for VR services.
- (3) Have signed an application form provided by DVR or provided a written request that includes the following information:
 - (a) Your name, address and county;
 - (b) The nature of your disability;
 - (c) Your birth date and gender;
 - (d) The date of application; and
 - (e) Your Social Security Number (optional).

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-0980, filed 12/20/02, effective 2/3/03.]

ELIGIBILITY

WAC 388-891-1000 Who is eligible to receive VR services? You are eligible for VR services if a DVR counselor determines that you meet all of the following criteria:

- (1) You have a physical, mental, or sensory impairment that results in a substantial impediment to employment;
- (2) You require VR services to prepare for, get or keep a job that matches your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice; and
- (3) You are capable of working as a result of receiving VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1000, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1005 How does DVR determine if I am eligible? (1) A DVR counselor reviews and assesses information and records about the current status of your dis-

ability and determines whether you meet the eligibility requirements outlined in WAC 388-891-1000. A DVR counselor bases the determination on observations, education records, medical records, information provided by you or your family, and information provided by other agencies or professionals.

(a) If information or records are not current, not available, or not sufficient for a DVR Counselor to determine if you are eligible, DVR provides the assessment services necessary to get the information needed to make a decision.

(b) VR services used to collect additional information and records to determine eligibility can include trial work, assistive technology, personal assistant services, or any other support services necessary to determine if you are eligible.

(c) DVR assists you to make informed choices in the decisions related to assessment services needed to make an eligibility determination.

(d) If you refuse to provide or consent to the release of records or if you refuse to participate in VR services necessary to obtain information required to make an eligibility determination your VR case service record is closed.

(2) If you receive Social Security benefits under Title II or Title XVI of the Social Security Act and you are capable of working after receiving VR services, DVR determines you are eligible upon verification of benefits.

(a) If you cannot provide appropriate evidence, such as an award letter or other type of verification, DVR may request the verification for you, with your consent.

(b) DVR makes maximum efforts to obtain the verification in a reasonable period of time and to determine eligibility within sixty days from the date you complete the application requirements.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1005, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1010 After I submit my application to DVR, how long does it take DVR to make an eligibility decision? (1) DVR makes an eligibility decision as soon as enough information is available, but no longer than sixty days after you complete the application requirements.

(2) If DVR does not have enough information to determine your eligibility within sixty days, you and a DVR counselor must agree to:

(a) Extend the eligibility period to collect additional information or records; or

(b) Conduct a trial work experience or extended evaluation, if a DVR counselor is not certain whether VR services will enable you to achieve an employment outcome because of the severity of your disability

(3) If you do not agree to extend the eligibility period, DVR must close your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1010, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1015 What if a DVR counselor cannot presume that I am capable of working as a result of receiving VR services because of the severity of my disability? If a DVR counselor cannot presume VR services will enable you to achieve an employment outcome because of the severity of your disability, DVR will assess your ability to perform work using a trial work experience or an extended evaluation. The DVR counselor will evaluate the results of the trial work experience or extended evaluation to determine whether you can work as a result of receiving VR services and whether you are eligible for VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1015, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1020 Am I eligible for VR services if I receive Social Security disability benefits? If you receive disability benefits under Title II or XVI of the Social Security Act (SSI or SSDI), DVR presumes that you are an eligible individual.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1020, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1025 What criteria are not considered in the eligibility decision? In making an eligibility decision, DVR does not consider you:

- (1) Type of disability;
- (2) Age, gender, race, color, creed, religion, national origin, or sexual orientation;
- (3) Rehabilitation needs;
- (4) Type of employment outcome you expect to achieve;
- (5) Source of referral;
- (6) Anticipated cost of services;
- (7) Income.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1025, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1030 What is involved in a trial work experience? (1) During a trial work experience, you perform in a realistic work situation with appropriate VR services and/or supports to address your rehabilitation needs, such as supported employment, on-the-job training, assistive technology or personal assistant services. A DVR counselor develops a written plan describing the VR services to be used in the trial work experience.

(2) You participate in one or more trial work experiences over a period of time necessary to produce clear and convincing evidence for a DVR counselor to determine:

- (a) You can benefit from VR services and achieve an employment outcome and are eligible for VR services; or
- (b) You cannot benefit from VR services and achieve an employment outcome because of the severity of your disability and you are ineligible for VR services.

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(3) Trial work experiences occur in the most integrated setting possible, based on your informed choice and rehabilitation needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1030, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1035 What if I cannot participate in a trial work experience? If you cannot participate in a trial work experience or if DVR has exhausted efforts to arrange a trial work experience, DVR conducts an extended evaluation to obtain the information necessary to determine whether you are eligible for VR services or to enable you to participate in a trial work experience.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1035, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1040 What is an extended evaluation? An extended evaluation involves one or more VR services designed to assess whether you are capable of working as a result of receiving VR services. A DVR counselor develops a written plan outlining the VR services to be used during the extended evaluation. Only those services necessary to make an eligibility determination are provided. VR services are provided in the most integrated setting possible, based on your informed choice and rehabilitation needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1040, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1045 What happens if DVR determines that I am not eligible or no longer eligible for VR services? (1) Before determining that you are not eligible for VR services or that you are no longer eligible for VR services, a DVR counselor consults with you and gives you an opportunity to discuss the decision.

(2) DVR sends you a notice in writing, or using another method of communication, if needed. The notice includes:

- (a) An explanation of the reason(s) you are not eligible or no longer eligible;
- (b) Your rights to appeal the decision; and
- (c) An explanation of the services available from the client assistance program.

(3) If you are ineligible based on a determination that you cannot achieve employment because of the severity of your disability, DVR reviews the decision within twelve months.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1045, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1050 If I am not eligible for VR services, can DVR help me find other services and programs to meet my needs? If DVR determines that you are not eligi-

ble for VR services, DVR provides you with information and refers you to other agencies or organizations that may provide services to meet your employment-related needs. This may include a referral to community rehabilitation programs offering extended employment (sheltered work) if you are determined ineligible based on a determination that you are too severely disabled to achieve employment as a result of receiving VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1050, filed 12/20/02, effective 2/3/03.]

IPE DEVELOPMENT

WAC 388-891-1100 What is an assessment for determining vocational rehabilitation needs? Each person determined eligible for VR services completes an assessment of VR needs that may include:

(1) An assessment for determining vocational rehabilitation needs includes a variety of services, including counseling and guidance, to determine your unique strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

(2) The purpose of the comprehensive assessment is to collect and review information you need to select the type of employment outcome to achieve and the VR services you need to achieve the employment outcome.

(3) The comprehensive assessment is limited to services necessary to select an employment outcome and to develop a plan for employment.

(4) DVR uses existing information gathered to determine eligibility, including information provided by you and your family, to the maximum extent possible and appropriate.

(5) The comprehensive assessment may include, as needed:

(a) An assessment of the personality, interests, interpersonal skills, intelligence and related functional abilities, educational abilities, work experience, vocational aptitudes, personal and social adjustments, employment opportunities, and other vocational, educational, cultural, social, recreational, and environmental factors that affect your employment and rehabilitation needs.

(b) Work in real job situations to evaluate and/or develop work behavior and capacities necessary to achieve an employment outcome, including work skills, attitudes, habits, tolerances and social behavior.

(c) Referral for assistive technology services to assess whether services or devices could increase your ability to perform work.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1100, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1105 Do I have to disclose criminal history information to DVR? (1) You must disclose information to DVR before you develop a plan for employment about conditions or circumstances, such as a criminal record,

identity and work status, that restrict the type of employment you can legally perform.

(2) If you select an employment outcome in a field that customarily requires a background check as a condition of employment, DVR must obtain a criminal history background check that verifies you are not excluded from employment in the field and/or specific job prior to IPE development.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1105, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1110 What other assessments might be required? (1) If you have a documented history of violent or predatory behavior that reasonably leads a DVR counselor to believe you may be a threat to yourself or others, you must participate in VR services necessary to determine the level of risk.

(2) If a VR counselor determines, based on an assessment conducted by a qualified professional, that your employment may pose a threat to the safety of you or others because you meet the conditions outlined in WAC 388-891-0110, the employment outcome and employment setting you choose must be evaluated for risk by an appropriate qualified professional.

(3) If a VR counselor becomes aware of a condition or circumstance after you have developed an IPE that may affect your ability to achieve an employment outcome, the VR counselor may conduct necessary assessment services to determine whether you are capable of achieving the employment outcome identified on your IPE.

(4) If you decline to authorize the release of information to DVR or participate in VR services necessary to collect pertinent information which prevents the development of an appropriate IPE, the VR counselor may close your case service record.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1110, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1115 What is an individualized plan for employment (IPE)? An individualized plan for employment (IPE) is a DVR form that documents important decisions you and a VR counselor make about vocational rehabilitation services. The decisions documented on the IPE include, but are not limited to:

- (1) The employment outcome you plan to achieve;
- (2) Each major step you need to accomplish to reach the employment outcome;
- (3) Your responsibilities in accomplishing each step of the plan;
- (4) DVR's responsibilities in assisting you to accomplish each step of the plan;
- (5) VR services needed to complete each step;
- (6) Terms and conditions you and your VR counselor agree are required for continued support from DVR.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chap-

ters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1115, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1120 Who develops an IPE? Each eligible individual develops an IPE, unless DVR is operating under an order of selection. If DVR is operating under an order of selection, each eligible individual in the priority category being served develops an IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1120, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1125 What information does DVR provide to help me develop my IPE? DVR provides the following information to help you develop an IPE:

- (1) Information about the options available for developing an IPE.
- (2) Information that must be included in the IPE.
- (3) Financial conditions or restrictions that apply to an IPE.
- (4) How to get help completing forms required by DVR.
- (5) Information about your rights if you disagree with a decision a DVR counselor makes relating to the IPE.
- (6) Information about the client assistance program (CAP) and how to contact the program.
- (7) Other information you request.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1125, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1130 What are the options for developing an IPE? (1) You may develop an individualized plan for employment (IPE) with support and assistance from:

- (a) A VR counselor employed by DVR.
 - (b) A VR counselor not employed by DVR, but who meets the minimum qualifications for a VR counselor established by DVR.
 - (c) Another person you choose, such as a representative, family member, advocate, or other individual.
- (2) If you choose to develop the IPE with someone other than a DVR counselor, DVR can help you identify individuals that may help you develop your IPE, to the extent resources are available.

- (3) You may develop an IPE on your own.
- (4) DVR does not pay for any related costs or fees charged by other parties to develop an IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1130, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1135 Does DVR support any job I choose? (1) The employment outcome you choose must be consistent with the information and results of the assessment of your VR needs.

- (2) DVR supports an individual to achieve an employment outcome as defined in WAC 388-891-0010. If you

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choose another type of employment, DVR refers you to other programs or organizations that offer the type of employment you choose, when available.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1135, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1140 What must be included on the IPE form? An IPE must include:

- (1) An employment outcome that is consistent with the definition of employment outcome in WAC 388-891-0010;
- (2) The VR services you need to achieve the employment outcome;
- (3) Timeline for each service on your IPE and for achieving the employment outcome;
- (4) The name of the person or organization selected to provide each service included on the IPE and how you will obtain the services;
- (5) Criteria you will use to evaluate whether you are making progress toward achieving the employment outcome;
- (6) Terms and conditions, including:
 - (a) A description of what DVR has agreed to do to support your IPE; and
 - (b) A description of what you have agreed to do to reach your employment outcome, including:
 - (i) Steps you will take to achieve your employment goal;
 - (ii) Services you agree to help pay for, and how much you agree to pay; and
 - (iii) Services you agree to apply for and use that are available to you at no cost from another program.
- (7) Expected need for post-employment services prior to closing the case service record and, if appropriate, a statement of how post employment services are arranged using comparable services and benefits;
- (8) An IPE that includes a supported employment outcome must also document:
 - (a) Supported employment services to be provided;
 - (b) Extended services or natural supports that are likely to be needed;
 - (c) Who will provide and pay for natural supports or extended services. If it is not known who will provide and/or pay for extended services or natural supports at the time the IPE is developed, the IPE must include a statement explaining the basis for determining that a resource is likely to become available;
 - (d) A goal for the number of hours per week you are going to work and a plan to monitor your progress toward meeting the goal;
 - (e) A description of how the services on your IPE are coordinated with other federal or state services you get under an individualized plan;
 - (f) If job skills training is provided, the IPE must reflect that the training is provided on-site;
 - (g) Placement in an integrated setting for the maximum number of hours possible based on your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.
- (9) An IPE for a high school student who is receiving special education services is coordinated with the individual-

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ized education plan in terms of the goals, objectives, and services identified to the extent possible.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1140, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1145 When does the IPE become effective? The IPE becomes effective when it is signed by you and a DVR counselor. DVR gives you a copy of the signed IPE, in writing or in another method of communication, if needed.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1145, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1150 Is the IPE reviewed and updated? You and a qualified VR counselor review the IPE at least once a year, or more often if needed, to assess your progress in achieving an employment outcome. You and a VR counselor amend the IPE if there are major changes in the employment goal, VR services, or service provider(s). Changes to an IPE take effect when you and a DVR counselor sign the amended IPE.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1150, filed 12/20/02, effective 2/3/03.]

LOANING EQUIPMENT

WAC 388-891-1200 Under what conditions does DVR loan equipment, devices or other items to me? If you need a device, tool, piece of equipment or other item to participate in VR services or to go to work, DVR loans a new or used item to you until you achieve an employment outcome. DVR loans a used item from the DVR inventory if available at the time needed and DVR determines it is adequate to meet your needs.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1200, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1210 What if I need an item customized for my own personal needs? A DVR counselor determines whether to loan or issue a device, tool, piece of equipment or other item based on the reasonable likelihood that the item could be used by another individual if returned to DVR. If the DVR counselor determines an item could not be used by another individual if it were returned to DVR, the DVR counselor may issue the item directly to you without a loan agreement and the item is owned by you at the time of issue.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1210, filed 12/20/02, effective 2/3/03.]

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WAC 388-891-1220 What conditions apply to the use of a device, tool, piece of equipment or other item that is loaned to me? Before DVR loans an item to you, you must sign an agreement with DVR to comply with the following conditions:

- (1) You agree to immediately return the item upon request or to pay for the item if you cannot return it to DVR;
- (2) You agree to maintain the item according to DVR instructions and manufacturer's guidelines, if applicable, and keep it secure from damage, loss or theft.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1220, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1230 What happens if I fail to return a device, tool, piece of equipment or other item if requested by DVR? If DVR directs you to return an item loaned to you and you do not immediately return it, DVR reports the loss to the DSHS office of financial recovery (OFR). The OFR attempts to recover the item or payment for the item from you. If the OFR cannot recover the item or payment for the item from you, the OFR may report the loss to the local county prosecutor for legal action.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1230, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1240 What happens to a device, tool, piece of equipment or other item if I need it when my DVR case service record is closed? DVR may transfer ownership of the device, tool, piece of equipment or other item to you at the time a DVR counselor closes your case service record if you have achieved an employment outcome and you need the item to keep your job.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1240, filed 12/20/02, effective 2/3/03.]

CASE CLOSURE

WAC 388-891-1300 Why does DVR close a case service record? A DVR counselor closes your case service record for any of the following reasons:

- (1) You achieve an employment outcome;
- (2) DVR determines that you are not eligible or no longer eligible;
- (3) You are no longer available to participate in services;
- (4) You decline VR services;
- (5) You cannot be located;
- (6) You ask DVR to close your case service record; or
- (7) You refuse to cooperate in required or agreed upon services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1300, filed 12/20/02, effective 2/3/03.]

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WAC 388-891-1310 How does DVR determine that I have achieved an employment outcome? DVR determines that you have achieved an employment outcome and no longer need VR services if:

- (1) You received services under an IPE that helped you achieve the employment outcome on your employment plan;
- (2) Your job matches your strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice;
- (3) You have been working at the same job for at least ninety days to ensure the stability of your employment; and
- (4) You and a DVR counselor agree the job is satisfactory, that you are performing the job well, and that you no longer need VR services.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1310, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1320 Am I involved in the decision to close my case? Before closing your case, a DVR counselor gives you an opportunity to discuss the decision. DVR notifies you in writing, or another method of communication, if needed, about the reason your case is being closed and your rights if you disagree with the decision.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1320, filed 12/20/02, effective 2/3/03.]

WAC 388-891-1330 Under what conditions does DVR follow up with me after my case is closed? (1) DVR contacts you within twelve months after your case service record is closed and annually for two years after that to review whether anything has changed to affect your eligibility if:

- (a) DVR closes your case after determining you are ineligible because you are too severely disabled to achieve an employment outcome as a result of VR services;
- (b) You achieve a supported employment outcome and earn wages under section 14(c) of the Fair Labor Standards Act while working toward competitive employment;
- (c) You choose extended employment; or
- (d) You and your DVR counselor cannot find a source for extended services and/or cannot establish natural supports during the initial eighteen months of your individualized plan for supported employment.

(2) After DVR completes the reviews annually for two years, you or your representative may request additional annual reviews.

[Statutory Authority: RCW 74.29.020, 74.08.090, August 1998 amendments to the Rehabilitation Act of 1973, 34 C.F.R. Parts 361 and 363, chapters 74.29, 43.19 RCW, RCW 43.43.832, 4.24.550, 71.09.340, 9A.44.130, and chapter 26.44 RCW. 03-02-014, § 388-891-1330, filed 12/20/02, effective 2/3/03.]

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Chapter 388-892 WAC

PURCHASE OF SERVICES—SELECTION CRITERIA—DVR VOCATIONAL REHABILITATION SERVICE CONTRACTS

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VOCATIONAL REHABILITATION SERVICES DVR PURCHASES BY CONTRACT

WAC 388-892-0100 What vocational rehabilitation (VR) services does DVR purchase by contract? DVR purchases the following VR services by contract:

- (1) Vocational evaluation services,
- (2) Job placement/retention services,
- (3) Transitional employment services.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0100, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0110 What are vocational evaluation services? There are three types of vocational evaluation services:

- (1) "Brief" vocational assessment services are:

(a) Paper and pencil tests, such as psychometric testing, personality testing, preference and interest inventories that identify an individual's work interests and abilities; and

(b) Typically completed in one day or less.

(2) Comprehensive vocational evaluation services:

(a) Consist of tests and/or assessment methods designed to measure and document an individual's interests, values, work related-behaviors, aptitudes, skills, physical capacities, learning styles and training needs;

(b) Are performed using a variety of techniques, i.e., assessment of functional/occupational performance in real or simulated environments, work samples, psychometric testing, preference and interest inventories, personality testing, personal interviews and analysis of prior work experience and transferable skills;

(c) Identify at least three employment options that the individual could successfully perform either with or without training and long-term employment supports; and

(d) May be completed in three days or less but may vary, more or less, to accommodate the unique needs and abilities of individuals receiving this service.

(3) Situational assessment services are:

(a) Experiences in which individuals perform work in an actual paid employment setting or other realistic work setting to identify an individual's unique work interests and abilities;

(b) Conducted over a negotiated period of time depending on the individual's needs.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0110, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0120 What are job placement/retention services? (1) Job placement/retention services mean referral of an individual to a specific job that results in a competitive employment job placement, training activities that enable an individual to adequately perform essential job functions and provision of services after job placement and training to enable an individual to retain their job for a minimum of ninety calendar days.

(2) There are two types of job placement/retention services—"general" and "specialized."

(a) General job placement/retention services are provided for individuals who need job placement assistance without additional on-the-job supports.

Individuals requiring general job placement/retention services may include, but are not limited to, those who meet one or more of the following conditions:

(i) Graduated from high school or attained a GED;

(ii) Successfully completed some post high school training, such as vocational/technical school or college academic program;

(iii) Have a recent and/or stable work history;

(iv) Were employed at the time of application for DVR services; or

(v) Have a high level of gross motor skills and/or cognitive functioning.

(b) Specialized job placement/retention services are provided for individuals who, as determined by DVR, require a high level of support prior to or during the initial phases of job placement and/or additional supports after job placement to achieve satisfactory job performance and retain the job.

[Title 388 WAC—p. 1438]

Individuals requiring specialized job placement/retention services may include, but not limited to, those who meet one or more of the following conditions:

(i) Have received SSI/SSDI or other types of public assistance;

(ii) Have received special education services;

(iii) Did not graduate from high school or attain a GED;

(iv) Have little or no work history;

(v) Have not worked in the previous two years;

(vi) Experience significant cognitive or sensory impairments; or

(vii) Have a criminal history and/or are subject to a community protection order.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0120, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0130 What levels of support are available under specialized job placement/retention services? Specialized job placement/retention services include two levels - level 1 and level 2:

(1) Level 1 services are provided for individuals who, as determined by DVR, may require a high level of support prior to or during the initial phases of job placement but do not require ongoing supported employment services to maintain their job after DVR closes the case.

(2) Level 2 services are provided for individuals who, as determined by DVR, require ongoing supported employment services to maintain their job after DVR closes the case.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0130, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0140 What are transitional employment (TE) services? Transitional employment services:

(1) Meet the vocational rehabilitation needs of individuals with severe and persistent mental illness.

(2) Assess and build an individual's skills and abilities in a real work setting.

(3) Utilize the clubhouse programs model/international center for club house development (ICCD).

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0140, filed 9/12/03, effective 10/13/03.]

DVR VOCATIONAL REHABILITATION SERVICE CONTRACT PROCUREMENT

WAC 388-892-0200 How does DVR procure vocational evaluation, job placement/retention and transitional employment services? (1) DVR contracts with qualified service providers for the provision of vocational evaluation, job placement/retention and transitional employment services through a request for qualifications (RFQ) contract procurement process that is administered by DVR.

(2) A qualified provider is one that meets all DVR qualifications for a VR service contract as outlined in the RFQ.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0200, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0210 How does an RFQ work? (1) RFQs are issued on a periodic cycle to be determined by DVR, for example, every two years. The duration of the VR service contracts resulting from the RFQ will be announced

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in the RFQ. DVR reserves the right to extend the contracts by offering up to three one-year extensions.

(2) DVR may advertise the RFQ in a variety of ways, including but not limited to the DVR web site, newspapers, and notices sent to potentially interested contractors.

(3) The scope of work, fee to be paid, and contractor qualifications are defined in a separate RFQ and contract for each specific type of VR service:

- (a) Brief vocational assessment,
- (b) Comprehensive vocational evaluation,
- (c) Situational assessment,
- (d) General job placement/retention,
- (e) Specialized job placement/retention level 1,
- (f) Specialized job placement/retention level 2, and
- (g) Transitional employment.

(4) Service providers, that are interested in obtaining a VR service contract as outlined in the RFQ, are instructed to submit their qualifications.

(5) First time respondents that demonstrate full conformance to the uniform VR service contract qualifications, as outlined in this chapter, may be granted an initial VR service contract.

(6) DVR may limit the number of VR service contracts it issues in a service delivery area as a result of an RFQ.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0210, filed 9/12/03, effective 10/13/03.]

INITIAL DVR VOCATIONAL REHABILITATION SERVICE CONTRACTS

WAC 388-892-0300 What are the uniform qualifications for an initial VR service contract? A VR service contractor must meet all of the following uniform qualifications, as specifically detailed in the DVR RFQ for VR service contracts, to obtain any/all specific types of initial VR service contracts. Such qualifications shall include but not be limited to, qualifications regarding conformance to:

- (1) Federal, state and local laws and DSHS regulations and policies;
- (2) Accessibility;
- (3) Safety and health;
- (4) Liability insurance coverage;
- (5) Having a system in place to report the effectiveness and efficiency of the provider's DVR services;
- (6) Having a system in place to gather and report DVR customer satisfaction;
- (7) DVR code of ethics and standards of practice;
- (8) Having a complaint and dispute resolution process in place for DVR customers;
- (9) Having current background checks in place for personnel serving DVR customers.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0300, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0310 How long does an initial VR service contract last? An initial VR service contract may be granted for a period of up to two years or for a duration as announced in the RFQ.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0310, filed 9/12/03, effective 10/13/03.]

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WAC 388-892-0320 Can an initial VR service contract be granted between RFQs? DVR may add VR service contractors between RFQs if DVR determines the contract is needed and the contractor meets all uniform VR service contract qualifications outlined in this chapter.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0320, filed 9/12/03, effective 10/13/03.]

SUBSEQUENT DVR VOCATIONAL REHABILITATION SERVICE CONTRACTS

WAC 388-892-0400 How does a contractor receive a subsequent VR service contract after completing their initial VR service contract? (1) To receive subsequent VR service contracts, a contractor must respond to each RFQ by submitting a proposal showing that they:

- (a) Continue to meet all uniform VR service contract qualifications;
- (b) Have met DVR's performance standards established in the prior VR service contract; and
- (c) Meet the additional qualifications for each VR service to be offered.

(2) Contractors that have been granted an initial VR service contract between RFQs have two years from the effective date of their initial VR service contract to meet the additional qualifications outlined in this chapter. If the contractor fails to provide documentation of conformance to the additional qualifications within two years from the effective date of the initial contract, DVR may terminate the existing VR service contract with ten days notice to the contractor.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0400, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0410 What are the additional qualifications for VR service contracts? (1) In addition to the uniform VR service contract qualifications, additional contractor qualifications apply to each specific type of VR service contract.

(2) A separate RFQ is published for each specific type of VR service contract that outlines the additional contractor qualifications that are pertinent to that service.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0410, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0420 What are the additional qualifications for vocational evaluation services contracts? (1) Individuals or organizations providing brief vocational assessment and/or comprehensive vocational evaluation services must maintain conformance to all uniform VR service contract qualifications and be:

- (a) Qualified as a certified vocational evaluator (CVE) by the commission on certification of work adjustment and vocational evaluation specialists (CCWAVES); or
- (b) Accredited in comprehensive vocational evaluation services by CARF - the rehabilitation accreditation commission; or

(c) Hold a current certification as a certified rehabilitation counselor (CRC) by the commission on rehabilitation counselor certification (CRCC) and have successfully completed three graduate level courses, from an accredited college or university, in vocational evaluation; standardized

assessment; psychological testing and measurement; or any combination of the above mentioned coursework.

(2) Individuals or organizations providing situational assessment services must maintain conformance to all uniform VR service contract qualifications, and be:

(a) Qualified as a certified vocational evaluator (CVE) by the commission on certification of work adjustment and vocational evaluation specialists (CCWAVES); or

(b) Accredited in employment planning services by CARF - the rehabilitation accreditation commission; or

(c) Licensed in employment services by the department of social and health services (DSHS)/mental health division (MHD); or

(d) Certified by the International Center for Clubhouse Development (ICCD); or

(e) Hold a current certification as a certified rehabilitation counselor (CRC) by the commission on rehabilitation counselor certification (CRCC) and have successfully completed three graduate level courses, from an accredited college or university, in vocational evaluation; standardized assessment; psychological testing and measurement; or any combination of the above mentioned coursework.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0420, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0430 What are the additional qualifications for job placement/retention services contracts?

(1) Organizations that provide any job placement/retention service must maintain conformance to all uniform VR service contract qualifications.

(2) There are no additional qualifications for organizations that provide general job placement/retention services.

(3) Organizations that provide levels 1 or 2 specialized job placement/retention services must also be:

(a) Accredited in community employment services by CARF - the rehabilitation accreditation commission; or

(b) Licensed in employment services by the department of social and health services (DSHS)/mental health division (MHD); or

(c) Certified by the International Center for Clubhouse Development (ICCD).

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0430, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0440 What are the additional qualifications for a transitional employment services contract?

Organizations that provide transitional employment services contracts must:

(1) Maintain conformance to all uniform VR service contract qualifications; and

(2) Be certified by the International Center for Clubhouse Development (ICCD).

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0440, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0450 How long does a subsequent VR service contract last? All DVR VR service contracts may be granted for a period of up to two years or for a duration as announced in the RFQ.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0450, filed 9/12/03, effective 10/13/03.]

[Title 388 WAC—p. 1440]

DVR VOCATIONAL REHABILITATION SERVICE CONTRACTS—GENERAL OPERATIONS

WAC 388-892-0500 What is DVR's payment system for VR service contracts? DVR establishes fixed fees for VR contract services as follows:

(1) DVR identifies geographic VR service delivery areas based on economic cost of living data.

(2) Every two years or on an interval as announced in the contract RFQ, with input received from the service providers, DVR will establish and publish a scheduled of fixed payment fee for each contracted VR service.

(3) All VR service contractors, within each geographic VR service delivery area, are paid the fixed payment fee for each contracted VR service.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0500, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0510 Can VR service contracts be denied or terminated? (1) DVR may decide not to accept a bid or an offer by a person or organization seeking to provide contracted VR services if the bid or offer does not meet minimum RFQ requirements. The DSHS bid protest procedures set forth in the request for qualifications shall be the exclusive administrative remedy for refusal to accept a bid or offer.

(2) VR service contracts may be terminated for cause or convenience at any time by DVR or the contractor in accordance with the terms of the contract. The contractor's administrative remedies shall be limited to those specified in the contract.

(3) Additionally, DVR may terminate all DVR individual case service delivery plans that are open with the contractor at the time their VR service contract is terminated. Termination provisions are outlined in the VR service contracts.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0510, filed 9/12/03, effective 10/13/03.]

WAC 388-892-0520 What exceptions does DVR have to contract for vocational evaluation, job placement/retention and/or transitional employment services outside of these rules? DVR may define and contract for the purchase of any vocational rehabilitation services outside of these rules if necessary to meet the vocational rehabilitation needs of any individual or group of DVR customers.

[Statutory Authority: RCW 43.20A.310(2), 74.29.020(3) and 74.29.080(8). 03-19-075, § 388-892-0520, filed 9/12/03, effective 10/13/03.]